Date	**11/06/2026**
Time	**09:30 - 12:30**
Location	**Microsoft Teams Meeting; HDD Picton - Tresaith**

Quality, Safety & Experience Committee

HDD_Quality, Safety & Experience Committee

NHS Wales

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09:30, 10 Mins

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1 - Governance

1.1 **09:40,**

1.1 - Welcome and Apologies

Eleanor Marks (Hywel Dda UHB - HDUHB Vice Chair)

1.2

1.2 - Declarations of Interest

HDdUHB Register of Board Members Interests 2026-27

1.3

1.3 - Minutes from the Previous Meeting and Table of Actions

Eleanor Marks (Hywel Dda UHB - HDUHB Vice Chair)

Attachments

2026-04-09 - Quality, Safety Experience Committee - Minutes.pdf

TOA QSEC.pdf

Draft Minutes of the Quality, Safety & Experience Committee

Date of Meeting:	**09:30, Thursday 09 April 2026**
Venue:	**MS Teams; Picton Terrace - Dolau Cothi Meeting Room**

Present:	Eleanor Marks (Chair of the Committee and Vice Chair of the Health Board) Chantal Patel (Independent Member) Neil Prior (Independent Member)
In Attendance:	Andrew Carruthers (Chief Operating Officer) Ardiana Gjini (Executive Director of Public Health) Caroline Burgin (Patient Safety and Assurance Manager) Cathie Steele (Interim Assistant Director of Nursing Assurance and Safeguarding) Craig Baker (Cellular Pathology Services Manager) (Part) Jo Bradburn (Deputy Director of Allied Health Professions) (Part) Dana Scott (Director of Midwifery & Professional Governance for Women & Children) (Part) James Severs (Executive Director of Allied Health Professions and Health Science) Joanne Wilson (Director of Corporate Governance/Board Secretary) Louise O'Connor (Assistant Director of Legal and Patient Experience) Mark Henwood (Executive Medical Director) Olwen Morgan (Assistant Director of Nursing) (Part) Sharon Daniel (Executive Director of Nursing, Quality & Patient Experience) Nadine Gould (Deputy Director of Nursing, Quality & Patient Experience) Sara Quarrie, (Clinical Care Group Service Director Planned & Specialist Care) (Part) Katie Lewis (Committee Services Officer)
Apologies:	Michael Imperato (Independent Board Member) Rhodri Evans (Independent Board Member)

Minutes Ref.	Item	Action
QSEC 26 (17)	**Welcome** The Chair welcomed everyone to the meeting.	
QSEC 26 (18)	**Declarations of Interest** There were no declarations of interest.	
QSEC 26 (19)	**Minutes from the Previous Meeting and Table of Actions from the meeting held on 12 February 2026**	

There were no amendments or changes proposed. The table of actions was reviewed, and it was noted that all actions were marked as complete.

Decision: The minutes from the Quality, Safety and Experience Committee (QSEC) held on 12 February were **APPROVED** as an accurate record.

QSEC 26 (20) **QSEC Annual Report 2025/26**

The Chair introduced the QSEC Annual Report for 2025/26, noting that the report required approval ahead of submission to Board on 25 June 2026. The Chair took the opportunity to thank everyone who had contributed to QSEC over the past year, highlighting the contributions of Mrs Anna Lewis, the previous Chair, Mrs Sharon Daniel Lead Executive for the Committee, The Executive Team, and the Independent Members. The Chair expressed appreciation for the time and commitment by all those who have supported the work of the Committee over the past year.

Mrs Daniel noted the comprehensive nature of the report and its honest reflection of the challenges, strengths, openness and transparency of the Committee.

Mrs Chantal Patel raised two points: questioning where the challenges with 'care in the corridor' are captured within the report and requested clarity on the process for dissemination of lessons learned. It was noted that these matters were being addressed through the Learning Framework and Listening and Learning Sub Committee, which provides routine updates to QSEC, alongside ongoing work to strengthen the dissemination of learning and thematic analysis. Ms Cathie Steele also advised that she and Mrs Louise O'Connor had refreshed the Hywel Dda online Learning Library to support the sharing of case learning through 7-minute briefings. In response to a query from Mrs Patel regarding how patients who had raised concerns are informed of resulting improvements, Mrs O'Connor confirmed that improvement actions are set out in correspondence to patients at the conclusion of the complaints process.

Decision: The Committee **APPROVED** the QSEC Annual Report 2025/26.

QSEC 26 (21) **Chair's Action: QSEC Terms of Reference**

Mrs Eleanor Marks presented the recently revised Terms of Reference which were approved at Board on 26 March 2026. Mrs Daniel highlighted the addition of the Deputy Director of Nursing Quality, Patient Experience to the Membership.

Decision: The Committee **APPROVED** the QSEC Terms of Reference.

QSEC 26 (22) **Assurance and Risk Report**

Mrs Joanne Wilson presented the Corporate Risk Report and advised that 10 of the 24 risks on the Corporate Risk Register fall within the remit of the QSEC. Members were advised that several of these risks would be considered further through the Allied Health Professional (AHP) Risk deep dive which is the next item on the agenda, including an update on the risks relating to ultrasound services.

Mrs Wilson noted that all risks included within the report had been reviewed and updated since the previous meeting, with risk scores either increasing or decreasing accordingly.

An update on Welsh Health Circulars (WHCs) was also provided, with Mrs Wilson highlighting that a number are now overdue without sufficient justification. Mr Andrew Carruthers explained that non-compliance with some WHCs was often attributable to financial or workforce constraints.

Mr Neil Prior expressed concern regarding the overall number of risks across the organisation, noting that there are 24 corporate risks, approximately half of which are overseen by this Committee. He further highlighted the significant number of operational risks, estimated at approximately 600–700, which presents challenges for effective risk management at an operational level. He acknowledged that this reflects the scale and complexity of the organisation, including staffing levels and the number of sites.

Mrs Daniel emphasised the need for the Committee to move towards a more system-level approach to risk oversight, supported by analytical and aggregated assurance, rather than focusing primarily on individual risks. She highlighted the importance of explicitly identifying high-impact, long-standing risks and clarifying where risk tolerance is being applied. Mrs Daniel noted that risk tolerance is a Board-level matter and referenced recent Board discussions on risk appetite. She suggested that future reports should clearly articulate the Board's agreed risk tolerance to support Committee scrutiny.

Mr Carruthers advised that the organisation's planning process for the year had adopted a risk-based approach, which had naturally resulted in an increase in operational risks recorded on the Risk Register. He confirmed that the risks presented to the Committee represent the highest-level risks, while operational risks are appropriately managed by the Executive Team.

Mrs Joanne Wilson queried whether it would be beneficial to deliver a risk management refresher session for Independent Members following year end. This could include an overview of the risk management framework, the distinction between corporate and operational risks, and the organisations risk appetite. She also invited reflection from Independent Members on whether risk is being managed as effectively as possible by individual risk owners within the current operational environment. Mrs Marks welcomed this suggestion and agreed that a refresher

JW

session would support a shared understanding of risk management across the Committee.

Mrs Wilson added that a number of the Health Board's risks are, in practice, ongoing challenges. She suggested that the proposed risk session could include a detailed walkthrough of a single risk, jointly led by an Executive Lead, to provide practical context. It was agreed that this could be considered following completion of year-end processes. **JW**

Mr Mark Henwood observed that the organisation is now discussing and declaring risks more openly and transparently. He noted that a number of the risks had historically existed, which are now being clearly articulated. He highlighted the inherently high-risk nature of healthcare delivery, given longstanding resource, workforce, and infrastructure constraints, and agreed that while this approach does not provide full assurance, it does improve Board visibility and understanding of risks.

Mrs Marks welcomed the completeness of the risk reporting and the concerns raised. She acknowledged that while the Committee cannot take full assurance due to the scale and complexity of the risks, assurance can be taken that appropriate processes are in place to monitor them. On that basis, the Committee agreed that assurance was gained in respect of the processes for risk management.

In relation to WHC's, the Committee sought clarity on those with 'unknown' status updates and tasked the executive leads to update progress and ensure that there is an articulated Risk on the Datix Risk Register that aligns with the overdue WHC's. **Executive Leads**

Mrs Marks confirmed that, subject to improved reporting and continued engagement with Welsh Government, assurance was received and Members agreed with this position.

Decision: The Committee:

Risk Management

- **RECEIVED ASSURANCE** that identified controls are in place and working effectively;

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

Welsh Health Circulars

- **RECEIVED PARTIAL ASSURANCE**, from the lead Executive Director or Supporting Officer that the management of WHCs within their area of responsibility, particularly in respect of understanding when the WHC will

be delivered, any barriers to delivery, impacts of non/late delivery and assurance that the risks associated with these will be updated accordingly.

Ministerial Directions (MD)

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

QSEC 26 (22) **Allied Health Professional Risks Deep Dive**

Ms Angela Bell, Ms Sara Quarrie and Ms Dana Scott joined the meeting.

Ms Angela Bell presented a detailed analysis of the Allied Health Professional Risks, focusing on the ultrasound diagnostic risks. This score reflects delays in diagnostics that may impact the consistency of care delivery without of direct patient harm. The matrix used to assess risks was discussed, emphasising the importance of evidence from each risk lead to justify risk scores. Concerns were raised about achieving Welsh maternity screening targets and the long wait times for non-obstetric ultrasound services. Potential actions and mitigations were discussed, with an emphasis on the importance of ongoing monitoring. The Clinical Care Group (CCG) prioritises addressing and mitigating identified risks which influences the annual planning process. There are currently 65 risks scoring 15 or above within the CCG, prioritised for action in the forthcoming year.

Mr Prior sought clarification on the implications of a risk score of 25 (extreme). Ms Bell explained that the extreme risk score reflects challenges in consistently delivering an acceptable quality of service and does not in itself indicate direct patient harm. Following Executive discussions, Mrs Daniel suggested separating the risk could improve transparency and support more manageable mitigating actions, particularly by differentiating between obstetric and non-obstetric ultrasound service. **AB**

Ms Dana Scott provided further insights into specific challenges, including missed foetal anomalies and advised that the team is working on a demand capacity review to address the shortage of sonographers, focusing on training midwives within one year compared to the longer radiography route. The annual planning process for maternity services includes a plan to secure a pipeline of training to meet national standards for surveillance scans.

The Committee appreciated the detailed update and recognised the challenges in managing these risks. There was a consensus on the need for further discussions at executive level to explore potential mitigations and ensure the Committee's understanding of the risks and actions being taken.

Ms Angela Bell and Ms Sara Quarrie left the meeting.

Decision: The Committee **RECEIVED ASSURANCE** that:

- the management of risks within the CCG are safe and sustainable,
- appropriate actions are in place to further manage and mitigate the risk, addressing any gaps in control and assurances.

QSEC 26 (23) **A Path to Safer Beginnings Update Report**

Ms Scott presented the benchmarking report for the 'Path to Safer Beginnings' initiative, which assessed neonatal and maternity services across Wales. The report indicated that the team performed well, particularly in governance and psychological safety. The initiative aligns neonatal and maternity services into one perinatal team, aiming for a unified approach to care and training.

The team has developed a transformation plan to address areas where they are not fully compliant with the national standards, with a goal to deliver the perinatal one team workforce strategy over five years. Ms Scott highlighted the importance of consistent language in national documents to ensure clear benchmarks for quality which has been fed back.

The strategy includes extensive stakeholder engagement and focuses on public health principles, particularly addressing social deprivation. The team is also investing in perinatal mental health services, recognising the need for generational change in public health.

Questions from the Committee centred on the expected outcomes of the strategy, particularly in terms of patient experience and measurable improvements. Ms Scott explained that the strategy aims to provide more individualised care, with initiatives such as interactive apps for mood assessments, two hour 1-2-1 appointments with midwives, and the use of continuity and centring in pregnancy models to provide comprehensive support for women.

The Committee appreciated the detailed explanation and recognised the importance of the strategy in improving perinatal care. There was a consensus on the need for continuous monitoring and reporting on the outcomes to ensure the strategy's effectiveness.

Mr Prior noted the significant improvements in Psychological Safety within the team and enquired whether there are opportunities to spread and scale the learning arising from this culture shift. Mrs Daniel and Ms Scott undertook to feed this back and consider, subject to capacity, whether leads would be able to facilitate the sharing of learning from the cultural improvements. **DS/ SD**

Decision: The Committee:

- **RECEIVED ASSURANCE** that the governance arrangements to support quality & safety of maternity services are robust, under regular review and focused on continuous improvement
- **NOTED** the Health Board's strong performance relative to national benchmarking.
- **ACKNOWLEDGED** the identified risks outlined in the paper are consistent with national system pressures & note the mitigation and controls currently being progressed.

QSEC 26 (24) **Review of Revised Quality and Safety Governance Arrangements**

Mrs Wilson provided an overview of the review of the revised quality and safety governance arrangements, which was initiated six months after the Operational Quality, Safety and Experience Sub Committee was disestablished. The review aimed to assess the effectiveness of the new arrangements, including the introduction of Quality, Safety Intelligence Group, the Clinical Care Group structure, and other governance elements. A special thank you was noted for Ms Alison Gittins for preparing the report and Ms Cathie Steele for her critical role in developing the new structures.

The review highlighted several areas for improvement, including the tracking of actions, a lack of up-to-date terms of reference, 'Alert/ Advise/ Assure' reporting inconsistencies, quorum, and administration support for the Quality, Safety Intelligence Group. It was noted that while improvements have been made, there is still a need to strengthen the governance underpinning these arrangements.

The Committee acknowledged the comprehensive nature of the review and the need for continuous improvement in governance arrangements to ensure effective oversight and management of quality and safety. Mr Carruthers and Mrs Daniel were invited to provide further insights into the operational aspects and the steps being undertaken to address the identified issues.

The Committee discussed the transition from the previous to the new operational governance arrangements which was agreed has been positive overall. However, Ms Marks noted that the report lacked clarity in terms of next steps and Mr Prior commented that the content did not sufficiently convey the impetus for driving the proposed improvements.

In response to concern raised from Ms Marks in terms of accountability, the Executive function and an update on the arrangements, Mr Carruthers highlighted that the Executive Team had only discussed the next steps for governance arrangements at the team meeting the previous day. The report had been prepared at a point in time where decisions had not been agreed.

Mr Carruthers confirmed that a detailed plan is scheduled for the Board Seminar meeting on 23 April 2026 and emphasised the need for clear accountability and effective escalation processes.

Mr Carruthers also referred to the cultural shift required within the organisation to ensure that decisions are made at the appropriate level. The importance of having clear terms of reference for all groups and ensuring that these are reviewed annually and adhered to was also highlighted.

The Committee agreed that this should be an 'advise' item for the Board at this stage and would be explored further at Board Seminar on 23 April 2026.

Decision: The Committee **NOTED** that that while the revised quality and safety governance arrangements introduced in September 2025 represent an improvement over the arrangements formerly in place, there is further work required to fully implement and embed the previously agreed actions which will be addressed through the Action Plan.

QSEC 26 (25) **Quality Assurance Report**

Ms Cathie Steele introduced the Quality Assurance Report and highlighted the following key points:

- A Never Event involving an Nasogastic (NG) tube and a Regulation 28 has been issued following a fatality.
- An update on infection, prevention control and the actions being taken to address lessons learned.
- Mrs Louise O'Connor introduced the new 'Listening to People' initiative, which aims to transfer the focus from process-driven complaint handling to a more compassionate and timely approach to addressing concerns and learning from them. The 'Listening to People' initiative, which was implemented on 1 April 2026 aims to treat complaints and incidents as core sources of quality, safety, and learning intelligence. The focus is on early, compassionate listening and timely response to concerns. Early feedback from families has been positive.
- Mrs O'Connor highlighted the operational pressures and the need to ensure capacity to engage in early resolution processes consistently across the organisation. A more detailed report will be prepared for the next meeting.

Decision: The Committee:

- **RECEIVED 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 • Duty of Candour • Patient Experience • Complaints management • Inquests and Regulation 28 • Infection prevention and control • Inspections and peer

reviews including activity of Healthcare Inspectorate Wales (HIW).

- **NOTED** the publication of the HIW: Strategic Plan for 2026-2030 and the NHS Wales Performance and Improvement: National Patient Safety Plan for NHS Wales for 2026-2031

QSEC 26 (26) **Listening and Learning Sub Committee (LLSC) Update Report**

Mrs O'Connor presented the LLSC update report which provided a focus on ophthalmology patient backlogs, risks to sight, facility challenges, and the need for operational solutions and impact assessment.

The Committee noted that the mitigations would continue to be monitored through the LLSC and that QSEC has scheduled a deep dive review into Ophthalmology in October 2026. **AC**

Decision: The Committee:

- **RESPONDED** to the items that the Sub-Committee is alerting them to.
- **NOTED** the items that the Sub-Committee is advising them of
- **RECEIVED ASSURANCE** from the items that the Sub-Committee is providing assurance on

QSEC 26 (27) **Infection Prevention Control Assurance Report**

Ms Steele presented the Infection Prevention Control Assurance Report. The report, now aligned with the Quality Management System (QMS) style, includes revised targeted intervention arrangements issued by the Welsh Government in January 2026.

The escalation to level 4 was discussed, highlighting the need to focus on reducing infections by 25% as part of the de-escalation criteria. Ms Steele noted that infection figures can be challenging to shift due to low numbers, which can result in disproportionate fluctuations from relatively small changes. She also referenced three new statements and standards received for implementation and assessment.

The Committee acknowledged the improvement in presenting evidence-based reports and the importance of embedding QMS within the organisation. The Committee agreed the report would be an 'assure' item for Board.

Decision: The Committee **RECEIVED ASSURANCE** on the Health Board's current infection prevention and control arrangements, governance structures and improvement activity.

QSEC 26 (28) **Fuller Inquiry Progress of Recommendations**

Mr Craig Baker joined the meeting.

Mr James Severs presented the progress on the Fuller Inquiry recommendations in his capacity as the corporate licence holder for the Human Tissue Authority. He reported that the Team has

worked diligently over the past 12 to 18 months on the 75 recommendations, with 21 applicable to hospitals. The majority of these actions have been completed, and the Committee welcomed the progress.

The Committee agreed this would be an 'assure' item for Board and commended the Team for their efforts and the caring environment they provide for families.

Mr Baker left the meeting.

Decision: The Committee **RECEIVED ASSURANCE** that Hywel Dda University Health Board has proactively addressed recommendations from both Phase 1 and 2 reports.

QSEC 26 (29) **Quality Improvement Framework**

Ms Marilize Preeze joined the meeting.

Ms Preeze presented the Quality Improvement (QI) Framework, outlining the strategic intent for the next three years, focusing on building capacity, capability, and delivering impact. The framework identifies six key areas for Quality Improvement (QI) and aims to embed QI within the QMS and strategic objectives. The Committee discussed the importance of measuring improvement with an emphasis on clearly defined outcomes. and Ms Patel emphasised the need for outcomes to be clearly articulated. The Committee acknowledged the progress made in embedding QI and noted the need for continuous improvement. **MP**

The Committee agreed this would be an 'assure' item for Board and encouraged the team to proceed with their plans once approved by Board.

Ms Preeze left the meeting.

Decision: The Committee **RECEIVED ASSURANCE** from the Quality Improvement Strategic Framework and supported submission to Board for final approval

QSEC 26 (30) **First Contact Physiotherapist Update Report**

Ms Jo Bradburn joined the meeting

Ms Jo Bradburn provided an update on the First Contact Physiotherapist incident raised in April 2023, detailing the governance established through the Incident Control Group, identified learning, and actions taken in response. The investigation affected nearly 4,000 patients and spanned multiple changes in senior leadership. Ms Bradburn highlighted the importance of sharing lessons learned across the Health Board and ensuring consistent models of service delivery.

The Committee discussed the challenges of inconsistent appointment / booking systems due to practices being managed through external General Medical Practices and the need for

consistent audit processes. Ms Marks acknowledged the increased number of incidents related to record keeping as a positive sign of improved auditing. The Committee agreed this would be an assure item for Board and commended the team for their efforts.

Ms Jo Bradburn left the meeting.

Decision: The Committee:

- **RECEIVED ASSURANCE** about the process followed to investigate this incident.
- **RECEIVED ASSURANCE** that the action plan responds to the learning identified in the report.
- **ENDORSED** the recommendation that the oversight of the action plan is delegated to the relevant Executive lead
- **DELEGATED** oversight of the completion of the action plan to Listening and Learning Sub-Committee for formal reporting to the Sub-Committee in six months' time

QSEC 26 (31) **Women's Health Hub**

Ms Scott presented the Women's Health Hub report, highlighting the completion of year one as per the specification. The hub has increased access to services for women and positive engagement with Primary Care has taken place. Ms Scott outlined plans to build a five-tier system and spread the 1.5 model across three counties. The focus for year two includes embedding skills and expanding services.

The Committee acknowledged the positive progress and appreciated the detailed report. They had no further questions and took assurance from the update.

Ms Dana Scott left the meeting.

Decision: The Committee **RECEIVED ASSURANCE** that:

- Year 1 delivery has achieved measurable progress that the programme is improving access, reducing escalation, and being delivered safely.
- Year 2 governance will be compliant with Welsh Government requirements.

QSEC 26 (32) **Targeted Intervention Progress Report**

Mrs Daniel presented the Targeted Intervention Progress Report, thanking Mr Shaun Ayres for preparing the report and providing a final escalation update against the original criteria under the quality, safety, and experience domains. The report included data on incidents, complaints, and infections.

Mrs Daniel advised that the Welsh Government issued a revised escalation framework in February 2026, and this would be the last report in its current format. Mrs Daniel agreed to work with Mr **SD**

Ayres to consider new reporting routes for QSEC. The Committee took assurance from the update.

Decision: The Committee **NOTED** this is the final report against the original targeted intervention criteria for this domain, following the revised escalation framework issued by Welsh Government on 20 February 2026.

Clinical Care Group Update Reports

QSEC 26 (33) **Planned and Specialist Care**

Ms Paula Goode and Ms Olwen Morgan joined the meeting

Ms Paula Goode introduced the Planned and Specialist Care Update report and focused on cancer care, highlighting significant pathway reviews, backlog reduction, and targeted work in radiology and pathology. Ms Goode raised concerns about the long waiting times for robotic prostatectomy, which are referred to external providers, and discussed potential outsourcing solutions. The psychological impact on patients was emphasised and the importance of regular waiting list audits to prioritise patients effectively.

Ms Olwen highlighted the positive progress in governance, with the escalation level now at 2, and the productive engagement in meetings. She noted ongoing work in risks, audits, and Welsh Health Circulars. The Committee acknowledged the progress and took assurance from the update.

Ms Goode and Ms Morgan left the meeting.

Decision: The Committee **RECEIVED ASSURANCE** on the quality governance arrangements in place within the Planned Services and Specialist Care Clinical Care Group in relation to quality, safety and patient experience.

QSEC 26 (36) **QSEC Work Plan 2026/27**

The QSEC work plan for 2026/27 was discussed, with a commitment to add points raised during the meeting. It was noted that the work plan contains a substantial amount of content, and there may be a need for an extra Committee session to conduct deep dives and ensure quality information is obtained.

QSEC 26 (37) **Reminder: Clinical Audit Programme 2026/27**

Mr Henwood shared a gentle reminder to Members regarding the clinical audit programme for 2026/27, highlighting the importance of embedding clinical audit within the organisation and seeking suggestions for audits from Committee Members. To date, no

responses have been received, and a gentle reminder was issued to support the clinical audit team develop the programme.

Date of Next Meeting: 11 June 2026

QUALITY, SAFETY AND EXPERIENCE COMMITTEE (QSEC)/ PWYLLGOR ANSAWDD, DIOGELWCH A PHROFIAD
09/04/2026
TABLE OF ACTIONS/TABL GWEITHREDOEDD

Key: AC-Andrew Carruthers; DS-David Sheppard; JW-Joanne Wilson; KL-Katie Lewis; LOC-Louise O'Connor; SD-Sharon Daniel; SQ-Sara Quarrie

MEETING DATE	MINUTE REF	ACTION	LEAD	TIME SCALE	PROGRESS
09/04/2026	QSEC (26) 22	Allied Health Professional Deep Dive • To split Risk 797 to differentiate between Obsetric and non obstetric ultrasound risks.	SQ	11/06/2026	Complete
09/04/2026	QSEC (26) 22	Risk and Assurance Report • To schedule a risk refresher session for Independent Members	JW	11/06/2026	Complete Complete - This session has been arranged for 13 August 2026.
09/04/2026	QSEC (26) 22	Risk and Assurance Report • To provide a status update on the overdue Welsh Health Circulars and ensure there is a risk aligned on the Datix Risk Register	SD, AC	11/08/2026	In progress This will be reported in August report
09/04/2026	QSEC (26) 23	A Path to Safer Beginnings • To consider opportunities to share learning from the changes in culture and psychological safety in Maternity Services across the organisation.	DS	00/01/1900	Complete Discussion taken place between the Director of Midwifery and Quality Assurance Team to share the learning via the suite of online investigation and concerns management training tools.
09/04/2026	QSEC (26) 26	Listening and Learning Sub Committee Update Report • To schedule a deep dive in to Ophthalmology Services for QSEC in October 2026.	KL	09/04/2026	Complete
09/04/2026	QSEC (26) 26	Listening and Learning Sub Committee Update Report • To schedule a report on Listening to People Regulations for the next QSEC meeting.	LOC	00/01/1900	Complete

MEETING DATE	MINUTE REF	ACTION	LEAD	TIME SCALE	PROGRESS
09/10/2025	QSEC 25 (62)	Epilepsy in Learning Disabilities Public Interest Report • To forward plan an update on the actions undertaken in response to the Public Interest report relating to Epilepsy Services for patients with a Learning Disability.	AC	12/02/2026	Complete There is a five point plan in the Public Interest Report that is in progress. All actions require completion in November 2025 or January 2026 and all are on track for completion. The plan is managed by the Ombudsman Case Manager, Learning Disability Service and the LD Epilepsy Task and Finish Group in respect to responsibility to complete the required actions.
09/10/2025	QSEC 25 (65)	Temporary Service Changes in Ceredigion Community Mental Health Team • To explore in more detail the localised increase in hospital admissions that has been observed and to also clarify local GP feedback following the temporary service change ahead of Board in November 2025.	AC	26/11/2025	Complete Planned attendance to North and South Collaborative meetings in November North Meeting on 20th November and South Ceredigion on 26th November to engage with GPs within the practices to obtain local GP feedback

2

15 Mins

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2 - Risk

2.1

2.1 - Risk and Assurance Report- Executive Leads

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

Attachments

QSEC PRR ORR AI Report - June 2026 -.pptx

Appendix 1 Audut Inspection Overdue Recommendations.pdf

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

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

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

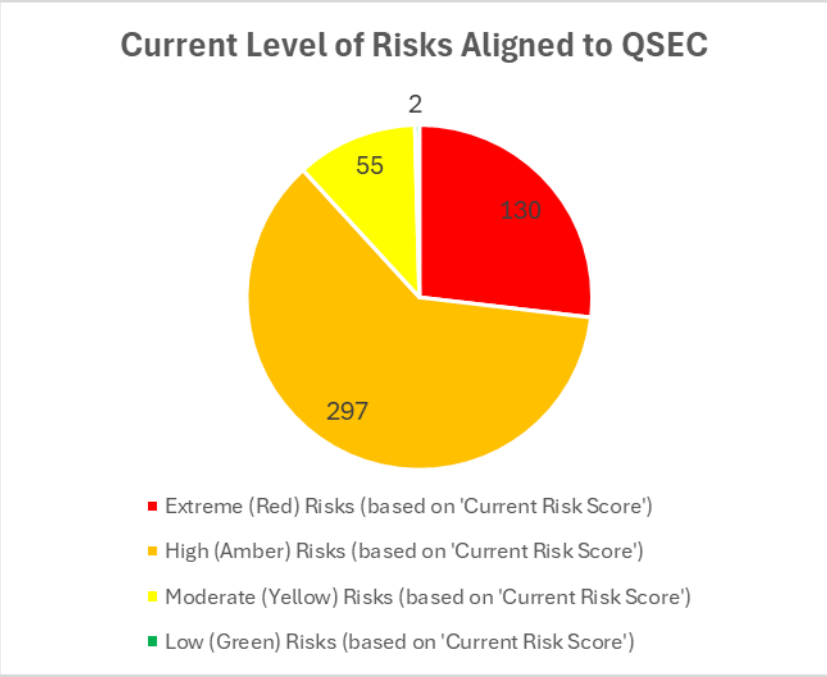
Operational Risks assigned to QSEC

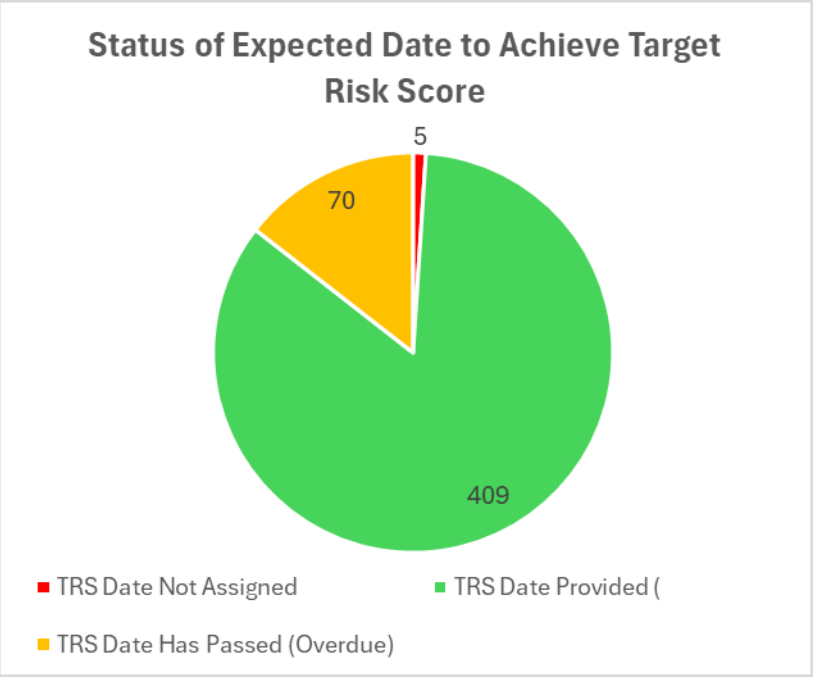
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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?).

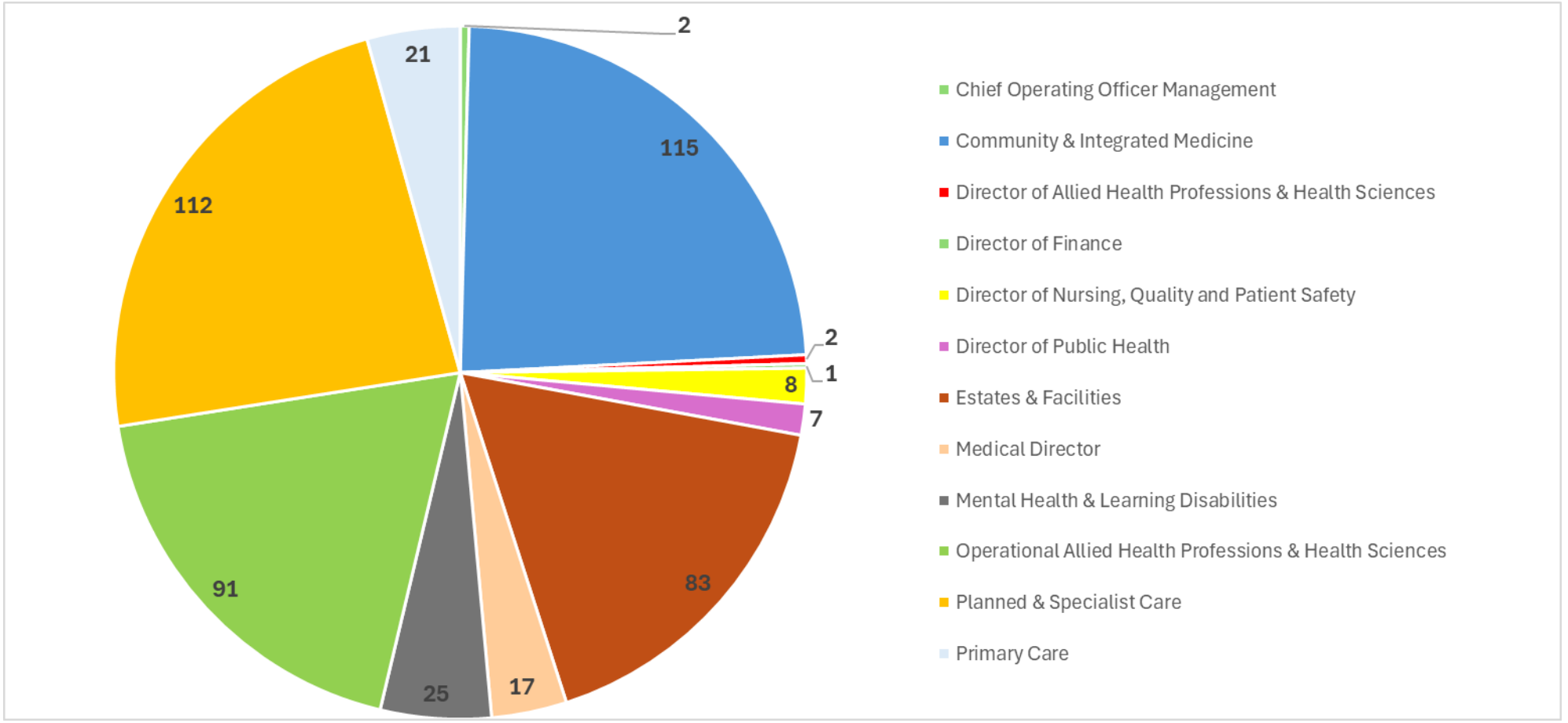




Operational Risks assigned to QSEC

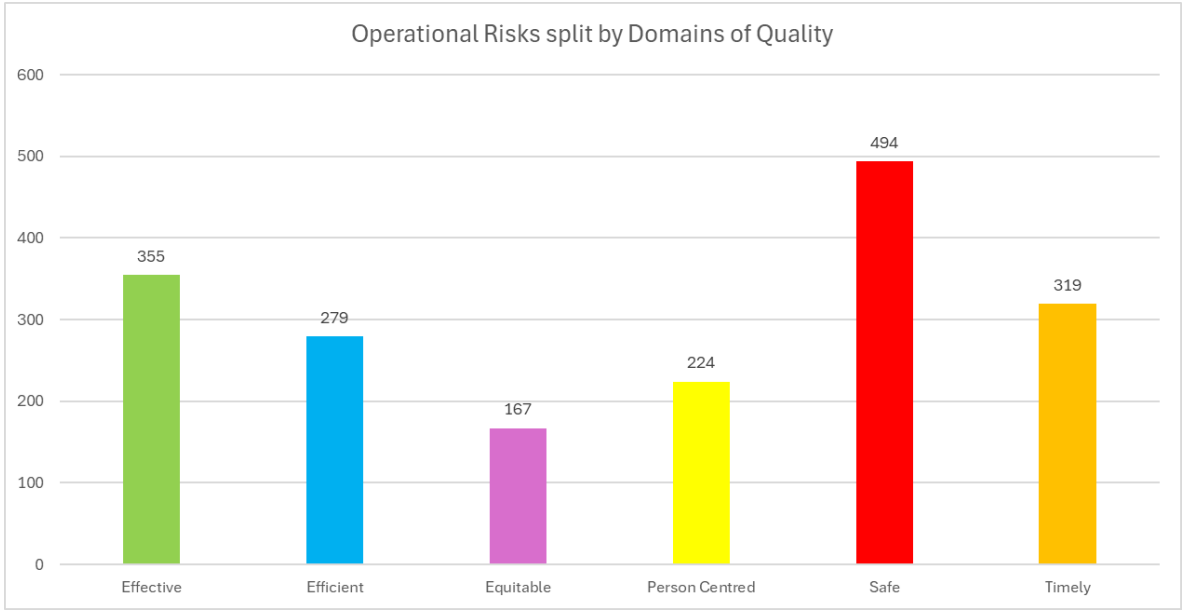
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risks Split Out By Clinical Care Group/Executive Function



Domains of Quality

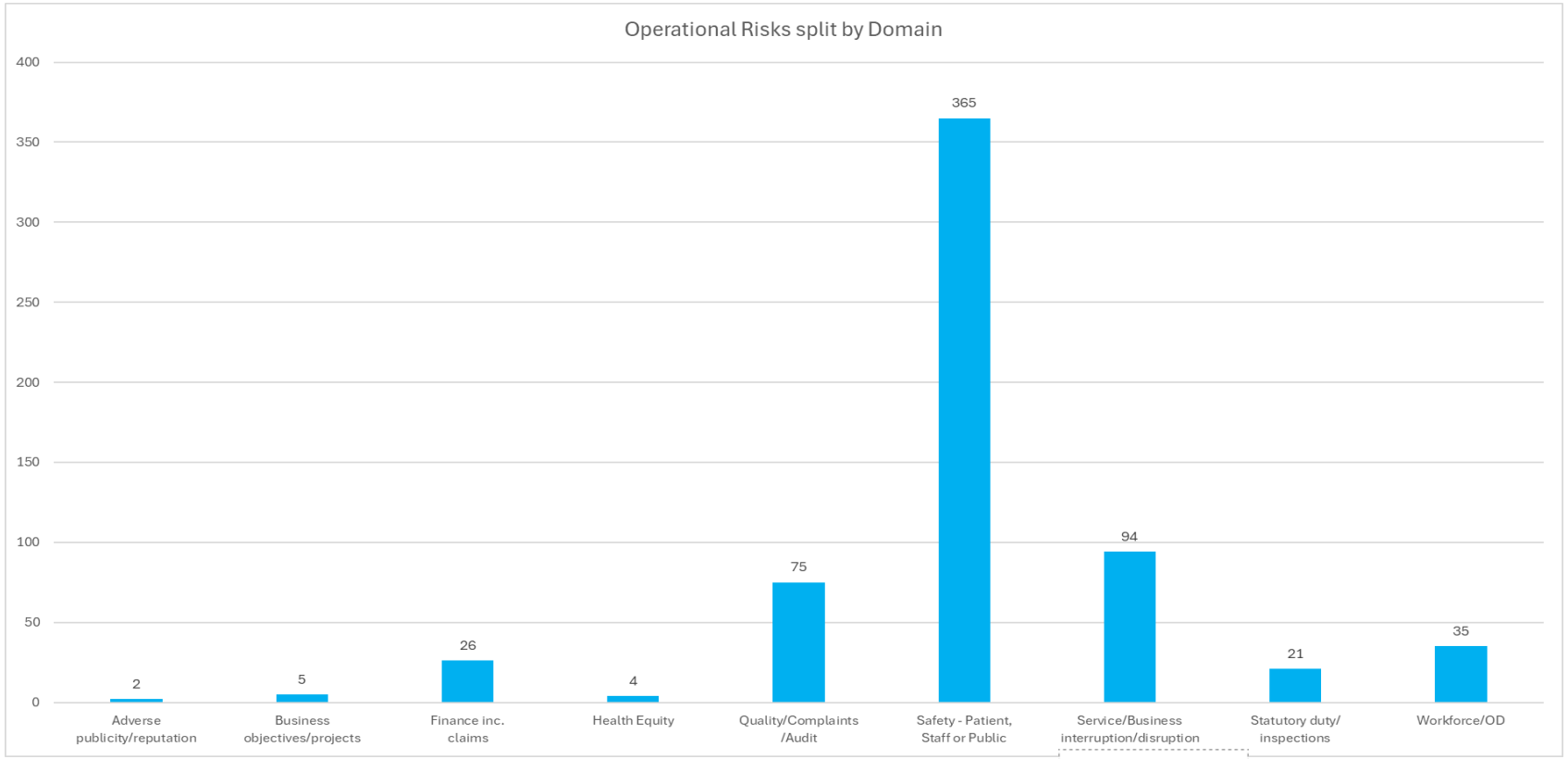
Risk owners can assign one or more of the six Domains of Quality to each risk. The chart shows the distribution of all operational risks across the six Domains of Quality (regardless of the Committee the risk is assigned to), highlighting that the highest number of risks is associated with the Safe domain (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
(Page 1 of 6)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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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Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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 Profession[illegible]nces	Chief Operating Officer	20	5	04/01/2027	24/04/2026

Extreme Level Operational Risks
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Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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
(Page 4 of 6)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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 Profession[illegible]nces	Chief Operating Officer	20	9	31/08/2026	07/05/2026

Extreme Level Operational Risks
(Page 5 of 6)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

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
(Page 2 of 6)

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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Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Date of report	Report Issued By	Report Title	Clinical Care Group/ Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommend-ations in original report	Overdue	In progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Barriers to Completion
Jun-24	Welsh Risk Pool	Welsh Risk Pool Concerns Assessment (December 2024)	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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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.*

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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

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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

Inspection Title	Recommendation	Action	Clinical Care Group/Executive Function	Lead Director	Original Due Date	Current Due Date
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

Inspection Title	Recommendation	Action	Clinical Care Group/Executive Function	Lead Director	Original Due Date	Current Due Date
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

Inspection Title	Recommendation	Action	Clinical Care Group/Executive Function	Lead Director	Original Due Date	Current Due Date
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

2.2

2.2 - Ophthalmology Deep Dive

Paula Goode (Hywel Dda UHB - Service Director for Planned and Specialist Care), Lisa Humphrey (Hywel Dda UHB - General Manager), Amorelle Jones (Hywel Dda UHB - Ophthalmology Service Delivery Manager)

Attachments

Deep Dive Template Ophthalmology June 2026 FINAL.pdf

Deep Dive: Ophthalmology

Quality, Safety and Experience Committee

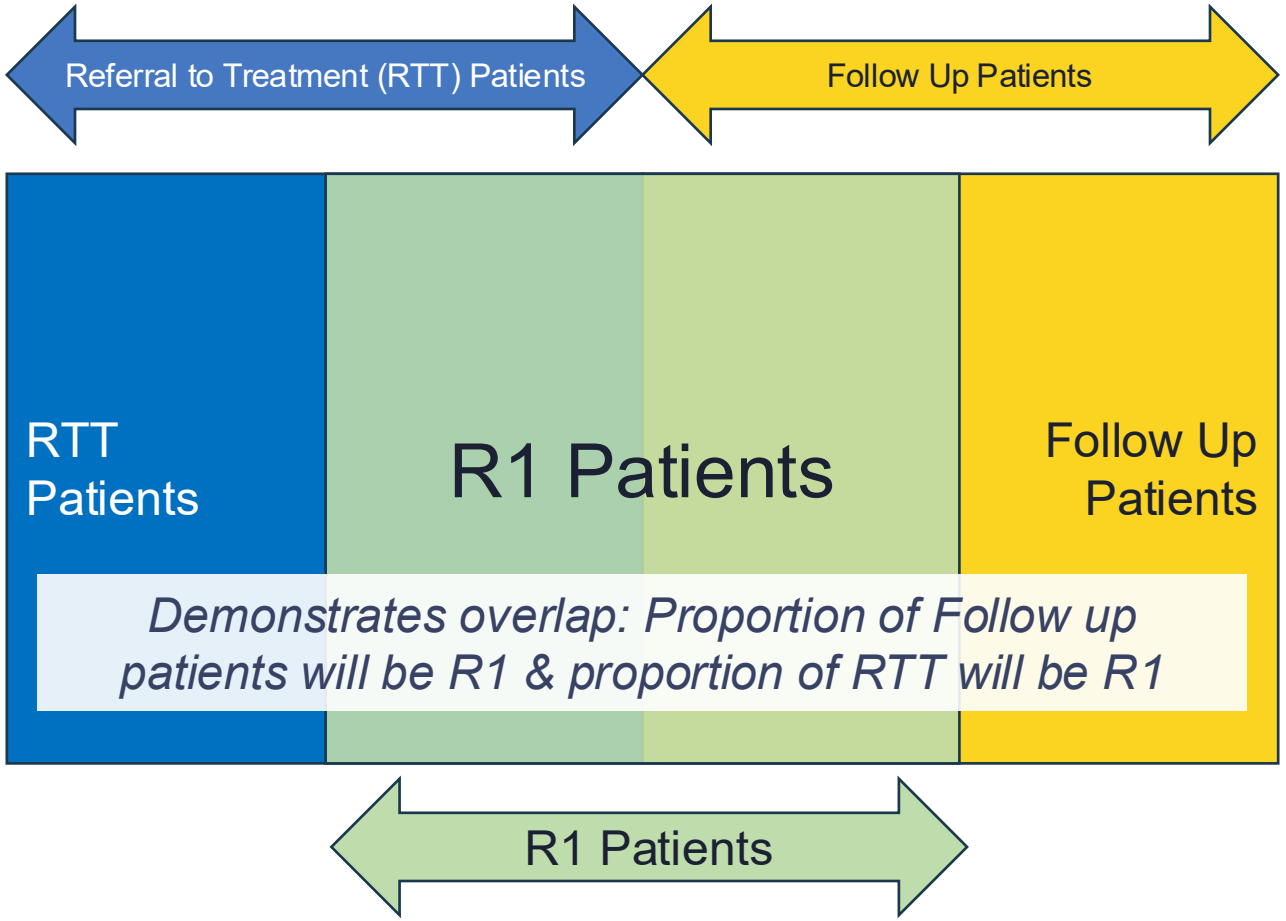
June 2026

Situation

The purpose of this report is to provide the Quality, Safety and Experience Committee with assurance on the current position of ophthalmology services, including the impact of capacity, workforce and pathway pressures on quality, safety, effectiveness and timely access to care.

This report highlights the principal risks affecting ophthalmology services, including sustained demand, treatment and follow-up backlogs, workforce constraints, diagnostic capacity and the actions in place to mitigate these pressures.

Background: Opthalmology



- **Medical retina** – e.g. Age-Related Macular Degeneration (AMD), diabetic retinopathy, retinal vascular disease
- **Vitreoretinal surgery** – retinal detachment, macular surgery
- **Glaucoma** – medical and surgical management of raised intraocular pressure
- **Cornea & external disease** – keratoconus, infections, corneal transplants
- **Cataract & refractive surgery** – cataracts, lens implants, laser vision correction
- **Oculoplastic (adnexal)** – eyelids, lacrimal system, orbital conditions
- **Paediatric ophthalmology & strabismus** – childhood eye disease, squints
- **Neuro-ophthalmology** – visual problems related to the nervous system
- **Uveitis** – inflammatory eye diseases
- **Ocular oncology** – eye tumours

* R1 – a patient whose clinical condition means they require urgent assessment and/or treatment, and cannot safely wait the standard (routine) waiting time

Background: Ophthalmology Risks

Risk Ref	Title	Tolerable score	Current rating (trend)	Target rating (L×I)	Overdue actions
1664	Risk to ophthalmology service delivery due to a national shortage Consultant Ophthalmologists and the inability to recruit	6	4×4=16 (↔)	2×4=8	0 of 26 (↔)
2142	Risk of being unable to provide consistent IVT service due to lack of specialist staff to allow capacity to meet demand		4×4=16 (↔)	1×4=4	1 of 3 (↑)
2066	Inability to conduct basic slit-lamp examination for some patients due to lack of a portable hand-held slit-lamp	6	4×3=12 (↔)	1×3=3	1 of 1 (↔)
2071	Risk of inability to review and diagnose corneal patients adequately due to age of topographer		3×4=12 (↔)	2×4=8	2 of 3 (↔)
1960	Risk of potential misdiagnosis or inability to treat due to ageing Ophthalmology equipment		3×3=9 (↔)	2×3=6	0 of 18 (↔)
2232	Risk of harm to patients with urgent eye conditions due to the lack of a functioning laser machine		2×4=8 (↔)	1×4=4	1 of 2 (↔)
2157	Risk of delay to patient diagnosis due to unavailable OCT equipment in Tywyl Eye		2×3=6 (↔)	1×3=3	2 of 4 (↔)

Source: Corporate Performance Dashboard

1664 (Corporate Risk) – shortage of Consultant Ophthalmologists

- Ongoing workforce constraints present a risk to the safe, timely and effective delivery of ophthalmology services. Recent recruitment of 2 SAS doctors, 1 regional vitreoretinal (VR) consultant, and 2 trainees with supported job plans strengthens the workforce enabler and supports service resilience. The risk remains under review to ensure capacity, clinical sustainability and continuity of care.

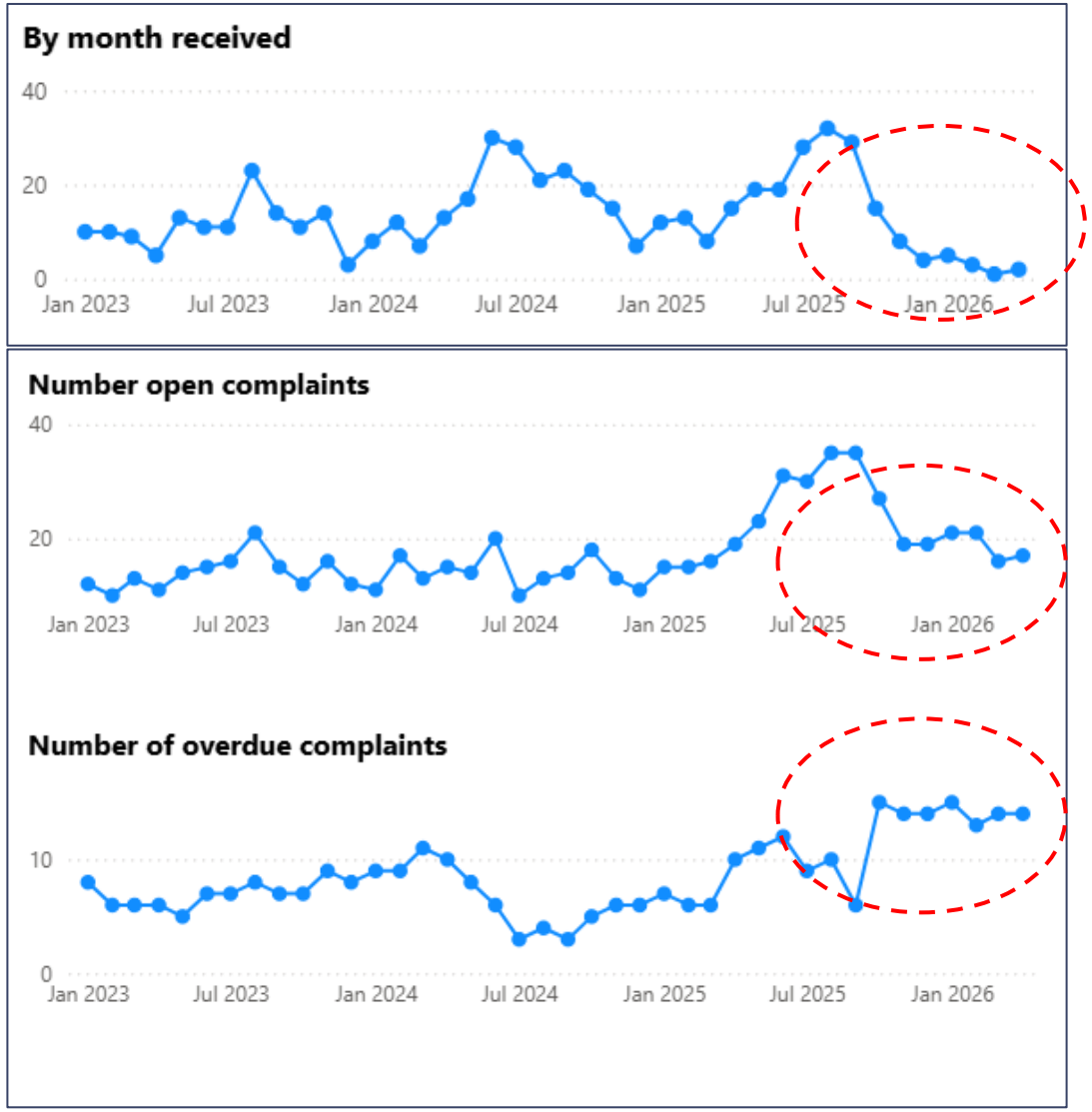
2142 - Provision of consistent IVT service

- Capacity pressures within ophthalmology present a risk to the safe, timely and effective delivery of treatment, particularly in relation to intravitreal therapy (IVT) pathways. Mitigating actions include outsourcing to maintain patient safety, upskilling staff to deliver IVT, and embedding IVT activity within additional recruitment plans. Recent analysis of R1 compliance shows 82% of patients are seen within target against a 95% target, highlighting an ongoing risk to timeliness, effectiveness, and the information enabler through continued performance monitoring.

Equipment*

- Equipment availability and replacement remain a risk to the efficient, safe and effective delivery of care and continue to be reviewed in line with capital allocation. Current support arrangements from temporary senior nurse managers help maintain operational oversight during substantive senior nurse absence, aligning to the leadership and workforce enablers while longer-term arrangements are addressed.

Background: Complaints



- Complaints have reduced from 32 in August 2025 to 2 in April 2026 (to note – waiting list enquiries were managed as complaints but there has been a Health Board wide change to manage these as enquiries resolving the enquiry in a timely manner)
- Open complaints reduced from 35 in September 2025 to 17 in April 2026
- Overdue complaints remained static since October 2025 due to clinical lead capacity to provide final review (**Note**: Clinical lead session – 1 per week)
  - Plan to increase clinical review sessions pending additional medical workforce onboarding
- Management team meet regularly to review concerns.
- Majority of concerns managed by service support manager/Senior Manager
- Learning, including updating of protocols, consistent application of protocols and case management, shared via the service Quality, Safety and Experience Groups

Source: Corporate Performance Dashboard *(internal only)*

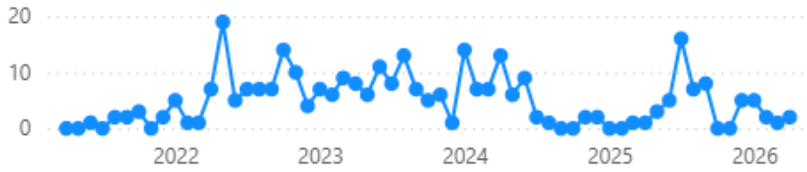
Background: Patient feedback

- Thank you cards from our patients to Cataract Outsource provider
- Compliments regarding process, transport & communication

Background: Incidents

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Incidents by month of occurrence



% reported incidents that have been closed by directorate

Open incidents

Press the button below to select the measure you require:

Incident type | Sub type | Level | Location | Awaiting review | Days open

Longest open incidents

Ref	Days open
HDD76650	237
HDD80503	150
HDD81646	120
HDD81968	111
HDD82388	101
HDD83278	80
HDD84419	52
HDD85646	22
HDD86241	7

Diogel Safe

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Effeithlon Efficient

- Average of 5 incidents logged per month (between 0 and 19)
- 9 open incidents
- 1 longest waiting incident (237 days)
- During Incident deep dive week (19 to 22 May 2026) 20 incidents closed
- Majority relate to delay in care
- Learning also discussed at local QSE

Service will continue to monitor routinely and participate in monthly targeted incident review process.

Learning will be shared via local governance processes

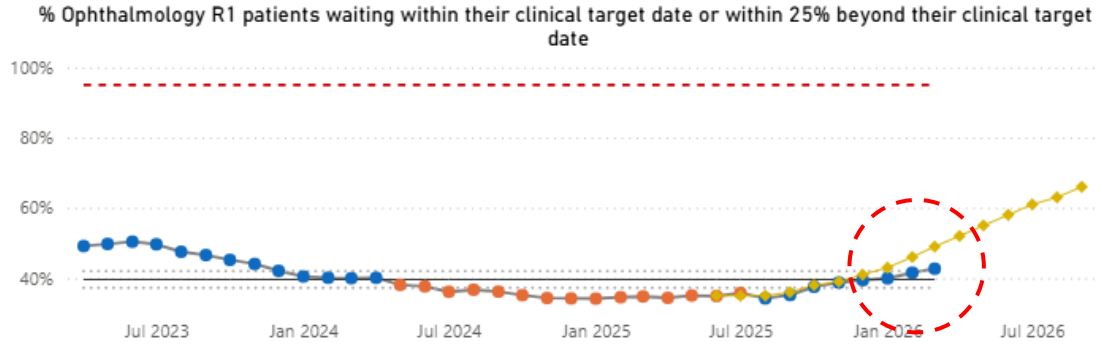
Source: Corporate Performance Dashboard *(internal only)*

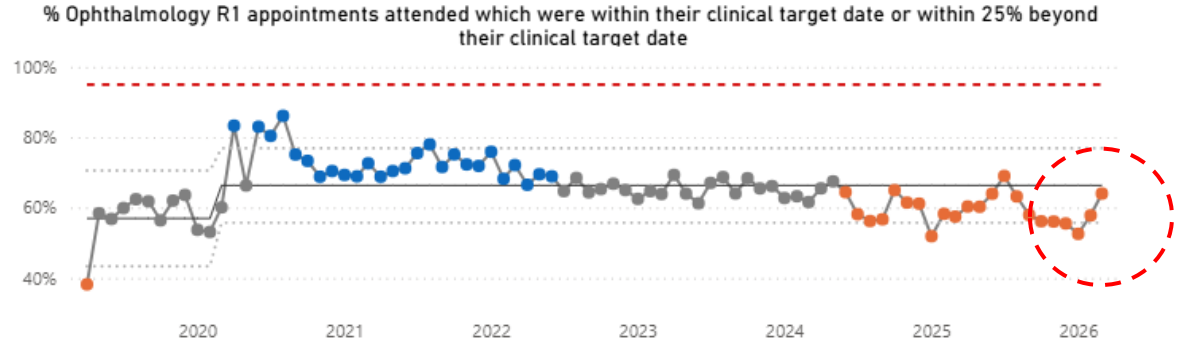
Background: Eye Care Measures (R1 delivery)

- **Eye Care Measures Target:** 95% patients seen or waiting to be seen are within target date (or 25% of target date)

- **In April 2026:**
  - 62% of those seen were within target
  - 43% waiting for an appointment were within target (or <25%).
  - 7-month consecutive improvement

- Inability to meet target due to challenges outlined on slide 11 and specifically non-emergency patient transport (NEPT) cancellations





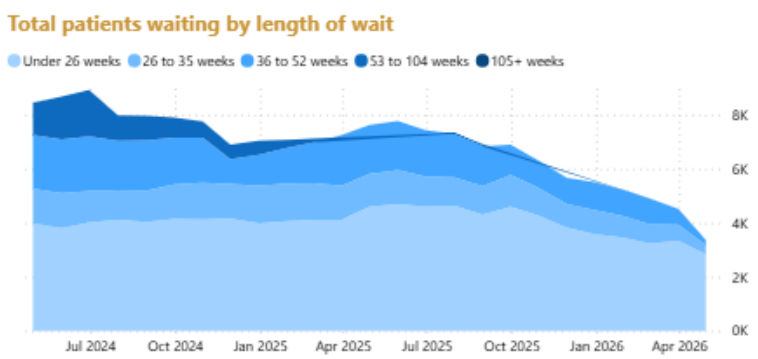
Source: Corporate Performance Dashboard *(internal only)*

Background: Referral to Treatment (RTT)

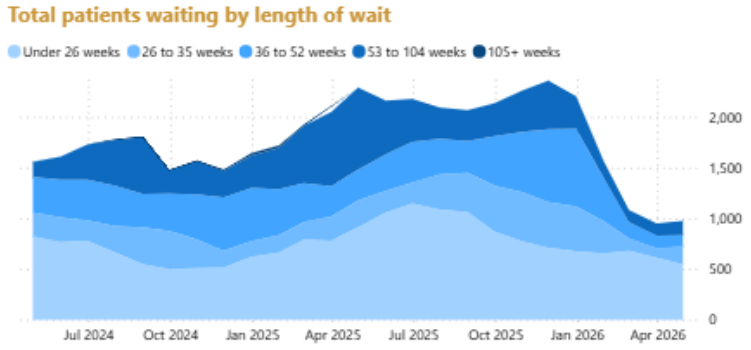
- **Stage 1 outpatient wait** has reduced from it's highest of 8,915 (June 2024) to 3,368 (April 2026). Recent HSBUK (Welsh Government initiative has helped this recovery).
- **Stage 3 diagnostic wait** has reduced from it's highest 2,368 (November 2025) to 976 (April 2026). A high volume of this is the correct coding of Cataract patients.
- **Stage 4 treatment waits** have slowly recovered from it's highest (6,538) to 6,029 in March 2026. The rise in April 2026 is partly due to the correct coding of Stage 2/3 patients and the pausing of outsourcing cataract patients (pending recovery funds).

Amserol Timely

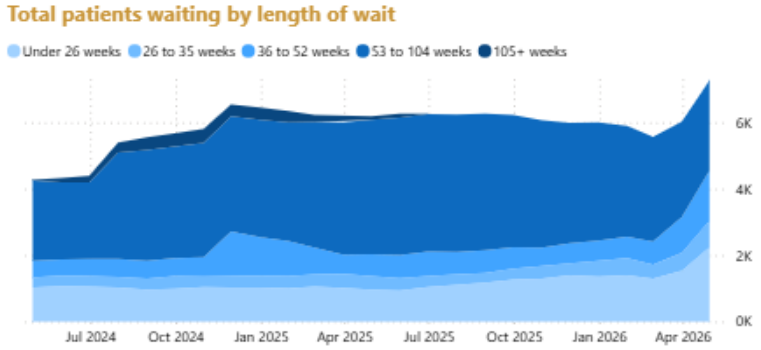
Stage 1



Stage 2/3



Stage 4



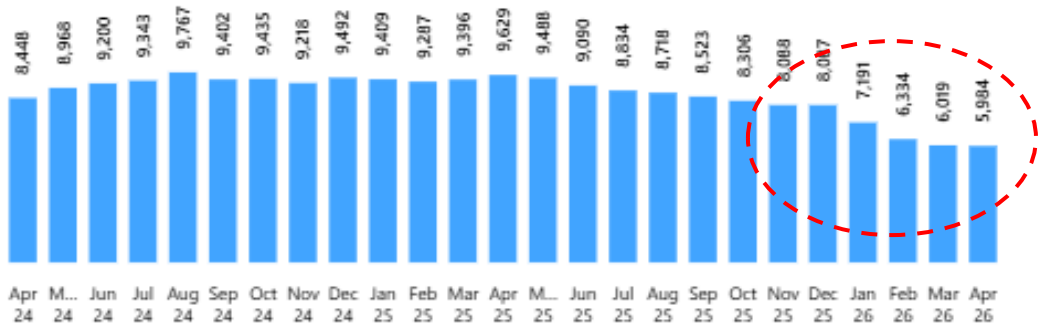
- Inability to reduce long waits to pre-pandemic levels due to challenges outlined on slide 11 and specially:
  - Pause in Welsh Government Recovery allocation
  - Inflated urgency of patients due to length of wait (i.e., a patient cannot wait 2 years but could wait 36 weeks)

Source: Corporate Performance Dashboard *(internal only)*

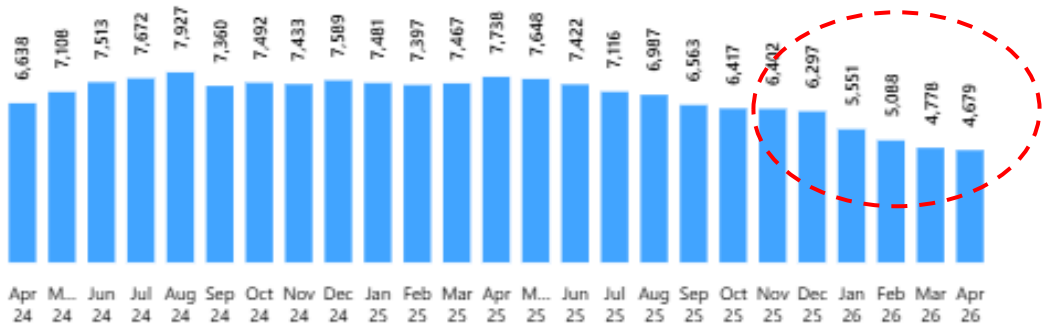
Background: Referral to Treatment

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

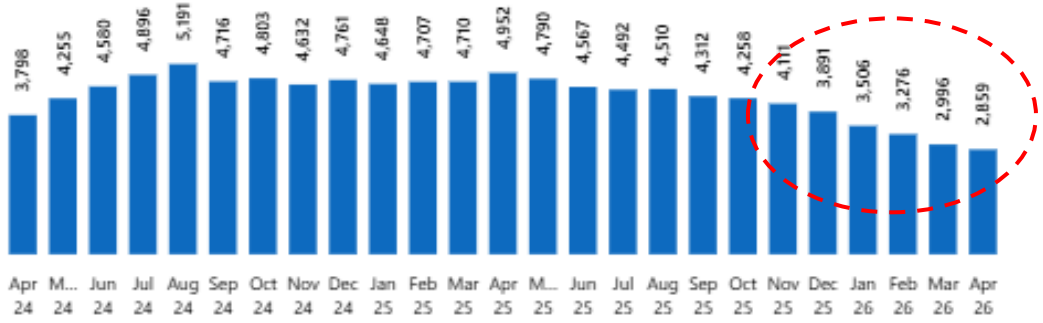
Patients waiting 26 weeks and over



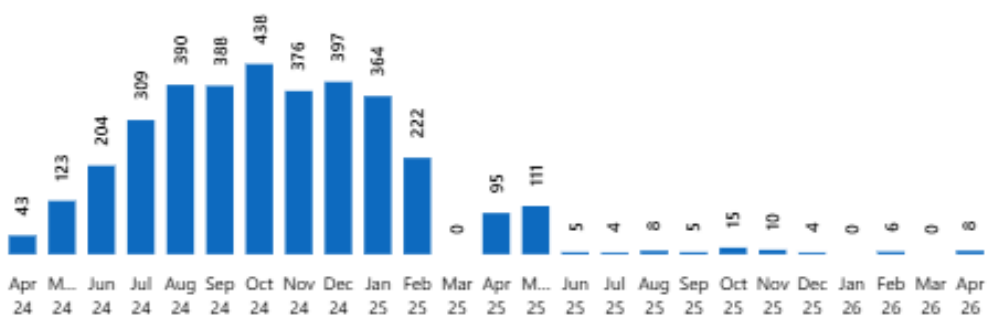
Patients waiting 36 weeks and over



Patients waiting over 52 weeks



Patients waiting over 104 weeks



Despite small volume of patients waiting over 104 weeks RTT in April 2026 the overall breaches for patients waiting over 26, 36 and 52 weeks **has improved**

Source: Corporate Performance Dashboard *(internal only)*

Background: Follow Up Waiting List (FUWL)

From April 2025 to April 2026:

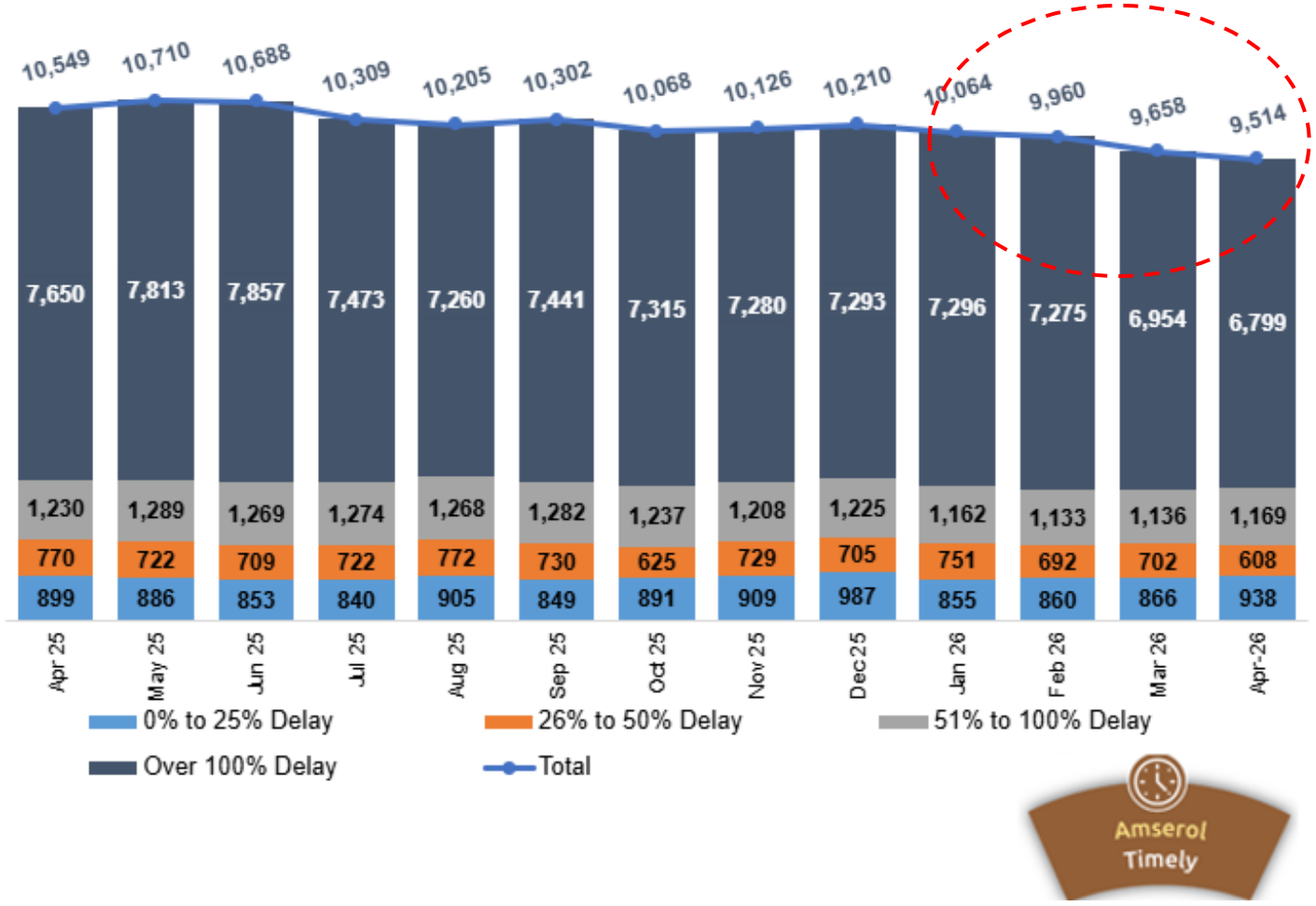
- Total FUWL reduced by 1,035
- 100% delayed reduced by 851

Majority need life-long management (Glaucoma)

Delivery restricted by challenges outlined in slide 11.

Specific challenges include:

- Confidence to discharge, See on Symptom (SOS)/Patient Initiated Follow up (PIFU) (turning off tap)
- Lack of primary care pathway knowledge (Welsh General Ophthalmic Services (WGOS))
- Admin to process WGOS



Source: Corporate Performance TEAM *(internal only)*

Assessment: Challenges

Safe

- High vulnerability during consultant leave or sickness in medical and admin teams
- High volume of sickness due to stress at work
- Estates & infrastructure issues limit ability to undertake activity

Timely

- Post-pandemic long waits reduce ability to provide sustainable services (*patients are marked urgent because they can't wait 2 years, leaving an inflated urgent cohort*).
- Repeated cancellations of Non-Emergency Patient Transport
- Gaps in delivery due to capacity gaps

Effective

- Consultants working single-handedly in subspecialties
- Daily operational issues impede service improvement

Efficient

- Service spread across 8 sites: reducing efficiency, increasing travel costs, limiting training opportunities, and creating equipmen variation
- On-call rota (1:6) understaffed, with 3 consultants covering 6 posts
- Equipment availability remains inconsistent across sites

Equitable

- National shortage of ophthalmologists, medical staff, and nursing staff

Person-Centred

- Workforce isolated and working in silos, often without senior support

Patient Story (from AVH not direct)

81-year-old male treated for Cataracts in AVH (one eye). No family support for transport. Drove to appointment. Had Cataract. Problems accessing car post surgery. Nursing supported. Discovered that patient was intending to drive home. When asked by team why this was (after dangers of driving post surgery had been shared) patient replied …

"I'm so desperate for my Cataract surgery, no one else could take me. So, I drove myself!

Note: Patient transport outlined as a challenge (slide 11). Service is e ected patient transport.

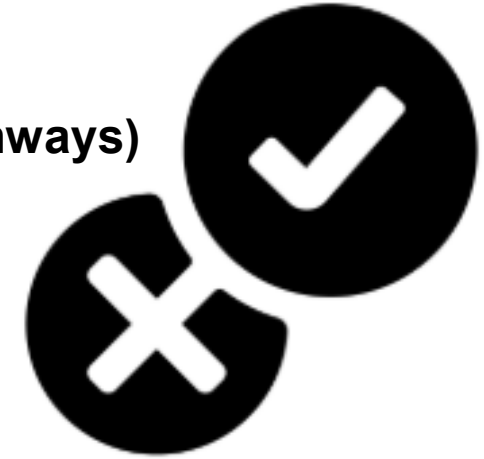
What we are doing: Summary

- Improving pathway management and validation
- Expanding & reviewing capacity
- Shifting to regional/peripheral models of care
- Increasing diagnostics and virtual review/care
- Improving theatre productivity
- Strengthening workforce
- Maintaining strong governance and performance oversight

WHAT WE ARE DOING

Improving pathway management & validation

- Ongoing Clinical validation via **non–patient contact desktop reviews**
- Ongoing **clerical validation of waiting lists**
- Increased use of **SOS / PIFU pathways**
  - Clinical condition standard operating procedures written and shared
- Greater use of **Welsh General Ophthalmic Services** (**WGOS) (primary care pathways)**
  - Community Co-Ordinator vacancy shortly out to advert
- Improving understanding and admin processes for WGOS referrals
  - Additional WGOS training
- Focus on **“turning off the tap”** (appropriate discharge management)



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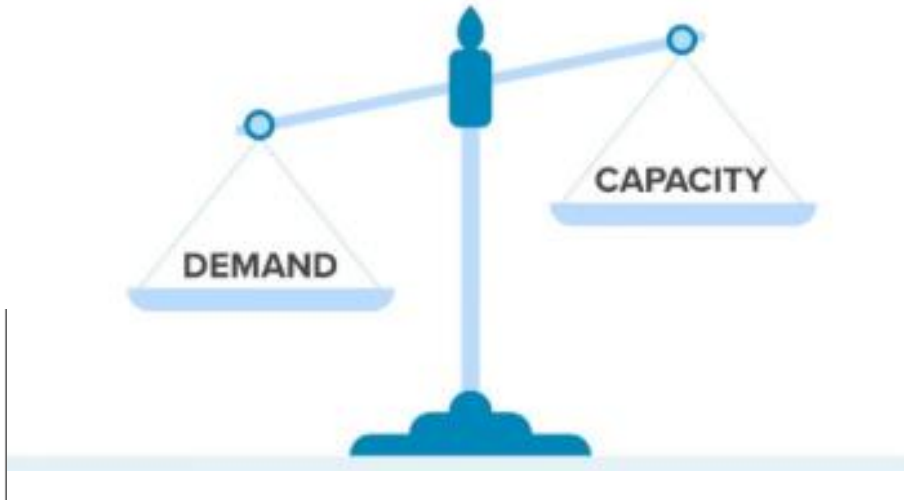
Expanding & Reviewing Capacity

- Increase clinic activity:
  - New SAS doctors onboarding (1 in Bronglais Hospital (BGH) & 1 in Glangwili Hospital (GGH))
  - Regional consultant Outpatient Department (OPD) activity (Glaucoma x 2 & VR x 1)
- Continue **outsourcing** with recovery funding alongside developing an **insourcing** plan (blended between our consultant & insourcing support)
- Explore High Volume, Low Complexity (HVLC) opportunity in BGH Day Surgery Unit
- Additional intravitreal injection clinics in Amman Valley Hospital
- Overbook high 'Did not attend' clinics to max utilisation (i.e., RACE Follow Up)
- Increase follow-up activity when workforce expands
- Develop Tech support OPD activity to mitigate nursing deficit
- Exploring ability to have **protected patient transport**



Shifting to Regional/Peripheral models of care

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Develop a regional ophthalmology model

To assist recruitment and attractiveness of working in HDUHB

Work with SBUHB for additional clinics and services

Move towards regional on-call model

Shared ROTA for General & VR

Deliver some care at regional hubs instead of local sites

Continue working within Clinical Implementation Networks

Increasing diagnostics & virtual review/care

- Develop **diagnostic hub (Aberaeron Integrated Care Centre)**
- Expand diagnostic capacity:
  - More **vision lanes**
  - Additional or reconfigured rooms
- Introduce **virtual diagnostic and clinic models**
- Establish **virtual hubs** for review (e.g. glaucoma pathway)
- Enable staff to work at **top of licence** via better facilities

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Improving Theatre Productivity

- Increase capacity via **outsourcing/Insourcing -** cataract, VR and plastics
  - BGH HVLC Insourcing hub being developed
- Review theatre lists to improve **start/finish efficiency/productivity**
  - AVH routinely achieves 8-9 eyes per list
- Continue implementing **GIRFT recommendations (51/59 complete)**
- Expand AVH into a **cataract hub** including 3 session days
- Increase specialist input in theatre lists (i.e., Band 7 Theatre practitioners)

Strengthen Workforce

- Recruit to other vacant posts across service
- Support Organisational Change Process for admin staff
  - Release 2.4 whole time equivalent (WTE) to Medical Records to do
  - Keep 4 x Band 4 Co-ordinators to manage pathways effectively
- Upskill nursing staff to undertake diagnostic scans / IVT / Triage
- Upskill Optometrists for specialist review, lasers & prescribing
- Develop **emergency eye care practitioners** (Releasing SAS capacity)
- Support SAS doctors to **complete competencies for full rota participa**
  - Laser competence
  - RACE & Discharge confidence
- Invest in **training** and **development** programmes
- (i.e. Advance Nurse Practitioner (ANP) for Nursing)

Maintain Governance & Performance oversight

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Governance

- Ongoing monitoring of incidents, complaints and regular Quality & Safety meetings (QSE) to share learning and implement change
- Expand clinical review capacity for complaints (job planning)
- Continue targeted incident deep dive
- Focus on patient feedback and experience improvements

Waiting List / Performance

- Reduce long waits through:
  - Validation
  - Capacity increases
- Improve coding accuracy
- Continue sustained **performance monitoring** and recovery trajectory
- Routine monitoring of DNA Rates
- Use data dashboards (Power BI) to drive improvement

On Call & IVT

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On Call

- Cover rota gaps via additional duty payments (short-term)
- Build sustainable rota via:
  - SAS competency completion
  - Consultant recruitment
- Move to regional out-of-hours model to avoid high spend
- Reliance on out-of-area referrals (e.g. Bristol) should reduce following VR Consultant recruited

IVT

- Continue outsourcing
- Prioritise loading dose & patients with one seeing eye
- Increase injections via additional activity (overtime)
- Develop 5-day IVT service at AVH
- Recruit medical retina consultant (via SB)
- Undertake deep dive Demand and Capacity workshop on 5 June 2026

Long Term Plan

- Continue development through Clinical Services Plan (CSP):
  - GGH Ophthalmology Unit
  - Aberaeron Diagnostic Hub
  - AVH Theatre 5 days per week
  - AVH OPD 5 days a week

Image generated via Artificial Intelligence (AI)

Any Questions

- Questions

Image generated via Artificial Intelligence (AI)

RECOMMENDATION

- The Quality, Safety and Experience Committee is asked to RECEIVE ASSURANCE on the current position of ophthalmology services, including the impact of capacity, workforce and pathway pressures on quality, safety, effectiveness and timely access to care.

3

60 Mins

3 - Assurance

3.1

3.1 - Quality Assurance Report

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

Attachments

3.1 QS Assurance Report Jun 2026 v1.0 final.pdf

Appendix June 2026 Overdue HIW actions final.pdf

Infection Prevention and Control Organisational Improvement Plan 2026-27.pdf

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)

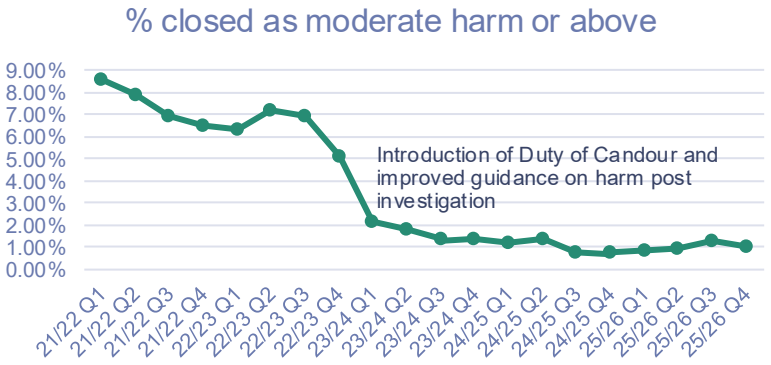
Appendices to this report

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

Patient Safety Incidents

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

Nationally Reportable Incidents (NRI)

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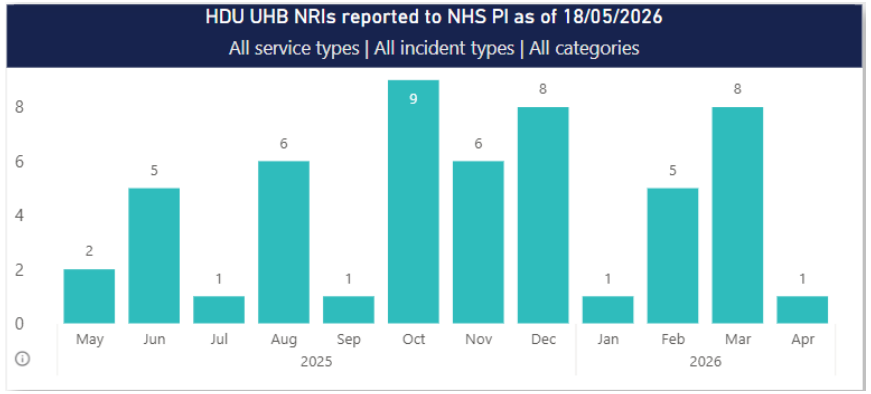
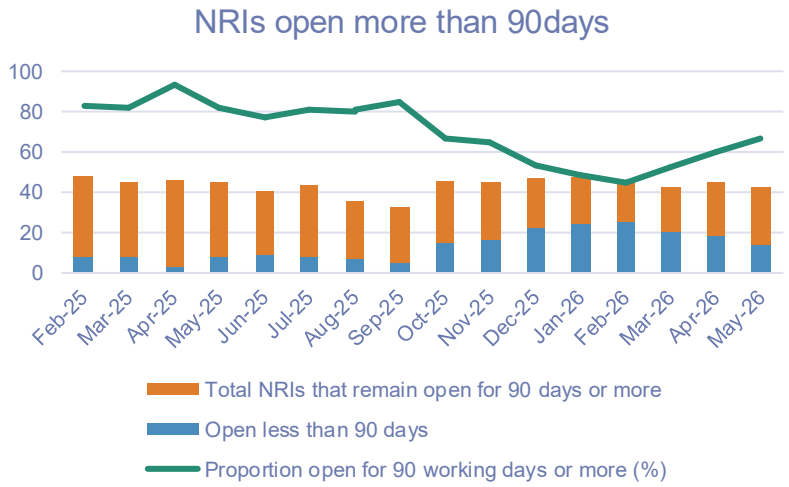
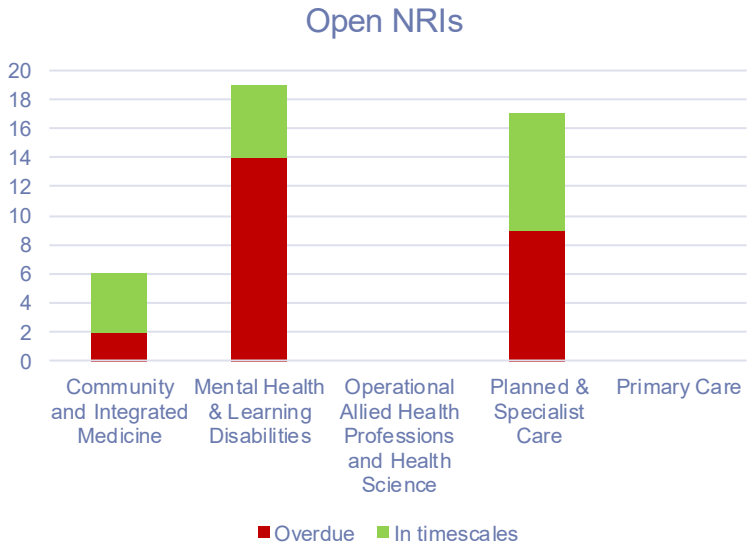
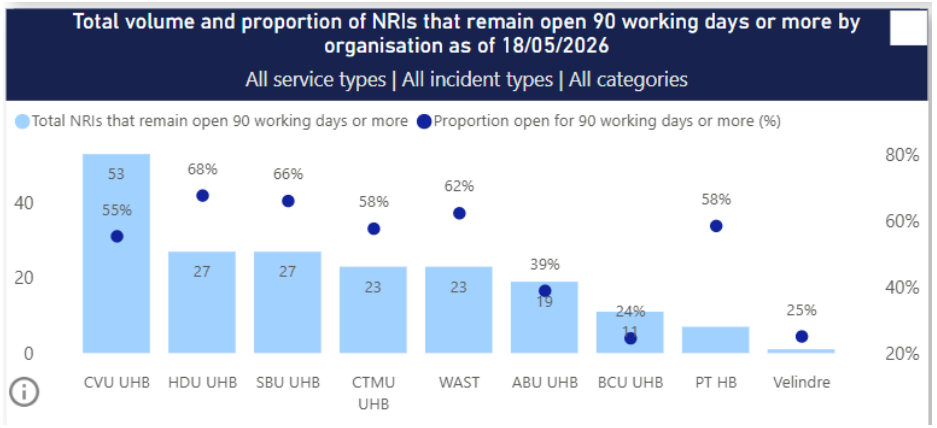


Source: Beacon Dashboard
19/05/2026







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

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

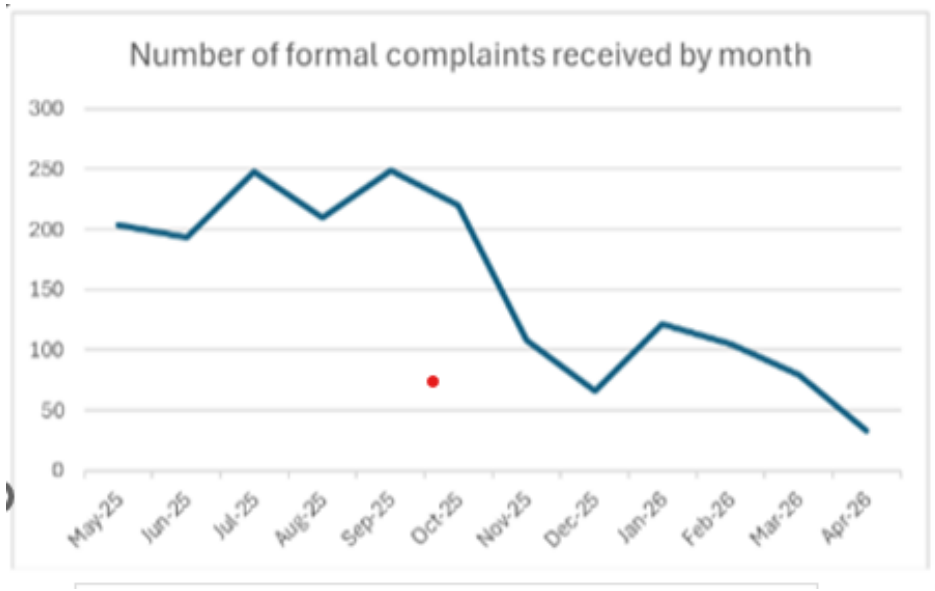
Report Category	Link	Reports
Child Death (from 2015)		**1**
HDUHB		**1**
Report date: 27/02/2026 Ref: (2026-0118)		1
Wales prevention of future deaths reports (2019 onwards)		**1**
HDUHB		**1**
Report date: 27/02/2026 Ref: (2026-0118)		1
Total		**1**

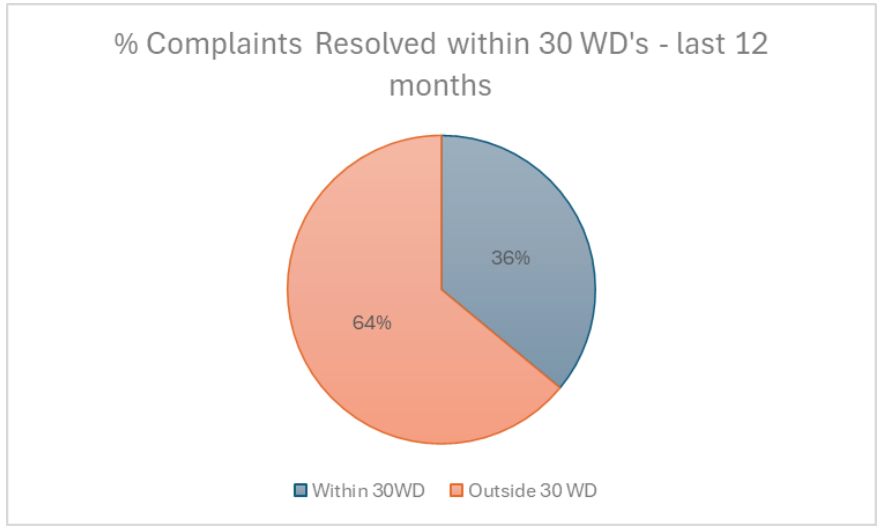
Source: Beacon Dashboard 19/05/2026

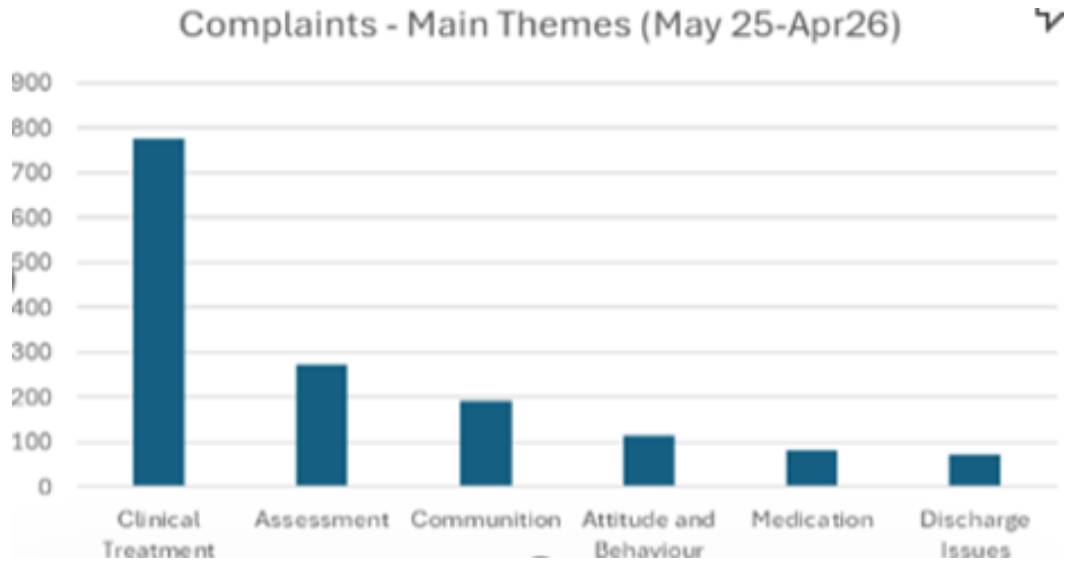
All Wales Regulation 28 - Prevention of Future Death Reports since 2022 - all categories of report (as of 15/05/2026)

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.

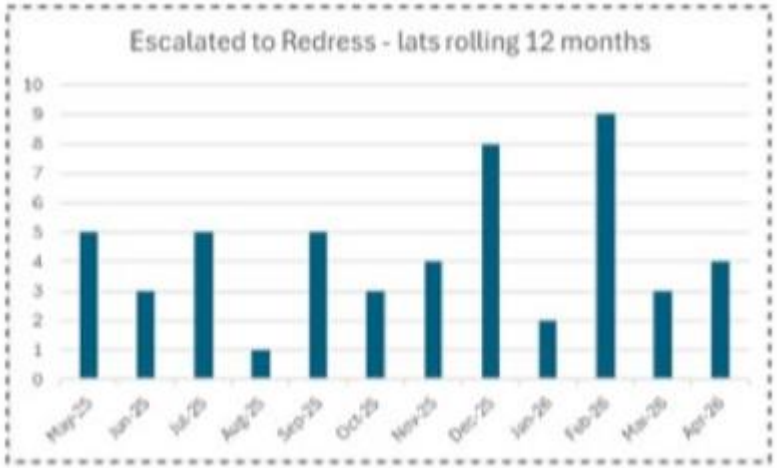
The reduction in the overall number of complaints received reflects the drive towards early resolution, especially since the beginning of 2026 where there was an increased focus on early resolution in anticipation of the new 'Listening to People' complaint regulations. Since coming into effect in April,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

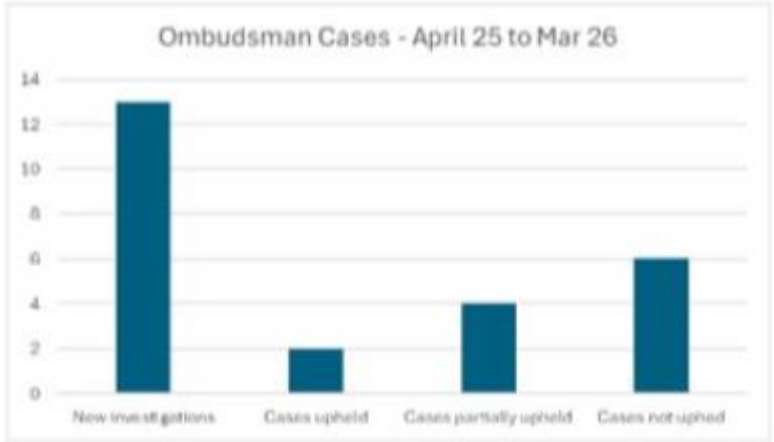
Health Board Overview: Outcomes and Closure Trajectory

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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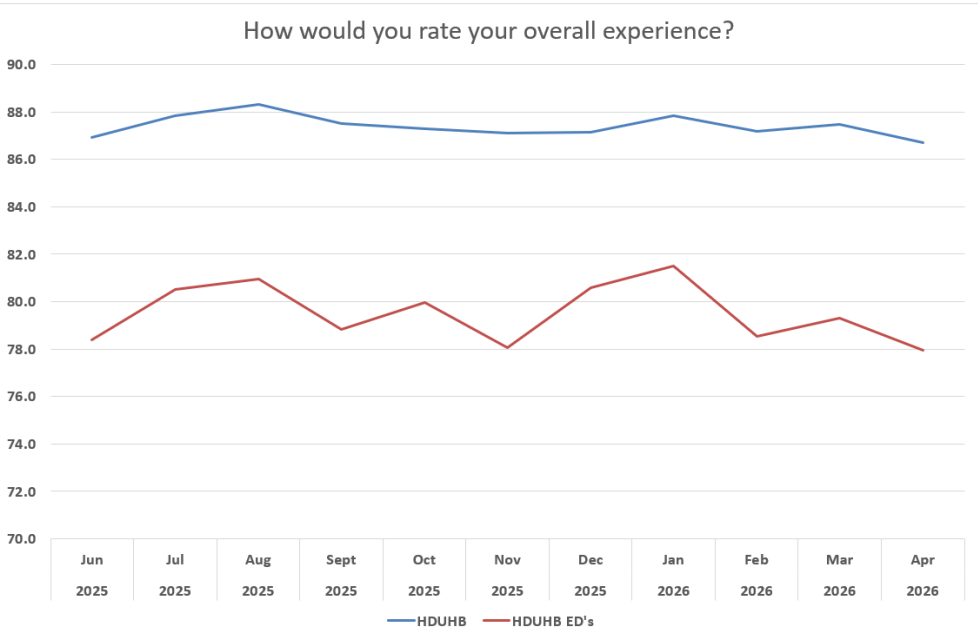
People's Experience Feedback



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

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

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Theme	Lesson Learnt
Early Identification & Isolation	Improve early identification and isolation of symptomatic patients at entry points to prevent bay-level spread.
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

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

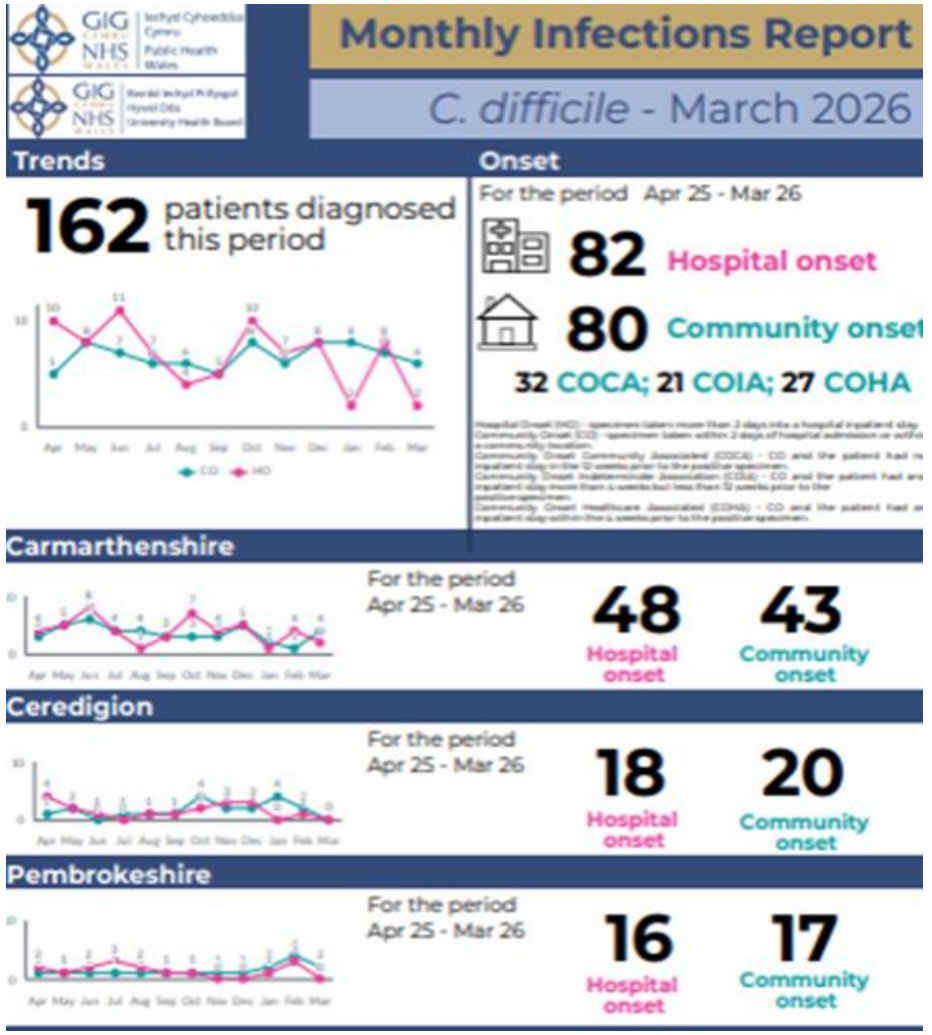
Table 2. Monthly count and rate of C. difficile in Hywel Dda UHB, 2026/27

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

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Learning Identified	Recommendations for the CCGs
Mattress cleaning: Ensure consistent, documented cleaning and decontamination	• Monthly mattress audits for wards/ departments • Mattress checking on discharge reinforced in line with decontamination and mattress cleaning policy
Hydrogen Peroxide Vapour (HPV) deep cleaning: Ensure HPV is used for all required deep cleans regardless of patient flow pressures.	• Trigger HPV decontamination in all required scenarios, even during operational pressures. • Non-compliance to be reported
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

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

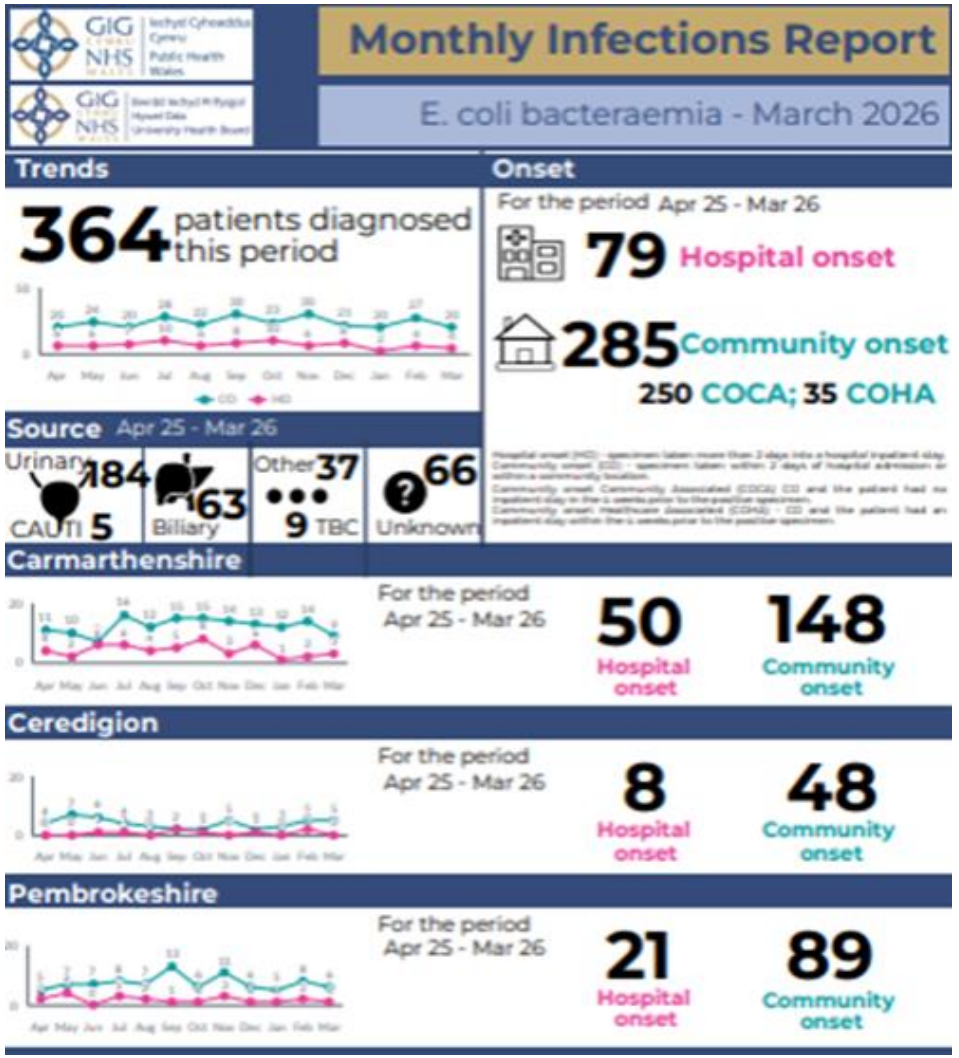
Additional filters for Table 2.
Select FY: 2026/27

	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

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

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

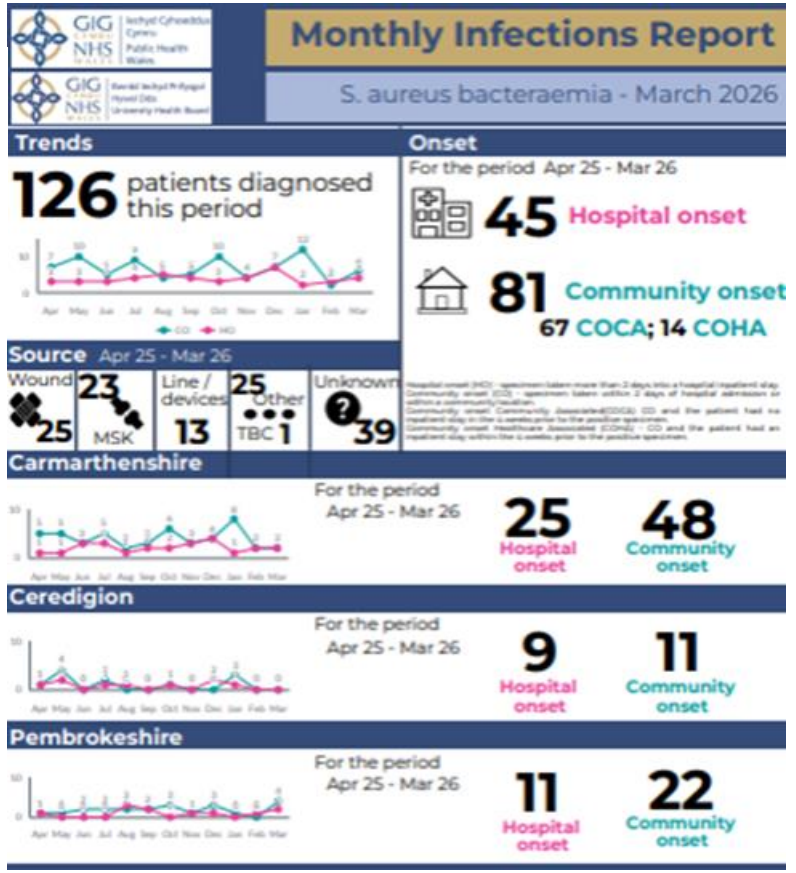
Table 2. Monthly count and rate of MRSA bacteraemia in Hywel Dda UHB, 2026/27

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

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

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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

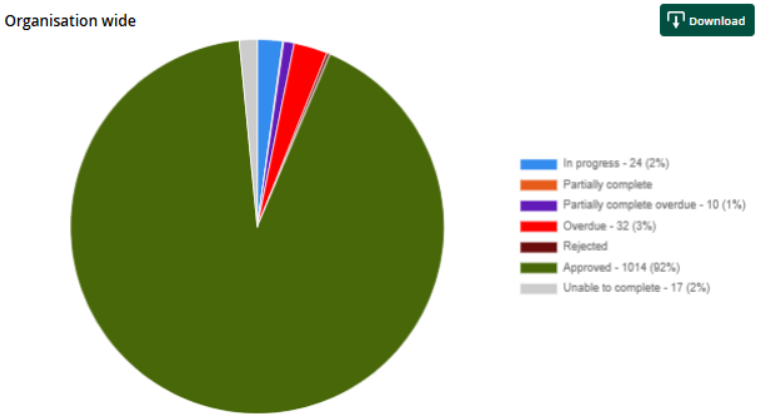
*Those shown in grey type have been previously reported to QSEC

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
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

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Code	Title	MD	SD	WN	PIR	Actions							
						In progress	Partially complete	Partially complete (Overdue)	Overdue	Unable to complete	Completed (awaiting approval)	Rejected	Completed
Healthcare Inspectorate Wales (HIW)/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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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:

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

		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:

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

	• *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					

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

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:

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

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

3.2

3.2 - Duty of Candour Report 2025/26

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

Attachments

QSEC DoC Annual Report 2025-26 SBAR.pdf

Duty of Candour Annual report 2025-26 v0.3.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	11 June 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Duty of Candour Annual Report: How the Health Board met the Duty of Candour in 2025/2026
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Sharon Daniel, Executive Director of Nursing, Quality and Patient Experience
SWYDDOG ADRODD: REPORTING OFFICER:	Cathie Steele, Interim Assistant Director of Nursing Assurance and Safeguarding Caroline Burgin, Patient Safety and Assurance Manager

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

All NHS organisations are required to publish an Annual Duty of Candour Report as part of the organisation's annual reporting process.

The purpose of this report is to share with the Quality, Safety and Experience Committee (QSEC) the current draft *Duty of Candour* Annual Report for 2025 to 2026 (Appendix 1).

Cefndir / Background

The Quality and Engagement Act became law on 1 June 2020 and came into force on 1 April 2023.
The Act:

- Ensures that NHS bodies and ministers think about the quality of health services when making decisions;
- Ensures NHS bodes and primary care services are open and honest with patients, when something may have gone wrong with their care; and
- Creates a new Citizen Voice Body to represent the views of people across health and social care.

There are two main duties under the Act which the Health Board must consider.

The Duty of Quality
Quality is more than just meeting service standards; it is a system-wide way of working to provide safe, effective, person-centred, timely, efficient, and equitable care in the context of a learning culture. To help achieve this, the Act:

- Places an overarching duty of quality on the Welsh Ministers; and
- Reframes and broadens the existing duty on NHS bodies.

This ensures the concept of “quality” is used in its broader definition, not limited to the quality of services provided to an individual or to service standards.

NHS bodies are placed under a duty to report on the steps they have taken to comply with the duty of quality on an annual basis.

The Duty of Candour
A culture of openness, transparency and candour is widely associated with good quality care. To help achieve this, the Act places a duty of candour on providers of NHS services (NHS bodies and primary care) – supporting existing professional duties.

The duty requires NHS providers to follow a process when a service user suffers an adverse outcome which has or could result in unexpected or unintended harm that is more than minimal, and the provision of health care was or may have been a factor. There is no element of fault, enabling a focus on learning and improvement, not blame.

The duty seeks to promote a culture of openness and improves the quality of care within the health service by encouraging organisational learning, avoiding future incidents.

Under the duty, NHS Bodies will be required to report annually on compliance with the duty and publish their reports. Local Health Boards will be required to collate this information from those primary care providers with whom they enter into a contract or arrangements for services and publish a combined report.

When reporting, NHS Bodies will be required to specify if the duty of candour has been triggered in the reporting year (defined as each period of 12 months ending on 31st March, (each financial year), and if it has:
1. state how often the duty of candour has been triggered during the reporting year.
2. give a brief description of the circumstances in which the duty was triggered; and
3. specify any steps taken by the body with a view to preventing similar circumstances from arising in the future.

The report must be prepared as soon as practicable after the end of each financial year.

Asesiad / Assessment

Preparation of the Duty of Candour Annual Report
Duty of Candour data within DatixCymru was also validated and information gathered in preparation for the report.

Appendix 1 contains the proposed annual report for 2025/26.

Developing Always on Reporting
Information on the duty of candour and duty of quality has been provided regularly to QSEC through the Quality Assurance Report. It is proposed that this regular reporting mechanism continue.

Next Steps
The finalised Duty of Candour Annual Report will be presented to the Annual General Meeting on 30 July 2026.

Argymhelliad / Recommendation

The Committee is asked to:

- Provide FEEDBACK on the draft Duty of Candour Annual Report for 2025/26 and RECOMMEND for Board approval.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.11 Ensure that the organisation is meeting the requirements of the Health and Social Care (Quality and Engagement) Act and recommend the Annual Duty of Quality and Duty of Candour Reports to Board for approval as soon as reasonably practicable after the end of each financial year. 5.22 Monitor progress of and assure the Board in relation to its compliance with relevant healthcare standards and duties, national practice, and mandatory guidance.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	No corresponding risk identified on organisational risk register
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	DatixCymru EQliP Programme
Rhestr Termau: Glossary of Terms:	Contained within the body of the report

Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	N/A

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
Ariannol / Gwerth am Arian: **Financial / Service:**	The Annual Report requires resource in the form of staff time to produce it. This comes principally from the Executive Director of Nursing, Quality and Patient Experience's budget. Resource will also be required from other areas such as Communications.
Ansawdd / Gofal Claf: **Quality / Patient Care:**	The Annual Report outlines the quality of HDdUHB services provided to the public and forms an important part of the Health Board's annual reporting process.
Gweithlu: **Workforce:**	Development of staff through pooling of skills and integration of knowledge
Risg: **Risk:**	The Annual Report presents reputational risks if it is not published or if its content is inappropriate or inaccurate. These risks are mitigated through review by Health Board committees and groups, the Director of Corporate Governance/Board Secretary, and Internal Audit.
Cyfreithiol: **Legal:**	The Annual Report has legal risks if it is not published, or if the information within it is inappropriate or inaccurate. These are mitigated through review by Committees/Groups of the Health Board and by the Director of Corporate Governance/Board Secretary, as well as audit by Internal Audit.
Enw Da: **Reputational:**	The Annual Report has legal risks if it is not published, or if the information within it is inappropriate or inaccurate. These are mitigated through review by Committees/Groups of the Health Board and by the Director of Corporate Governance/Board Secretary, as well as audit by Internal Audit.
Gyfrinachedd: **Privacy:**	N/A

Cydraddoldeb: Equality:	The Annual Report focuses on services and aims to cover as many areas as possible, although it cannot include every aspect of service provision.

Duty of Candour

Annual Report

How we met the Duty of Candour between April 2025 and March 2026

Welcome from the Chair of the Quality, Safety and Experience Committee and Executive Director of Nursing, Quality and Patient Experience

We are delighted to bring you this report for 2025 to 2026 which shows how we, Hywel Dda University Health Board (the Health Board), are fulfilling our requirements under the Health and Social Care (Quality and Engagement) (Wales) Act 2020 (the Act) to meet the Duty Candour.

This report provides you with a summary of what is in place to ensure the Health Board is able to meet its obligations under the Act in relation to the Duty of Candour, how often the Duty has been triggered and what the themes are.

We continuously monitor our systems and processes so that we can learn and improve to ensure safe and high-quality care. We welcome your feedback in the form of complaints, concerns and compliments and provide a variety of ways in which you can do that. We work together with Healthcare Inspectorate Wales and Llais who give us independent feedback in light of visits to the Health Board and ensure that we act upon their recommendations.

Eleanor Marks, Vice Chair and Chair of the Quality, Safety and Experience Committee

Sharon Daniel, Executive Director of Nursing, Quality and Patient Experience

The Health and Social Care (Quality and Engagement) (Wales) Act 2020

Welcome to our Duty of Candour Annual Report for 2025 to 2026. This report is intended for our population, as well as our Board members. It gives us the opportunity to share with you how we are fulfilling our requirements under Duty of Candour which is a statutory duty within the Health and Social Care (Quality and Engagement) (Wales) Act 2020 (the Act).

The Health and Social Care (Quality and Engagement) (Wales) Act became law on 1 June 2020 with its full implementation completed April 2023. Its intention is to:

- Ensures that NHS bodies and ministers think about the quality of health services when making decisions;
- Ensures NHS bodes and primary care services are open and honest with patients, when something may have gone wrong with their care; and
- Creates a new Citizen Voice Body to represent the views of the people across health and social care.

There are two main duties under the Act which the Health Board must consider.

The Duty of Quality

Quality is more than just meeting service standards; it is a system-wide way of working to provide safe, effective, person-centred, timely, efficient and equitable health care in the context of a learning culture.

Significant progress has been made to improve the quality of health services in Wales but we still have challenges and changes that we must make to achieve better outcomes for patients across Carmarthenshire, Ceredigion, Pembrokeshire and the borders.

The Duty of Candour

The key intention of the Duty of Candour is to promote a culture of openness, learning and improving that is owned at organisational level, whether a person receives care from the NHS, or from a regulated provider of health care services, and that person can be assured that they will be dealt with in an **open and honest** way by their care provider.

Meeting the Duty of Candour: how we are ensuring we are open and transparent

The Health Board recognise the importance of the Duty of Candour in promoting a culture of openness and ensuring that there is learning and improving that is owned at organisational level.

Even when the Health Board does its very best to prevent harm, people may experience harm. This is why the duty of candour is in place. If the care provided has caused moderate harm, severe harm or death to a patient, this means that the organisations health and care professionals must tell its patients, or someone acting on their behalf, that harm has been caused.

By being open and honest, it will give people confidence and increase trust in the care and treatment they received from the Health Board.

Organisational Requirements

NHS bodies are required to follow a procedure when the duty of candour is triggered. The Act also requires NHS providers to report annually about when the duty has come into effect, how often the duty has been triggered, a description of the circumstances leading to the event and the steps taken by the provider with view to preventing any further occurrence. Triggering the duty does not mean an NHS body accepts any fault or blame.

Triggering the Duty of Candour

The Duty of Candour comes into effect if it appears to the NHS body that both of the following conditions are met:

- The first condition is that a person (the 'service user') to whom health care is being, or has been, provided by the body has suffered an adverse outcome which is more than minimal harm;
- The second condition is that the provision of the health care was, or may have been, a factor in the service user suffering that outcome.

For the purpose of the first condition, a service user is to be treated as having suffered an adverse outcome if the user experiences, or if the circumstances are such that the user could experience, any unexpected or unintended harm that is more than minimal.

The Duty of Candour Statutory Guidance 2023[1] prescribe the actions that must be taken and supports the existing processes for 'Putting Things Right' (the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011) with updates made to the Putting Things Right' (PTR) Regulations to include the Candour Guidance.

[1] https://www.gov.wales/sites/default/files/publications/2023-03/duty-of-candour-statutory-guidance.pdf

More than minimal harm

“More than minimal harm” is not defined in the Act. However, for the purposes of this guidance “more than minimal harm” is considered to constitute moderate harm, severe harm and death.

Moderate harm: is any significant but not permanent harm or harm that requires a ‘moderate increase in treatment’ relating to the incident. A moderate increase in treatment is defined as an unplanned return to surgery, an unplanned readmission, a prolonged episode of care, extra time in hospital or as an outpatient or transfer to another treatment area such as intensive care Severe harm: is the permanent lessening of the bodily, sensory, motor, physiologic or intellectual functions, including the removal of the wrong limb or organ or brain damage, which is related directly to the incident and not related to a natural course of the service user’s illness or underlying condition.

Death: A death caused or contributed to by a patient safety incident, as opposed to a death which occurs as a direct result of the natural course of the patient’s illness or underlying condition

Harm that is ‘unintended’ or ‘unexpected’

For Duty of Candour to be triggered, the harm must be unintended or unexpected. It can be as a result of either an actual intervention/treatment, or an omission in care, for example, a missed cancer diagnosis.

Medical or surgical treatment and all care interventions may of course come with inherent risks or may in itself cause a temporary increase in symptoms.

Harm which is caused by the treatment itself (e.g. impairments in function as a result of surgery,) would not necessarily be notifiable. These may fall into the category of a known risk, which may have been explained to, and accepted by, the patient as part of the consenting process.

How are we assessing patient safety incidents

Each Clinical Care Group and Clinical Service Group have processes to manage patient safety incidents. This includes an initial review by a designated manager of the incident report. If a patient safety incident is categorised, by the manager undertaking the initial review of the report, as moderate or above and health care was, or may have been, a factor, the Duty of Candour is triggered, and the procedure must be followed. The Datix Cymru system is used to record all activity relating to the patient safety incident including key dates relating to the Duty of Candour.

Dashboards are available within the Datix Cymru system for each directorate and service to ensure the Candour procedure is followed and performance indicators are met.

Candour performance is validated by the Quality Assurance and Safety Team and is reported through the Clinical Service Improving Together meetings.

We would like to take this opportunity to thank our staff who strive for improvements to the quality of care provided to our patients, who continue and are proud to be open and honest and learn from concerns when things do not go as well as we would wish. Staff have embraced the Duty of Candour and are aware of the processes to comply with the requirements of the Act. There is further work to do to support staff to comply in a timelier manner with the reviews and responses to concerns, and we are committed to make improvements in this area.

Health Board Performance

During 2025/2026[2], 1952 patient safety incidents were reported where the reporter said their initial harm assessment was moderate or above. Of these incidents, following the Manager's Interim Harm Assessment, 1,352 patient safety incidents were downgraded to low harm or no harm. This shows an 69.2% downgrade rate across the Health Board (in 2024/2025, we reported a downgrade rate of 75%).

During the reporting period, Datix Cymru is reporting as showing 85 patient safety incidents graded by the reporter as no or low harm which, following 'Manager's Interim Harm Assessment', were re-graded as moderate harm or above.

There can be a difference between the reporter's harm grading and the manager's interim harm assessment. The reporter may give the outcome for the person affected with no consideration as to whether there was an act or inaction in the healthcare or they may report on what they expect the harm will be for the person affected rather than the actual harm.

This data suggests further work is required to ensure staff are aware of the classification of harm to be record when reporting an incident.

Duty of Candour Triggered

During 2025/26, both conditions[3] were met and the duty of candour was triggered in 109 patient safety incidents[4].

The manager undertaking the initial assessment is asked to provide information as to the rationale for triggering the Duty of Candour. The high level themes are:

- Inpatient fall (16.5%)
- Pressure Damage developed / worsened in hospital (4.5%)
- Maternity adverse event (3.6%)
- Medication issues (2.75%)

The top 5 reported categories of incidents where the Duty was triggered:

- Accident / Injury (21%)
- Treatment / Procedure (14%)

[2] *Patient safety incidents reported between 01.04.25-31.03.26 where the reporter has stated their initial assessment of harm is moderate, severe or catastrophic/death*

[3] *The Duty of Candour comes into effect if it appears to the NHS body that both of the following conditions are met:*

- *The first condition is that a person (the 'service user') to whom health care is being, or has been, provided by the body has suffered an adverse outcome which is more than minimal harm;*
- *The second condition is that the provision of the health care was, or may have been, a factor in the service user suffering that outcome*.

[4] *Patient safety incidents where the duty was triggered between 01.04.25-31.03.26*

- Assessment / Investigations (11.9%)
- Access / Admission (11%)
- Medication / IV fluids (11%)

Incident Classification	Number of DoC Triggered Incidents
Access, Admission	12
Accident, Injury	23
Assessment, Investigation, Diagnosis	13
Behaviour (including violence and aggression)	1
Communication	2
Equipment, Devices	1
Infection Prevention and Control	3
Maternity adverse occurrence	6
Medication, IV Fluids	12
Patient/service user death	8
Pressure Damage, Moisture Damage	10
Transfer, Discharge	2
Treatment, Procedure	16
Grand Total	**109**

Post investigation harm

Of the 109 patient safety incidents where the duty was triggered between 01/04/2025 and 31/03/2026, 28 incidents have been investigated and the record subsequently closed. Post investigation harm assessment shows that 7 (25%) did not cause moderate harm or above as a result of healthcare.

Of the 109 patient safety incidents where the duty was triggered between 01/04/2025 and 31/03/2026 the difference between the Interim and Post Harm is shown below:

	Managers Interim Harm Assessment	Harm Assessment Post Investigation
Moderate	75	44
Severe	24	4
Catastrophic	10	9
Low	-	10
No	-	2

Learning identified

Of the patient safety incidents where the duty was triggered and the investigation has concluded, the learning includes:

- A patient contacting a practice for urgent care on three consecutive days should be offered an appointment. It is likely that the patient could have been treated successfully in a primary care setting and this scenario could have been avoided.

- Abnormal CTG patterns must be accurately classified and escalated promptly to senior clinicians.
- Fall identified promptly and family communicated with appropriately. Updates MFRA (Multifactoral Risk Assessment) and Manual handling risk assessment required after the fall. Updates to documentation regarding footwear required.
- Importance of Hover Jack and neurological observations to be documented.
- A reminder regarding the documentation of holistic care during skin checks.
- Importance of delirium screens to be documented
- Learning for inclusion in a Primary Care Briefing (Lessons Learned section) and for sharing with Secondary Care colleagues. The patient was in the incorrect area in the department and the importance of escalating any concerns regarding deterioration to be documented.
- As part of the learning from this incident, immediate action was taken to commence the development of Emergency Department–specific guidelines, policies, and clinical pathways to support consistent decision making for patients presenting with syncope. A key lesson from this case is the critical importance of early recognition and escalation of red flag features suggestive of a cardiac cause. In this instance, the patient's presentation included exertional syncope, shortness of breath, indigestion type chest discomfort, and sudden loss of consciousness without prodromal symptoms—features which are widely recognised as high risk indicators of potential cardiac pathology but were not escalated for specialist review at the time. This incident reinforces that syncope occurring during exertion, particularly when accompanied by chest related symptoms, should prompt urgent cardiac assessment and consideration of admission or specialist referral, regardless of symptom resolution or normal findings on initial ECG and observations.
- A further learning point from this incident is the importance of timely cardiology involvement in patients presenting with high risk features suggestive of a cardiac cause of syncope. Earlier referral or admission for cardiac assessment at the point of Emergency Department attendance may have facilitated more prompt investigation of underlying cardiac pathology. The timeline also illustrates how delays to senior clinical review within a high-pressure Emergency Department environment can influence clinical reasoning. In this case, the near six-hour interval between triage and medical review may have contributed to diagnostic anchoring on a benign cause, such as vasovagal syncope, and a reduced perceived urgency for further cardiac investigation once the patient was asymptomatic.

Contracted Services – Primary Care

Contractors within the Primary Care setting, which includes Community Pharmacists, General Medical Practitioners, General Dental Practitioners and Optometrists, are required to submit data to the Health Board relating to the Duty of Candour in September 2026.

Concerns Management

High quality, safe and compassionate care is at the heart of health care being delivered by our staff. Despite these intentions, inevitably from time to time our patients may suffer harm due to challenging and / or complex situations. When harm does occur, being open and honest should feel like the right thing to do.

Dealing with these situations quickly, sensitively and openly is of great importance and can make a difference to a patient's ongoing relationship with the Health Board.

Throughout 2025/26 at our Board meetings, we have reported how we are improving our people's experience which includes our concerns management and patient experience survey data. An example from the Board meeting in November 2025, can be found through the following link Board agenda and papers 27 November 2025 - Hywel Dda University Health Board

Listening and Learning Sub-Committee

The Listening and Learning Sub-Committee is a sub-committee of the Health Board's Quality, Safety and Experience Committee. The sub-committee provides clinical teams across the Health Board with a forum to share and scrutinise learning from concerns (incidents, complaints, and claims) and other quality areas such as external inspections, and to share innovation and good practice.

During 2025/26, the Listening and Learning Sub-Committee considered the following themes. This was in addition to the Learning from Events Reports (LfER) relating to Redress payments and claims and recommendations made by the Public Services Ombudsman for Wales. A summary of the Sub-committee can be found in the agenda and papers for the Quality, Safety and Experience Committee.

- A&E
- Communication (Can I trust you)
- Mental Health/Learning Disabilities
- Communication & Regulatory Updates
- Ophthalmology

3.3

3.3 - Quality Assurance Report for Commissioned Services

Anne Simpson (Hywel Dda UHB - Head of Strategic Commissioning), Julia McCarthy (Hywel Dda UHB - Head of Long Term Care)

Attachments

QSEC Commissioning presentation June 2026.pdf

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Hywel Dda
University Health Board

Commissioning for Quality

Quality, Safety and Experience Committee

11 June 2026

Quality and safety are integral to the Long-Term Agreement (LTA) contractual meetings with providers, involving representatives from the quality and safety teams of both organisations. A new report has been introduced by SBUHB, covering incidents, complaints and concerns for Hywel Dda (HD) residents.

SBUHB Quality & Safety Report for HD Residents 25/26 (includes JCC commissioning responsibility)

Incidents = 1,047 (1,041 patient/service user)

Top 5 incidents relate to pressure damage/moisture damage, assessment/investigation & diagnosis, treatment/procedure issues, information issues and accident & injury. Top 5 specialties include cellular pathology, cardiology, vascular, oncology and cardiothoracic.

Complaints = 162

Qtr1 = 47, Qtr 2 = 42, Qtr 3 = 35, Qtr 4 = 38

Majority of complaints relate to Cardiology, Maxillofacial, Orthodontics, Orthopaedics/Spinal and Burns and Plastics specialties. They are driven primarily by delays and communication issues across high volume specialties.

Claims/Inquests = 23 (Claims = 15, Inquests = 8)

Claims and Inquests show that the highest level of harm arises when delays, communication failures and clinical decision making issues occur together, especially in high acuity specialties.

The data shows consistent specialty concentration (cardiology, orthopaedics) but harm is primarily driven by system issues (delays, communication) rather than an isolated service.

Commissioning & Contracting Oversight Group

A new Commissioning & Contracting Oversight Group was formed in July 2025 to oversee regional agreements and specialised services. This group provides strategic oversight of agreements with neighbouring Health Boards, specialised services provided by the NHS Wales Joint Commissioning Committee (NWJCC) and other regional programmes of work, such as South West Wales Cancer Centre. Quality & Safety is a core thread across all areas of oversight, with routine consideration of quality & safety arising from commissioned services.

Consequently, the Quality & Safety report (slide 2) has been discussed and considered in both recent LTA meeting with Swansea and also at a recent Commissioning & Contracting Oversight Group.

To Note

- HD has always received serious incidents and complaints for their residents via the national reporting route.
- All Health Boards (HBs), as a Provider of services are bound by the Duty of Candour, which requires them to be open, honest and transparent with patients or their families when something goes untoward during care or treatment, resulting in, or potentially causing harm. Therefore, whilst the patient may be resident in another HB area, HDdUHB would expect all patients to be managed in the same way, including following the same complaints/concerns procedures to that of a provider resident.

Actions/Next Steps

No immediate single service concerns were raised/identified; however, the quality and commissioning team will monitor and where appropriate undertake a thematic review of the top 5 incident categories to determine whether these align with known service fragilities or commissioned service pressures. This review will be reported through the Oversight Group.

The analysis presented is predominantly based on SBUHB data. It is recognised that commissioned services operate across a wider provider landscape, including Cardiff and Vale University Health Board (CAVUHB) as a main Provider. Work is ongoing to develop a more comprehensive, whole system commissioning dataset to strengthen oversight.

Quality & Safety 25/26 – NHS Wales Joint Commissioning Committee (NWJCC)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Quality: Incidents and Complaints The number of quality and incidents are described in Figure 1 and Figure 2 describes the number of complaints broken down by origin, health board and commissioning team by month 8 25/26.

What is NWJCC doing?

The information enables an understanding of how well services are performing and where improvements are needed. Consistent monitoring of quality supports the Duty of Quality and ensures that commissioning decisions are grounded in accurate, timely clinical insights about patient experience and outcomes.

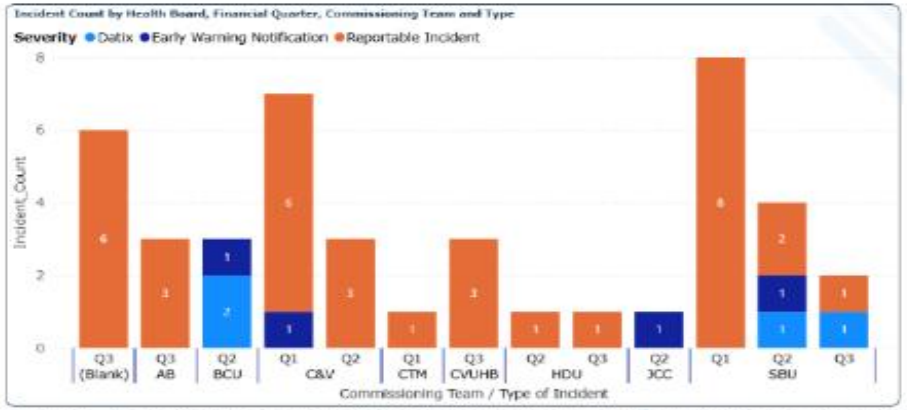

Figure 1. It shows the number of incidents reported to the NWJCC by severity type, health board, and by commissioning team by M8 2025/26.

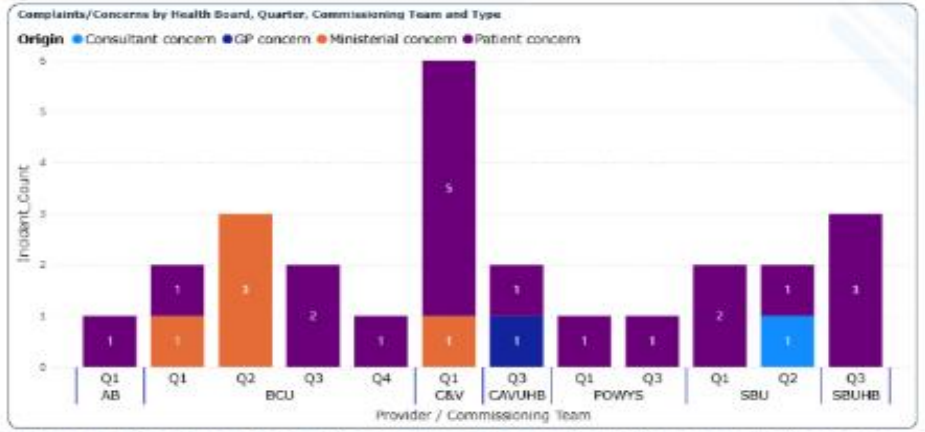

Figure 2. The figure shows the number the number of complaints / concerns reported to the NWJCC by severity type, health board, and by commissioning team by M8 2025.

NWJCC Quality & Safety Outcomes Committee (QSOC) – HDdUHB Chief Executive Officer (CEO) is a sub-committee member, reports received include:-

- Receive report from 3 commissioning areas (Specialist Services, Ambulance Services & 111 and MHLD & Vulnerable Groups)
- Listening and learning – patient story
- Incident and Concerns Report

JCC – receive bi-monthly QSOC highlight reports

NWJCC undertake quality visits with main providers, also have routine Service Level Agreement (SLA) meetings

NWJCC meet with quality leads routinely.

Work in progress in standardising the 3 commissioning areas and ens[illegible]s included as a standard agenda item, across applicable meetings.

Tertiary Paediatric Neurology – Outreach Clinics – NWJCC

NWJCC commissions the tertiary care element of paediatric neurology services from CAVUHB and in some cases Bristol, while responsibility for secondary care remains with HDdUHB.

Previously, CAVUHB provided outreach clinics within the HD area, however these have not been reinstated since the retirement of a Cardiff Consultant at the end of last year. The Cardiff & Vale workforce has reduced 3-4 Consultants against an establishment of 6 Consultants, with retirements and unsuccessful recruitment contributing to a fragile service position.

In the absence of the tertiary outreach provision, HDdUHB secondary care service are managing these patients as far as possible. However there is an immediate need to agree both interim and longer-term solutions with Cardiff and NWJCC.

HDdUHB service has also been asked to provide NWJCC with detailed information on patient numbers, waiting times and local monitoring arrangements.

While discussions between NWJCC, Cardiff and Hywel Dda are ongoing, if a clear resolution is not reached, NWJCC will need to escalate through their formal escalation process.

Actions/Next Steps – Service & Commissioning by Q2

- Continue to Escalate through NWJCC and provider discussions to secure:
- Time bound workforce plan
- Restoration of outreach clinics
- Agree and implement interim arrangements (where appropriate)
- Monitor impact (waiting times, activity) and escalate further if required.

Waiting Times Month 12 25/26 - SBUHB

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The table below shows the latest position as at the end of March 2026 for patients waiting by top 5 speciality within SBUHB.

Specialty	New Out-Patient	Follow-up Out-Patient	Day Case	In Patient	Grand Total
Oral/Maxillo Facial Surgery OMFS)	1212	622	319	48	2201
Plastic Surgery	202	108	575	110	995
Spinal	288	154	14	258	714
Trauma & Orthopaedic (T&O)	80	27	253	82	442
Cardiology	244	43	33	112	432

Top 5 Specialties

- New Outpatients - 3 patients are awaiting > 52 weeks (2 Spinal and 1 Cardiology patient)
- OMFS – HDdUHB has requested further detail on the underlying causes, alongside clear recovery plans and actions to manage and reduce waiting times.
- Plastic Surgery – All aspects of plastic surgery are currently commissioned by NWJCC and for the population of South Wales are provided by SBUHB. There is an understanding that a high % of plastic surgery is non-specialised work and therefore there is an intention for commissioning responsibility for this cohort of patients to transfer to HBs, no date confirmed as yet. This is to form part of the work plan for Commissioning & Contracting Oversight group.
- T&O/Spinal – is part of the South Wales Regional Programme and there are regional groups in place to move this forward.

Actions/Next Steps by Q2

- Require clear recovery plans from SBUHB for high-risk specialties (OMFS, plastics etc)
- Monitor and track patients waiting >52 weeks through commissioning oversight
- Use LTA and oversight meetings to challenge progress and trajectory

Waiting Times Month 12 25/26 - CAVUHB

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

The table below shows the latest position as at the end of March 2026 for patients waiting by top 5 speciality within CAVUHB

Specialty	3. Outpatient Waiting List	4. Inpatient/Daycase Waiting List	5. In Follow-Up Cycle	Grand Total
Trauma & Orthopaedics	88	92	34	214
Neurosurgery	65	41	14	120
Paediatrics	28	29	59	116
General Surgery	16	51	33	100
Clinical Haematology	35	6	25	66

Top 5 Specialties

- Outpatients - 34 patients are awaiting > 52 weeks (30 Orthopaedics and 4 Clinical Haematology patients)
- Trauma & Orthopaedics - HDdUHB has requested further detail on the underlying causes, alongside clear recovery plans and actions to manage and reduce waiting times.
- Neurosurgery – All aspects of Neurosurgery are currently commissioned by NWJCC.

Actions/Next Steps by Q2

- Seek detailed recovery trajectories for orthopaedics and haematology waits
- Align actions with regional programmes (e.g. orthopaedics)
- Continue escalation via routine commissioning and LTA routes.

Note – prolonged waiting times are a recognised contributor to delayed diagnosis, deterioration and poorer patient experience, aligning with themes identified in incident and complaint data.

Recommendation for the Committee:

- **Note** the overall quality and safety position for commissioned services.
- **Acknowledge** that SBU incident, complaints and claims data identify recurring system themes, particularly delays and communication.
- **Note** the emerging risk relating to tertiary paediatric neurology provision.
- **Receive assurance** that issues are being actively monitored and escalated through commissioning arrangements.

Long Term Care Assurance for Commissioned Nursing Homes

Long Term Care Commissioning
(Effective, Efficient, Equitable & Person-centred)

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

Effective Assessment of Needs

- Multidisciplinary assessments consider holistic care needs to ensure suitable care placements

Efficient Governance and Resource Use

- Transparent governance supports timely decisions and responsible use of public resources balancing needs and sustainability

Equitable Access to Care

- Consistent criteria and processes ensure fair access to care irrespective of location or Provider

Person-Centred Approach

- Assessments focus on individual needs, risks, preferences and family involvement to support personalised care

Ongoing Monitoring & Quality Assurance
(Safe, Timely, Effective)

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

Safety through Oversight

- Oversight by our specialist nurses ensures early risk identification and rapid escalation of safety concerns

Timely Reviews and Engagement

- Regular reviews and active engagement with Providers address issues early to prevent escalation and maintain care standards

Effective Reassessment Processes

- Structured reassessments confirm care meets needs throughout the care duration

Collaborative Quality Assurance

- Shared intelligence across forums supports coordinated system response and proactive, preventative monitoring models

Patient Safety & Safeguarding
(Safe, Timely, Person-centred)

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

Collaborative Safeguarding

- Safety & quality of care is supported through safeguarding teams, clinical leads, commissioning teams & Local Authorities

Timely Risk Response

- Escalation pathways enable a timely response to incidents, aiming to reduce harm and support protective actions for patients

Person-Centred Care

- A strong focus upon individual needs and preferences, with care plans regularly reviewed to ensure they reflect individual needs

Risk Monitoring and Governance

- Active monitoring and transparent reporting of risks promote oversight and consistency in safeguarding and commissioning decisions

Routine Engagement & Provider Support
(Effective, Efficient & Safe Assurance)

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

Structured Monthly Meetings

- Monthly meetings between specialist nurses and care home managers enable timely review of care quality and emerging concerns

Quarterly Monitoring Visits

- Regular observational visits provide assurance on care delivery, staffing, environment, and early risk identification

Balanced Support and Accountability

- Engagement model fosters strong provider relationships while ensuring accountability and robust challenge where needed

Regional Quality Assurance
(Effective, Safe & Efficient Collaboration)

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

Collaborative Oversight

- Regional collaboration enables effective monitoring of quality and sharing intelligence across organisations

Enhanced Safety

- Shared awareness of risks and coordinated responses strengthen safety

Efficiency through Shared Resources

- Reducing duplication of efforts and utilizing shared expertise improves efficiency

Clear Governance and Accountability

- Defined escalation routes and contract management ensure consistent and transparent resolution

Out of County Placements
(Safe, Equitable, Effective)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Equitable Commissioning Standards

- Applying a consistent commissioning process ensures informed consideration of all placements regardless of location

Safety Assurance

- Safety is ensured through full MDT assessment, inspection reviews, and pre-admission provider evaluations

Collaborative Effectiveness Monitoring

- Collaboration with Local Health Boards/Integrated Care Homes enables shared intelligence and effective oversight of placements

Ongoing Quality Governance

- Quality Assurance Panels and remote monitoring maintain governance

Continuous Improvement & Provider Development
(Effective & Efficient)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

- Manager forums facilitate shared learning
- Access to training and specialist support
- Improves outcomes and experience

In summary, as the commissioning Health Board, our goal is not just to purchase care, but to support nursing homes to deliver safe, high-quality and sustainable care

Recommendation

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

DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG

SAFE | SUSTAINABLE | ACCESSIBLE | KIND

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

3.4

3.4 - Clinical Audit Programme for Approval

Ian Bebb (Hywel Dda UHB - Clinical Audit Manager)

Attachments

Clinical Audit Update QSEC May 2026.pdf

Clinical Audit Programme 2026-2027 (April-September).pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	11 June 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Clinical Audit Programme Update
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Mark Henwood, Medical Director
SWYDDOG ADRODD: REPORTING OFFICER:	Ian Bebb, Clinical Audit Manager

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

To present the 2026/27 Clinical Audit Programme to the Quality, Safety and Experience Committee for review, discussion, and approval, ensuring alignment with organisational priorities, national standards, and regulatory requirements.

Cefndir / Background

The Health Board develops an annual Clinical Audit Programme which is carried out by the operational Services. This programme consists of a list of key clinical audit projects that have been prioritised in line with Health Board (service specific or otherwise) aims and objectives. This programme also includes all projects mandated by Welsh Government (National Clinical Audit and Outcome Review Plan (NCAORP) and other national bodies. National benchmarking is possible through this mechanism.

The Health Board needs to support effective clinical audit that leads to improvements in the quality of care that we provide. Audit projects should contribute to the achievement of Health Board priorities and be clear about how patient care will be improved. There is a need to adhere to all external mandatory priorities whilst continuing to support quality local audit activity related to Health Board priorities. With finite resources for audit activity there is a limited number of projects which can be supported by the Clinical Audit Department and the wider Health Board, therefore, it is vital that we have a robust system to prioritise, approve, and monitor audits.

National Clinical Audit
The National Clinical Audit and Outcome Review Plan (NCAORP) is a mandatory audit programme in Wales. The programme is set and monitored by Welsh Government and derived from the mandatory English programme.

The Health Board is responsible for participating in 40 (variable from year to year) mandatory national audits that feature in the NCAORP. In addition to this there are ad hoc Outcome

Reviews (e.g. National Confidential Enquiry into Perioperative Death (NCEPOD) studies) that are also mandated.

Mandatory national audits are automatically included on the Clinical Audit Programme.

Local Clinical Audit Programmes
The Clinical Audit Department (CAD) liaise with several services to establish a local programme each financial year. Clinical Audit Programmes are split into two 6 monthly segments to allow services to focus on more timely audit completion as well as grant more opportunities for services to contribute to the programme.

The programme audits are set by key governance and quality groups/committees representing the various service areas. The CAD and other bodies may be given indicators as to what audits should be included in audit programmes and will provide suggestions when appropriate.

Priorities for inclusion in the programme:

- National Clinical Audit and Outcome Review Programme - *automatically included on the programme*
- Patient Safety Issues
- National Institute for Care Excellence (NICE) guidance
- Welsh Risk Pool/Health Inspectorate Wales (HIW)/Other required audits
- Audits associated with the risk register
- Complaints/Incidents/Litigation that require clinical audit
- Other Health Board priorities
- Important local audit priorities

Asesiad / Assessment

Clinical Audit Programme 2026/27

The Clinical Audit Programme for 2026/27 (Apr-Sept) has a total of 40 clinical audit projects. Many of the audits featured on the programme are continuous audits or re-audits and will continue to future programmes. The importance of re-audit is critical to demonstrate that we are continuing to make improvements where standards of practice are not being met. These types of projects generally have more impact than isolated audits and are encouraged whenever possible.

The 40 NCAORP projects are automatically included in addition, bringing the total to 80. The Clinical Audit Department (CAD) are continuing to work with services to expand this programme as well as to ensure projects are completed and focused on quality improvement. Projects are not typically called out as aligning with the Safe, Timely, Equitable, Efficient, Effective, Person Centred (STEEEP) principles, however all audit projects are aimed at creating safer, timely, effective and more equitable care. All clinical audits should be centred around evidence based practice. Clinical audit is therefore a key component in demonstrating and evidencing STEEP. Many of the Nursing audits are directly related to STEEEP.

A copy of the programme is attached for this Committee to discuss and review.

It should be noted that the following groups have submitted draft action plans, requiring final approval and are expected imminently.

- Infection Prevention Strategic Steering Group
- Senior Nursing and Midwifery Team

- Public Health

The Clinical Audit Department has agreed a bespoke approach with Allied Health and Health Sciences Clinical Care Group to formulate an audit programme.

A separate list of the NCAORP audits has also been included as an additional TAB in the document. Reporting, data collection, and other parameters vary significantly between national audits. A distinction is made to avoid confusion when reporting as well as to highlight the priority of these key projects.

Organisational Alignment

For this iteration of the Clinical Audit Programme, the Quality, Safety and Experience Committee and the Audit, Risk and Assurance Committee were invited to propose audit topics for inclusion. While no specific audit projects were identified through this process, the opportunity to suggest topics remains open. The programme will therefore remain flexible, with additional audits incorporated throughout the year as required to respond to emerging risks, priorities, or assurance needs.

Argymhelliad / Recommendation

- The Quality, Safety and Experience Committee is asked to discuss and consider approval of the Clinical Audit Programme for 2026/27

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	5.17 Shape and Approve the annual clinical audit plan, ensuring that internally commissioned audits are aligned with strategic priorities.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	1. Safe 2. Timely 3. Effective
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	3. Data to knowledge 4. Learning, improvement and research
Amcanion Strategol y BIP: UHB Strategic Objectives:	3. Striving to deliver and develop excellent services
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	2. Develop a skilled and flexible workforce to meet the changing needs of the modern NHS

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	National Clinical Audit and Outcome Review Programme 2023/24 Hywel Dda UHB Forward Clinical Audit Programme 2022/23, 2023/24
Rhestr Termau: Glossary of Terms:	NCAORP – National Clinical Audit and Outcome Review Programme CAD – Clinical Audit Department
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	Mandy Davies, Assistant Director of Nursing and Quality Improvement Sharon Daniel, Director of Nursing, Quality and Patient Experience

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not applicable
Ansawdd / Gofal Claf: Quality / Patient Care:	The principals of audit imply that quality/patient care will be impacted. However, the impact of the audits held within this report are positive examples of improvement activities and are individually called out.
Gweithlu: Workforce:	Workforce engagement in Clinical Audit provides an understanding of the impact of quality of service and clinical care delivery and is a key driver for appraisal for medical staff and professional practice development in all clinical disciplines.
Risg: Risk:	Audit specific risks are contained within service/specialty specific risk registers. This includes non-participation with mandatory national audits.
Cyfreithiol: Legal:	Not applicable

Enw Da: **Reputational:**	There is the potential for reputational impact when the Health Board does not participate in mandatory audit projects. None of the criteria in the impact assessment apply.
Gyfrinachedd: **Privacy:**	Not applicable
Cydraddoldeb: **Equality:**	Not applicable

AUDIT STATUS	ORIGINATING COMMITTEE	SPECIALITY	AUDIT TITLE
In Progress	MH CAEG	Mental Health	Physical Health Monitoring on Adult Acute Psychiatric Wards of Hywel Dda University Health Board
In Progress	MH CAEG	Mental Health	Rapid Tranquilisation Monitoring Standards
In Progress	Nutrition and Hydration Group	Nutrition & Dietetics	Meal Time Audit (Patient)
In Progress	Nutrition and Hydration Group	Nutrition & Dietetics	Meal Time Audit (Ward)
In Progress	Nutrition and Hydration Group	Nutrition & Dietetics	Fluid Balance
In Progress	Nutrition and Hydration Group	Nutrition & Dietetics	WAASP
In Progress	SNMT	Professional Standards Team	Bare Below the Elbows - All Wales Core
In Progress	SNMT	Professional Standards Team	Continence Care Audit
In Progress	SNMT	Professional Standards Team	Controlled Drugs Audit
In Progress	SNMT	Professional Standards Team	Falls Extensive Check Audit
In Progress	SNMT	Professional Standards Team	Hand Hygiene - All Wales Core Audit
In Progress	SNMT	Mental Health & Learning Disabilities	Learning Disabilities Audit
In Progress	SNMT	Professional Standards Team	Medicines Management Patient Audit - All Wales Core
In Progress	SNMT	Professional Standards Team	Medicines Management Ward Audit - All Wales Core
In Progress	SNMT	Professional Standards Team	Personal Protective Equipment (PPE) - All Wales Core
In Progress	SNMT	Professional Standards Team	Positive Patient Identification Audit
In Progress	SNMT	Professional Standards Team	Rostering Audit
In Progress	Cardiology Quality, Safety & Assurance	Cardiology	WHO Surgical and Safety Checks Audit
In Progress	HDUHB RADAR	Cross Speciality Improvement	NEWS2
In Progress	HDUHB RADAR	Cross Speciality Improvement	PEWS Audit
In Progress	SNMT	Professional Standards Team	Maternity Record Keeping Audit: January 2025 - January 2026
In Progress	Thrombosis	Thrombosis	RE-AUDIT '25 - Venous Thromboembolism Inpatients Audit NICE QS 201 S1 - Cycle 5
In Progress	Thrombosis	Thrombosis	RE-AUDIT '25 - Venous Thromboembolism Lower Limb Immobilisation Audit NICE QS 201 S2 - Cycle 5
In Progress	Thrombosis	Thrombosis	RE-AUDIT '25 - Venous Thromboembolism Outpatient Follow Up Audit NICE QS 201 S4 & S5 - Cycle 5
In Progress	Thrombosis	Thrombosis	RE-AUDIT '25 Venous Thromboembolism Radiology Referral USS Audit NICE QS 201 S3 (H61) - Cycle 3
Awaiting Report	HDUHB RADAR	Cross Speciality Improvement	All Wales Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR)
Awaiting Action Plan	Respiratory Annual Forum	Respiratory	Acute NIV Health Board Wide

Complete	Care of the Elderly	Hywel Dda Palliative and End of Life Care Group	All Wales Care Decisions for the Last Days of Life (April 2024 - March 2025)
Planning	Care of the Elderly	Hywel Dda Palliative and End of Life Care Group	All Wales Care Decisions for the Last Days of Life (April 2025 - March 2026)
Planning	SNMT	Professional Standards Team	Mouthcare
Planning	SNMT	Professional Standards Team	Pressure Damage Management
Planning	SNMT	Professional Standards Team	Infection Prevention & Control Management Audit
Planning	SNMT	Professional Standards Team	Record Keeping - Content
Planning	SNMT	Professional Standards Team	Record Keeping - General
Planning	Safeguarding Steering Group	W&CH	Routine Enquiry
Planning	SNMT	Professional Standards Team	Senior Peer Review/15 steps audit
Planning	HDUHB RADAR	Cross Speciality Improvement	Sepsis Medical Emergency
Planning	HDUHB RADAR	Cross Speciality Improvement	MEWS
Planning	HDUHB RADAR	Cross Speciality Improvement	NEWTT2
Planning	HDUHB RADAR	Cross Speciality Improvement	Medical Emergency Trolley Audit

	Title
CARDIOLOGY	Myocardial Ischaemia National Audit Project (MINAP)
	National Heart Failure Audit (NHFA)
	National Audit of Cardiac Rehabilitation (NACR)
	National Audit of Cardiac Rhythm Management (NACRM)
CHILDREN, WOMEN & FAMILY HEALTH	National Ovarian Cancer Audit (NOCA)
	National Maternity and Perinatal Audit (NMPA)
	National Neonatal Audit Programme (NNAP)
	National Pregnancy in Diabetes Audit (NPID)
	NCAORP Epilepsy 12
	NCAORP National Children and young peoples asthma (CYPA)
	NCAORP National Paediatric Diabetes Audit (NPDA)
	National Audit of Primary Breast Cancer (NAoPri)
	National Audit of Metastatic Breast Cancer (NAoMe)
RESPIRATORY	National Pulmonary Rehabilitation Audit (PR)
	Chronic Obstructive Pulmonary Disease (COPD)
	Adult Asthma (AA)
	Wales Primary Care Audit (Asthma & COPD)
	National Lung Cancer Audit (NLCA)
CARE OF THE ELDERLY	National Audit of Dementia (NAD)
	Stroke Sentinel National Audit Programme (SSNAP)
	Fracture Liaison Service (FLS)
	National Audit of Care at the End of Life (NACEL)
	National Audit of Inpatient Falls (NAIF)

DIABETES	National Diabetes Foot Care Audit (NDFA)
	National Core Diabetes Audit (NCDA)
	National Diabetes Inpatient Safety Audit (NDISA)
PLANNED CARE	All Wales Audiology
	Comparative Audit of Critical Care Unit Adult Patient Outcomes (ICNARC)
	National Hip Fracture Database (NHFD)
	National Joint Registry (NJR)
	National Major Trauma Registry (NMTR)
	National Early Inflammatory Arthritis Audit (NEIAA)
	National Emergency Laparotomy Audit (NELA)
	National Bowel Cancer Audit (NBOCA)
	Oesophago-Gastric Cancer Audit (NOGCA)
	National Pancreatic Cancer Audit (NPaCA)
	National Non-Hodgkin Lymphoma Audit (NNHLA)
	National Kidney Cancer Audit (NKCA)
	National Prostate Cancer Audit (NPCA)
MENTAL HEALTH	National Audit of Psychosis (NCAP)

3.5

3.5 - Nurse Staffing Levels Spring Cycle Report

Helen Humphreys (Hywel Dda UHB - Head of Nursing for Professional Standards and Regulation)

Attachments

QSEC SBAR Spring 2026 Nurse Staffing Levels Calculation Cycle FINAL .pdf

Nurse Staffing Levels Assurance report 2025-2026 FINAL .pdf

Appendix 1 Annual Presentation NSL Spring 2026.xlsx

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	11 June 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Nurse Staffing Levels (Wales) Act 2016: Annual Presentation of Nurse Staffing Levels
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Sharon Daniel, Executive Director of Nursing, Quality and Patient Experience
SWYDDOG ADRODD: REPORTING OFFICER:	Helen Humphreys, Head of Nursing, Professional Standards and Regulation Catrin Jones, Nurse Staffing Programme Lead.

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Statutory Guidance for the Nurse Staffing Levels (Wales) Act 2016 requires an annual report to the Health Board each November, and updates when ward use or services change in a way that affects staffing levels, or when deemed necessary.

The Quality, Safety and Experience Committee is asked to receive the outcome of the Spring 2026 Nurse Staffing Levels - Appendix 1 (covering all Section 25B wards), and to be assured that the legal duty to calculate nurse staffing levels for acute adult medical, surgical, and paediatric wards is being met.

This SBAR covers the changes that have been made to nurse staffing levels for wards covered by Section 25B (S25B) of the Nurse Staffing Levels (Wales) Act 2016 between Autumn 2025 and Spring 2026:

- 18 adult acute medical inpatient wards
- 12 adult acute surgical inpatient wards
- 2 paediatric inpatient wards

Cefndir / Background

The Nurse Staffing Levels (Wales) Act 2016 requires Health Boards to:

- Calculate and maintain nurse staffing levels in adult medical/surgical and paediatric inpatient wards.
- Use a prescribed triangulated methodology.
- Monitor and report the impact of staffing levels on patient care.
- Provide formal assurance to the Board and Welsh Government
- An annual assurance report is presented to the Board each May, in line with NHS Wales agreement, to evidence compliance and support statutory reporting.

There are two key reporting requirements:

1. The Board receives an annual presentation of the Nurse Staffing Levels which have been calculated for all Section 25B wards (presented to Board in November).
2. The Board receives a (non-statutory) annual assurance report which is structured in a way to provide the basis of the statutory 3-year report to Welsh Government (WG) which the Health Board will be required to submit every third year (next due 2027) (presented to the Board in May).

Asesiad / Assessment

The Board receives an annual presentation of the Nurse Staffing Levels which have been calculated for all Section 25B wards (presented to Board in November) and updates are provided to the Quality, Safety and Experience Committee when ward use or services change in a way that affects staffing levels, or when deemed necessary.

Calculating the Nurse Staffing Levels: In line with the Nurse Staffing Levels (Wales) Act 2016 and its Statutory Guidance, the 'nurse staffing level' refers to the number of registered nurses—and delegated staff—required to deliver the planned roster. While other healthcare professionals contribute to patient care and coordination, they are not included in the information set out in Appendix 1.

For each inpatient ward (adult and paediatric) to which Section 25B applies under the Nurse Staffing Levels (Wales) Act 2016, a systematic review and recalculation of nurse staffing levels have been completed.

There was no change to the planned roster and required establishment of 28 of the adult medical/surgical wards and one paediatric ward, following the Spring 2026 calculation cycle.

The changes following the Spring 2026 cycle were:

- An additional 2.72wte Registered Nurse (RN) requirement on ward 10, Withybush Hospital (WGH) (additional RN on day duty x seven days), with a reduction of 2.52wte band 4, Assistant Practioner based on acuity.
- A change in the proportion of long days worked by Nursing Support Workers on Cadog ward.
- A change in the proportion of long days worked by both RN and Nursing Support Worker on Angharad ward.

The process was led by the Executive Director of Nursing, Quality and Patient Experience, supported by the Assistant Director of Nursing. It involved all Senior Sisters/Charge Nurses from Section 25B wards, Senior Nurse Managers, and relevant Heads of Nursing.

In line with the Act, the prescribed triangulated methodology for calculating nurse staffing levels has been applied rigorously across all relevant wards. Key considerations included ward capacity and specialty, current staffing (including non-rostered roles), patient acuity (last 12 months, using the SafeCare system), care quality and safety indicators (last 12 months), infection control data, financial and workforce metrics, staffing performance data, national standards, patient flow/activity, and roster fill rates. The impact of shift patterns (including long days) and the 26.9% uplift for leave and absence has also been incorporated into workforce and financial calculations.

It is noted that the table below includes the financial and workforce impact of spring 2026. A process is in place to reset S25B ward budgets, where necessary, following each cycle. This

enables timely in-year financial and workforce adjustments, supporting budget and roster stability and strengthening local team control.

	Additional requirements £		RN £	HCSW & Other £		RN WTE
1a. Adult inpatient wards						
Carmarthenshire Integrated System Glangwili Hospital (GGH) & Prince Philip (PPH)	-39,299		-6,214	-33,085		-0.02
Pembrokeshire Integrated System WGH	25,453		141,668	-116,215		2.75
1b. Service change:						
Carmarthenshire Integrated System						
• Padarn	327,256		280,993	46,263		5.45
• Cleddau	569,008		386,066	182,942		7.23
Ceredigion Integrated System						
• Enhanced Care Unit/Rhiannon	75,204		3,336	71,867		0.05
Planned & Specialist Care						
• Picton – Healthcare Support Worker (HCSW)	110,376		-33	110,409		0.00
2.a Planned and specialist care – Bronglais Hospital (BGH) Angharad (NSL Change)	66,599		96,011	-29,412		1.63
2b. Planned and specialist care – GGH Cilgerran & PACU (Service Change)	265,291		-126,114	391,405		-1.94

1. Adult inpatient wards

1a BGH, WGH, PPH and GGH: For adult inpatient wards funded through the 'nurse staffing funding' allocation, there is a net reduction of £13,846 following the Spring 2026 cycle.

Although Ward 10 (WGH) requires an additional 2.72 WTE registered nurses, this is offset by a reduction of 2.52 WTE Band 4 posts (£25,453) and a change in the proportion of long-day shifts on Cadog Ward (GGH).

An additional increase of 2.72 WTE registered nurses on Ward 4 (WGH), agreed as part of the Spring 2025 cycle, is excluded from the above figures as the funding will be realigned from Ward 12 (WGH).

1b. Service Change

Four wards require additional resources due to service changes, totalling £1,081,844:

- **Picton Ward (GGH):** Additional night-shift nursing support required following changes to the gynaecology emergency pathway during the COVID-19 pandemic; this remains unfunded.
- **Padarn:** Band 4 Assistant Practitioner role supporting respiratory treatment room activity, plus additional 24/7 registered nurse cover for the Non Invasive Pathway (NIV) pathway.
- **Cleddau (GGH):** Post-COVID-17 service change with bed numbers increased to 21, requiring an additional 7.23 WTE registered nurses and 4.62 WTE nursing support workers.
- **ERU/Rhiannon (BGH):** Additional 1.77 WTE nursing support workers. Despite funding provided to the Enhanced Care Unit in 2024/25, a gap remains between required and funded establishment.

2. **2a Paediatric inpatient wards:** An additional £331,890 is required for the paediatric wards.

   The associated staffing requirements for paediatric inpatient wards have been funded by Women and Children's Services since the Act was extended to these areas in October 2021, utilising the Puffin/WGH budget.

   In the future and depending on the configuration of services once additional outpatient provision is established at WGH, funding for these requirements may need to be aligned with the adult inpatient wards, in line with the agreed principles.

The Director of Nursing, Quality & Patient Experience is due to meet with the relevant Clinical Care Group to discuss the finance and workforce implications of the Spring 2026 cycle.

Maintaining the Nurse Staffing Levels: There are established processes in place whereby operational teams are applying their professional judgment to ensure that the staffing levels wherever possible, are maintained – and, where not possible, that risks are mitigated:

- Systems in place whereby risk assessments are undertaken considering patients' needs (including acuity and dependency) versus the available staff (both substantive and temporary), staff knowledge and skills and team stability.
- Deployment of staff from other areas within the organisation.

For information: The Board receives a (non-statutory) annual assurance report which is structured in a way to provide the basis of the statutory 3-year report to Welsh Government (WG) which the Health Board will be required to submit every third year (next due 2027) (presented to the Board in May).

The second report which accompanies this SBAR is the annual assurance report which will be presented to the Board on 29 May 2026. It provides assurance to the Board that the Health Board has met its statutory duties under the Nurse Staffing Levels (Wales) Act 2016 and supports preparation of the three-yearly statutory report to Welsh Government.

The assurance report demonstrates that:

- Nurse staffing levels have been **calculated and reviewed in accordance with statutory methodology.**
- **Reasonable steps** have been taken to maintain staffing levels across all Section 25B wards.
- Variations to establishments reflect changes in acuity, ward function, bed base, or service configuration.
- Systems are in place to monitor roster maintenance and staffing impact using Allocate Safecare data.

Impact on Care:

Adult Medical & Surgical Inpatient wards: During the 2025-26 reporting period there were:

- Three falls resulting in moderate harm which met the threshold for inclusion in this report - it was deemed that the failure to maintain the planned roster had been a contributory factor in all three incidents. The investigations showed that there was a high acuity of patients on the three wards at the time of the incident. The planned roster was not maintained (due to an existing deficit and staff sickness), although "baywatch" (where a

member of staff is always present in the bay) was in place during these periods. Concerns around the staffing deficits were escalated to the site manager.
- No hospital acquired pressure damage (grade 3, 4 and unstageable) that met the threshold for inclusion in this report.
- No medication administration error incident which met the threshold for inclusion in this report.
- No complaints which met the threshold for inclusion in this report.

Paediatrics inpatient wards: During the 2025-26 reporting period there were:
- No reportable hospital acquired pressure damage (grade 3, 4 and unstageable); falls resulting in serious harm or death (i.e. level 3, 4 and 5 incidents); medication administration errors (i.e. level 3, 4 and 5 harm or never events); or infiltration/ extravasation injuries that met the threshold for inclusion in this report.
- No complaints, which met the threshold for inclusion in this report.

Argymhelliad / Recommendation

The Quality, Safety and Experience Committee is asked on behalf of the Board to take assurance that:

- Hywel Dda University Health Board (HDdUHB) is meeting its statutory duty to calculate nurse staffing levels for all wards within the scope of Section 25B of the Nurse Staffing Levels (Wales) Act 2016.
- By presenting this SBAR, HDdUHB is fulfilling its statutory requirement to provide a written update on nurse staffing levels for each relevant ward to the Board (or its delegated committee) where there has been a service change affecting staffing levels or were deemed necessary by the designated person (Paragraph 12).

The Quality, Safety and Experience Committee is requested to note the content of the Annual Assurance Report.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.16 Seek assurance on the delivery of the requirements arising from the Health Board's auditors, inspectorates and regulators, Welsh Government and professional bodies.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	1. Safe 3. Effective 4. Efficient 6. Person-Centred
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	1. Leadership 2. Culture and valuing people 3. Data to knowledge

Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	1 Workforce Stabilisation 2 Financial recovery and route map
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	2. Develop a skilled and flexible workforce to meet the changing needs of the modern NHS 5. Offer a diverse range of employment opportunities which support people to fulfill their potential

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	The evidence underpinning the triangulated approach to calculating the nurse staffing levels has been articulated through the working papers of the all Wales Nurse Staffing Group
Rhestr Termau: Glossary of Terms:	S25B – Section 25B of the Nurse Staffing Levels (Wales) Act 2016 WGH – Withybush General Hospital BGH – Bronglais General Hospital GGH – Glangwili General Hospital PPH – Prince Phillip Hospital CCU – Coronary Care Unit WTE – whole time equivalent HDdUHB – Hywel Dda University Health Board WG – Welsh Government NIV – Non-invasive ventilation NSW – Nursing Support Worker AP – Assistant Practitioner RN – Registered Nurse ECU – Enhanced Care Unit PACU – Paediatric Ambulatory Care Unit QI data – quality indicator data
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	Sisters/Charge Nurses, Senior Nurse Managers and Heads/Deputy Heads of Nursing of each S25B.

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	The financial impact of the Spring 2026

Ansawdd / Gofal Claf: **Quality / Patient Care:**	The intention underpinning the Act is to ensure safe, effective, and quality patient care. One of the key requirements of the Act is to monitor the impact of nurse staffing levels on care quality. The SBAR refers to the information reviewed as part of the triangulated methodology set out in the Act and which is used when implementing the 'duty to calculate'. There are wards which required an uplift to their RN or NSW establishment and there may be a negative impact on care quality if the outcome of the calculation cycle is not responded to operationally which could result in limiting in-patient numbers to the available staffing.
Gweithlu: **Workforce:**	This paper relates to adjustments to the staffing levels which have been calculated as being required across the acute adult medical and surgical wards and paediatric inpatient wards. The potential impact on the workforce of the calculations referenced within this paper are detailed in Appendix 1. It is anticipated that the Act will enable a positive impact on staff well-being
Risg: **Risk:**	There are financial and workforce risks associated with the outcome of the work described in this paper. The risks relate to the ability to both finance and recruit a sufficient workforce of RN/NSWs. Alternatively, there is a risk of providing insufficient inpatient facilities to meet the population need if the number of in-patient beds is reduced to the levels that the current workforce/budgets can deliver: Having met the 'duty to calculate the nurse staffing level' as described within this paper, the risk now shifts to how best to respond to the revised calculations
Cyfreithiol: **Legal:**	The Act sets out the Board's overarching responsibilities and the Designated Person's specific responsibilities to calculate and maintain nurse staffing levels in S25B wards, The legal risk associated with calculating the nurse staffing levels relates not to the issues described within this paper (which relate to the duty to calculate the nurse staffing levels) but rather to the potential of noncompliance with the 'duty of maintaining the nurse staffing levels. The 'duty to maintain the nurse staffing level' requires the financial and the workforce risks detailed above to be addressed, and this poses a more significant challenge than the duty to calculate described in this paper
Enw Da: **Reputational:**	The reputation of the nursing services and the effectiveness of the collaboration within the Health Board is enhanced through the level of engagement shown between the operational and corporate teams in ensuring that the statutory requirements relating to the Act are met.
Gyfrinachedd: **Privacy:**	Currently no impact in relation to privacy identifiable within this work

Cydraddoldeb: Equality:	No negative EqIA impacts identified

Annual Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act: Report for Board/Delegated Committee			
Health board/trust	Hywel Dda University Health Board		
Date annual assurance report is presented to Board	28th May 2026 This annual report covers the period from 6 April 2025 to 5 April 2026. It will contribute to the three yearly assurance report to be submitted to the Welsh Government within 30 days of the reporting period ending in 2027, with the final submission due in October 2027.		
	Adult acute <u>medical</u> inpatient wards	**Adult acute <u>surgical</u> inpatient wards**	**Paediatric inpatient wards**
During the last year, the lowest and highest number of wards	18 wards in Autumn 2025 19 wards in Spring 2025	12	2
During the last year, the number of occasions (wards where section 25B applies) where the nurse staffing level has been reviewed/ recalculated outside the bi-annual calculation periods	Not applicable	Not applicable	Not applicable
The process and methodology used to calculate the nurse staffing level.	In accordance with the Nurse Staffing Levels (Wales) Act 2016 ('the Act') - a systematic triangulated review and recalculation of nurse staffing levels have been undertaken for all Section 25B wards (Adult and Paediatric) in line with legislative requirements. The methodology set out in Section 25C of the Act was applied for all relevant wards during the Spring and Autumn 2025 cycles. The reviews drew on the following core information: • Ward profiles, including bed numbers, specialty, treatments, or procedures undertaken, and any proposed service or patient pathway changes. • Current nursing establishment, including staff groups not included in the core roster (e.g. supernumerary senior sisters/charge nurses, frailty or rehabilitation support workers, and ward clerks and administrators). • Patient acuity data from the preceding 12 months, measured using the evidence-based Welsh Levels of Care Tool (Levels 1–5).		

	• Care quality indicators from the previous 12 months, including pressure ulcers, falls, medication errors, paediatric infiltration/extravasation injuries, and complaints relating to nursing care. • The proportion of 'long day' shifts worked, to ensure establishments accurately reflect staff working patterns. Financial arrangements remain sufficiently flexible to respond to changes in the balance between 'long day' and traditional early/late shifts, as determined by substantive staff preferences. The triangulated methodology ensures that nurse staffing levels are not determined by acuity data alone but are informed by a rounded assessment of patient need, workforce configuration, clinical risk, and professional judgement. This approach enables nurse staffing establishments to be both evidence-based and sufficiently flexible to respond to changes in patient acuity, service delivery models and staff working patterns.
Informing patients of the nurse staffing levels	The Health Board meets its statutory duty to inform patients of nurse staffing levels through formal reporting mechanisms, including an annual report to the Board for each Section 25B ward and written updates to the Quality, Safety and Experience Committee as required. A nationally agreed process is in place to inform patients of the planned nurse staffing levels on all Section 25B wards. This includes the display of bilingual information at ward entrances, comprising a nurse staffing poster, an explanation of the Nurse Staffing Levels (Wales) Act, and a Frequently Asked Questions leaflet available in standard and easy-read formats. Updated templates are issued to wards following each calculation cycle. Internal audit work undertaken in April 2025 identified instances where the required patient information was not consistently displayed across all wards. Immediate corrective actions were taken at ward level, supported by oversight from senior nursing leadership. A further audit during the Spring 2026 calculation cycle confirmed full compliance, with all Section 25B wards displaying the most up-to-date bilingual nurse staffing information. During 2025/26, the All-Wales Nurse Staffing Level Reporting Group reviewed the national informing-patients process in response to recommendations from the Senedd Health and Social Care Committee (2024). As a result, the display template was revised to improve clarity, accessibility, and compliance with Welsh Language Standards. Key enhancements included removal of unnecessary text, improved layout, use of easy-read imagery, and the addition of a QR code linking to online FAQs.

Section 25E (2a) Extent to which the nurse staffing level has been maintained.

As nurse staffing levels under 'the Act' comprise both the planned roster and the required establishment, this section provides assurance on the extent to which planned rosters have been maintained and how required establishments for Section 25B wards have been achieved and sustained over the reporting period.

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses – and other staff to whom nursing duties have been delegated by a registered nurse – required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within the data for this report.

Extent to which the required establishment has been maintained within <u>adult acute medical and surgical wards.</u>

	Period Covered 2025/26		
	Number of Wards:	**RN (WTE)**	**HCSW (WTE)**
Required establishment (WTE) of adult acute medical and surgical wards <u>calculated</u> during first cycle (May) (Spring 2025)	**30**	**535.98**	**571.78**
WTE of required establishment of adult acute medical and surgical wards <u>funded</u> following first (May) (Spring 2025) calculation cycle.		**533.19**	**568.71**
Required establishment (WTE) of adult acute medical and surgical wards <u>calculated</u> during second calculation cycle (Nov) (Autumn 2025)	**30**	**533.20**	**576.50**
WTE of required establishment of adult acute medical and surgical wards <u>funded</u> following second (Nov) (Autumn 2025) calculation cycle		**540.42**	**577.90**
WTE Supernumerary band 7 Sister/Charge nurse (funded but excluded from planned roster) (Autumn 2025)	**WTE: 30**		

The variation in WTE required establishment calculated and funded in the above table are:

- The additional WTE required because of changes to the service models on two of the wards which are subject to business cases.

Following the Autumn 2025 cycle, the following changes were made:

- the twilight shift on Caredig ward in BGH was changed to a night shift (based on acuity data).

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- a reduction in the RN workforce on Ward 6, PPH (Based on changes in the pattern of activity).

See appendix 1 for details of the individual wards.
</td></tr>
<tr><td rowspan="7">Extent to which the required establishment has been maintained within <u>paediatric inpatient wards.</u></td><td></td><td colspan="2">Period Covered 2025/26</td></tr>
<tr><td></td><td>Number of Wards:</td><td>RN (WTE)</td><td>HCSW (WTE)</td></tr>
<tr><td>Required establishment (WTE) of paediatric inpatient wards <u>calculated</u> during first cycle (May) (Spring 2025)</td><td rowspan="2">2</td><td>59.91</td><td>19.83</td></tr>
<tr><td>WTE of required establishment of paediatric inpatient wards <u>funded</u> following first (May) (Spring 2025) calculation cycle</td><td>59.91</td><td>19.83</td></tr>
<tr><td>Required establishment (WTE) of paediatric inpatient wards <u>calculated</u> during second calculation cycle (Nov) (Autumn 2025)</td><td rowspan="2">2</td><td>59.93</td><td>19.83</td></tr>
<tr><td>WTE of required establishment of paediatric inpatient wards <u>funded</u> following second (Nov) (Autumn 2025) calculation cycle</td><td>59.93</td><td>19.83</td></tr>
<tr><td>WTE Supernumerary band 7 Sister/Charge nurse (funded but excluded from planned roster) (Autumn 2025</td><td colspan="3">WTE: 3 (2 supernumerary Band 7 on one ward)</td></tr>
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The variation in WTE required establishment calculated and funded in the above table are:

- A change to the RN roster based on the proportion of long days worked on Angharad ward BGH as part of the Spring 2025 cycle.
- A change to the RN roster based on the proportion of long days worked on Cilgerran ward GGH as part of the Autumn 2025 cycle.

See appendix 1 for details of the individual wards.
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Process & systems for capturing data on the extent to which the planned roster has been maintained on wards where section 25B applies.[i]	Extensive work has been undertaken across NHS Wales to implement a national informatics system that supports compliance with the Act, aligns with the Once for Wales approach, and ensures consistent reporting. The system provides a central repository to evidence the extent to which nurse staffing levels have been maintained and to assure that all reasonable steps have been taken to meet required staffing levels. Safecare is the nationally agreed system for recording and reviewing any variance between deployed staffing and the planned roster, and for capturing the acuity data that informs nurse staffing calculations. The data presented in the following section for this reporting period is sourced from Safecare. Variability currently exists in how planned roster compliance is reported across Wales, with most Health Boards, including Hywel Dda University Health Board, using a headcount-based measure and one using an hours-based approach due to enhanced data access. Differences in shift patterns mean these methods can produce differing interpretations of compliance. Now that enhanced data access is available across Wales, the All-Wales Nurse Staffing Programme is progressing work to agree a single, standardised reporting metric ahead of the next reporting cycle. Information on the extent to which planned rosters have been maintained is monitored by the Quality, Safety and Experience Committee on behalf of the Board.
Extent to which the planned roster has been maintained within <u>adult acute medical and surgical wards</u>[1]	**Extent to which the planned roster has been maintained within adult acute medical and surgical wards – 6th April 2025-5th April 2026** It is important to note that the planned roster represents the expected deployment of staff based on the funded establishment and agreed staffing model. There are occasions where the planned roster may not be met due to short-term workforce fluctuations; however, the nurse in charge may determine that the staffing on duty remains appropriate to meet the care needs of patients at that time. Conversely, there may be occasions where the planned roster is met but staffing is assessed as not appropriate due to increased acuity or other mitigating factors. The application of professional judgement is therefore a critical component of nurse staffing assurance under the Act.

	2021/2022	2022/2023	2023/2024	2024/2025	2025/2026
Data source	Health Care Monitoring System (HCMS)	Health Care Monitoring System (HCMS) and Safecare	Safecare	Safecare	Safecare
Total number of shifts	23094	23920	23679	23358	21836

[1] The met/not met data captured on the Allocate Safecare module is automatically populated (which was not the case when the data was captured on the previous system). The nurse in charge is required to enter data twice a day to state whether the number of staff on duty is appropriate or not appropriate to meet the needs of the patients on the ward at that time. The 'not stated' are shifts where planned roster was met/not met but data on whether this was appropriate or not has not been entered.

Data completeness	97.03%	Not known	89.85%	92.09%	89.72%
Shifts where planned roster met and appropriate	14642 63.40%	10159 42.47%	5115 21.06%	11368 48.6%	10195 46.69%
Shifts where planned roster met but not appropriate	557 2.41%	641 2.68%	2069 8.74%	3724 15.94%	2323 10.64%
Shifts where planned roster met but appropriateness not stated	Not recorded in HCMS	Not recorded in HCMS	1103 4.66%	1386 5.93%	1476 6.76%
Shifts where planned roster not met but appropriate	2033 8.80%	2965 12.40	8705 36.76%	3347 14.33%	3787 17.34%
Shifts where planned roster not met and not appropriate	5862 25.38%	10155 42.45%	5386 22.75%	3072 13.15%	3286 15.05%
Shifts where planned roster not met but appropriateness not stated	Not recorded in HCMS	Not recorded in HCMS	1301 5.49%	461 1.97%	769 3.52%

- The data shows that the planned roster was met for 64.09% of the shifts.
- The nurse in charge determined that number of staff on duty (irrespective of whether the planned roster was met or not) was appropriate to meet the care needs of the patients on the ward at the time for 64.03% of the shifts (an increase of 1.1% on the 2024/25 position).
- The nurse in charge determined that the number of staff on duty (irrespective of whether the planned roster was met or not) was not appropriate to meet the care needs of the patients on the ward at the time for 26.14% of the shifts (a decrease of 2.95% on the 2024/25 position).
- There were 10.28% of the shifts where the nurse in charge did not state whether the number of staff on duty was appropriate or not (an increase of 2.38% on the 2024/25 position). This does not indicate that an assessment was not made; rather, it reflects a system limitation whereby appropriateness data entered outside of the defined census periods (0630-0830 and1900-2100), is recorded as ‘not stated’. Work is underway to address this through reinforcement of census-period recording requirements, targeted feedback to ward teams, and ongoing monitoring by ward managers. This will remain an area of focus during 2026/27 to further improve data completeness and strengthen assurance.

It is recognised that nurse staffing levels data has changed significantly since first reported in 2021/22, with the percentage of shifts reported as met and appropriate decreasing from 63.4% in 2021/22 to 46.69% in 2025/26. Several factors may have contributed to this change, including:

- A reduction in the number of wards included, from 35 in 2021/22 to 30 in 2025/26
- A change in systems, from the Health & Care Monitoring System—where the “met” status relied on manual input—to Safecare, which automatically calculates whether staffing requirements are met
- Level of appropriateness “not stated” recorded on Safecare which was not available via HCMS

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- Differences in data entry, with 2021/22 data primarily entered by Ward Managers or Deputy Ward Managers, whereas in 2025/26 all appropriately trained Registered Nurses can input data into Safecare and the variation in whether the number of staff on duty is appropriate or not is based on the professional judgement of the Registered Nurse making the assessment.

</td></tr>
<tr><td>Extent to which the planned roster has been maintained within <u>paediatric inpatient wards.</u> [2]</td><td>

Extent to which the planned roster has been maintained within paediatric inpatient wards – 6th April 2025-5th April 2026

It is important to note that the planned roster represents the expected deployment of staff based on the funded establishment and agreed staffing model. There are occasions where the planned roster may not be met due to short-term workforce fluctuations; however, the nurse in charge may determine that the staffing on duty remains appropriate to meet the care needs of patients at that time. Conversely, there may be occasions where the planned roster is met but staffing is assessed as not appropriate due to increased acuity or other mitigating factors. The application of professional judgement is therefore a critical component of nurse staffing assurance under the Act.

	2021/2022	2022/2023	2023/2024	2024/2025	2025/2026
Data source	Health Care Monitoring System (HCMS)	Health Care Monitoring System (HCMS) and Safecare	Safecare	Safecare	Safecare
Total number of shifts	744	1552	1764	1460	1460
Data completeness	99.47%	Not known	95.24%	95.55%	94.73%
Shifts where planned roster met and appropriate	613 82.39	1077 69.39%	707 40.08 %	738 50.55%	757 51.85%
Shifts where planned roster met but not appropriate	4 0.54%	2 0.13%	10 0.57%	6 0.41%	6 0.41%
Shifts where planned roster met but appropriateness not stated	Not recorded in HCMS	Not recorded in HCMS	26 1.47%	42 2.88%	52 3.56%
Shifts where planned roster not met but appropriate	103 13.84%	427 27.51%	883 50.06%	629 43.08%	601 41.16%
Shifts where planned roster not met and not appropriate	24 3.23%	46 2.96%	80 4.54%	22 1.51%	19 1.30%
Shifts where planned roster not met but appropriateness not stated	Not recorded in HCMS	Not recorded in HCMS	58 3.29%	23 1.58%	25 1.30%

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[2] The met/not met data captured on the Allocate Safecare module is automatically populated (which was not the case when the data was captured on the previous system). The nurse in charge is required to enter data twice a day to state whether the number of staff on duty is appropriate or not appropriate to meet the needs of the patients on the ward at that time. The 'not stated' are shifts where planned roster was met/not met but data on whether this was appropriate or not has not been entered.

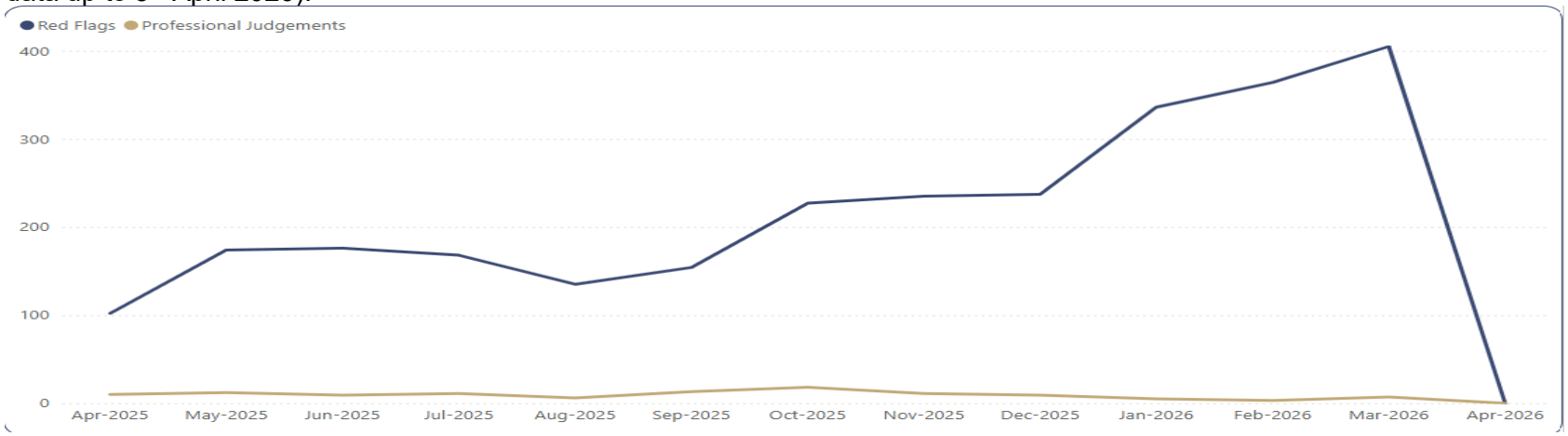
	• The data shows that the planned roster was met for 55.82% of the shifts. • The nurse in charge determined that number of staff on duty (irrespective of whether the planned roster was met or not) was appropriate to meet the care needs of the patients on the ward at the time for 93.01% of the shifts (a decrease of 0.62% on the 2024/25 position). • The nurse in charge determined that the number of staff on duty ((irrespective of whether the planned roster was met or not) was not appropriate to meet the care needs of the patients on the ward at the time for 1.71% of the shifts (a decrease of 0.21% on the 2024/25 position). There were 4.86% of the shifts where the nurse in charge did not state whether the number of staff was appropriate or not (an increase of 0.4% on the 2024/25 position). As previously stated, this does not indicate that an assessment was not made; rather, it reflects a system limitation whereby appropriateness data entered outside of the defined census periods (0630-0830 and1900-2100), is recorded as 'not stated'. "All reasonable steps" taken to maintain the nurse staffing levels as per the requirements of the Act and the nationally agreed paediatric operational guidance document. Operational teams apply their professional judgment to ensure that the staffing levels wherever possible, are maintained – and, where not possible, that risks are mitigated, whilst also having regard for the health board's overarching duty of "providing sufficient nurses to allow the nurses time to care for patients sensitively." It is recognised that nurse staffing levels data has changed significantly since first reported in 2021/22, with the percentage of shifts reported as met and appropriate decreasing from 82.39% in 2021/22 to 51.85% in 2025/26. Several factors may have contributed to this change, including: • The data for 2021/22 is for a six month period (October 2021 to April 2022) rather than the full reporting period as the Act was only extended to Paediatrics in October 2021 (Any data captured before October 2021 is not included). • A change in systems, from the Health & Care Monitoring System (HCMS)—where the "met" status relied on manual input—to Safecare, which automatically calculates whether staffing requirements are met • Level of appropriateness "not stated" recorded on Safecare which was not available via HCMS • Differences in data entry, with 2021/22 data primarily entered by Ward Managers or Deputy Ward Managers, whereas in 2025/26 all appropriately trained Registered Nurses can input data into Safecare and the variation in whether the number of staff on duty is appropriate or not is based on the professional judgement of the Registered Nurse making the assessment.
Process for maintaining the Nurse staffing level	Where the nurse in charge determines that the number of staff on duty is not appropriate to meet patient needs, a 'red flag' is raised within Safecare. Red flags are events that prompt the requirement for an immediate response (i.e. to consider/take all reasonable steps to address the issue of concern and/or to escalate) by the registered nurse in charge of the ward and include unable to provide 1:1 care, ward manager not supernumerary, acuity not met by current nurse staffing levels, surge beds, or insufficient registered nurses or support workers on duty. The response may include allocating additional nursing staff to the ward, reducing workload or other appropriate reasonable steps as deemed appropriate by the nursing and senior management teams.

In addition to Safecare system red flags, a RAG rating is applied based on the variance between actual nursing hours and the planned roster (for example, staffing levels 10% or more below plan are rated red). However, the nurse in charge's professional judgement ultimately determines whether staffing levels are appropriate, based on professional judgement. Where staffing is considered appropriate despite the roster not being met (resulting in an amber or red rating), the nurse in charge may amend the RAG rating accordingly in line with the agreed Safecare standard operating procedure. Conversely, the RAG rating may be downgraded from green to amber or red if the roster is met but staffing is deemed not appropriate. Reasons for professional judgement may include ward closures (e.g. infection prevention measures), surge beds, high use of temporary staff, or increased patient acuity.

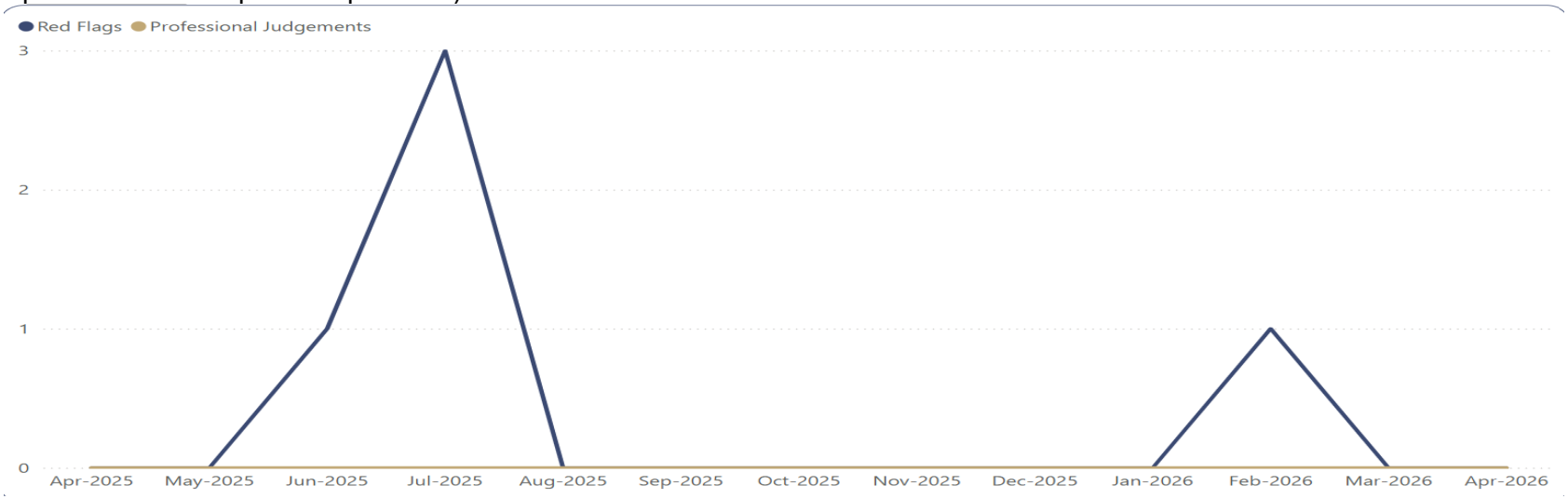
Red flags and professional judgement raised during the reporting period evidence the application of professional judgement by nursing and operational teams in response to fluctuations in patient acuity, dependency, and workforce availability. Actions taken included redeployment of staff, escalation to site management and on-call teams, deployment of supernumerary staff into clinical care, and use of temporary staffing where available.

Significant training and support have been provided to ward teams during this reporting period to strengthen understanding and use of red flags as a key assurance mechanism. The increase in red flags recorded during this reporting period, particularly within adult wards, is interpreted as evidence of improved reporting culture and appropriate escalation, rather than a deterioration in nurse staffing management. Red flags are now being used more consistently as an assurance mechanism to highlight risk at the point of care and prompt timely mitigating action. Further work is required on strengthening the use of professional judgement reasons, and this will be a focus for 2026/27.

Adult Wards – the below graph shows the number of Red Flags raised and amendments made based on Professional Judgement on the Adult Wards during this reporting period (it is noted that April 2025 is data from 6th April onwards and the data for April 2026 is data up to 5th April 2026).



Paediatric Wards – the below graph shows the number of Red Flags raised and amendments made based on Professional Judgement Paediatric Wards during this reporting period (it is noted that April 2025 is data from 6th April onwards and the data for April 2026 is data up to 5th April 2026).



Collectively, this data provides assurance that all reasonable steps have been taken to maintain nurse staffing levels in line with the Nurse Staffing Levels (Wales) Act 2016 and nationally agreed operational guidance, and that risks are actively identified, escalated, and mitigated when staffing shortfalls occur.

In addition to the operational actions outlined above, a range of broader strategic and corporate measures have been implemented to further demonstrate that *all reasonable steps* have been taken to maintain nurse staffing levels. These actions apply not only to Section 25B wards but across all Health Board services, recognising the interdependency of the wider system.

Key strategic measures include:

- Successful nurse stabilisation programme resulting in sustained improvements in recruitment and retention including:
  - Targeted recruitment initiatives led by Workforce and OD to address the specific needs of individual wards and departments.
  - Recruitment of internationally educated nurses
  - Multiple pathways into nursing, including apprenticeships, 'grow your own' programmes and Open University routes.

The nurse stabilisation programme has seen a 79.9% reduction in agency usage since January 2023.

Section 25E(2b) Impact on care due to not maintaining the nurse staffing levels on adult acute medical and surgical inpatient wards[ii]

Incidents of patient harm with reference to quality indicators and complaints about nursing care (note: for all rows, only incidents that have been closed are included)	**Avoidable hospital acquired pressure damage (grade 3, 4 and unstageable).**	**Falls resulting in moderate harm, serious harm, or death (i.e. level 3, 4 and 5 incidents).**	**Medication administration errors resulting in moderate harm, severe harm, death & never events (i.e. level 3, 4, 5 and never events incidents).**	**Any complaints received about nursing care which identify a breach in the duty of care[3]**
	TOTAL	**TOTAL**	**TOTAL**	**TOTAL**
Number of incidents/complaints closed during the current reporting period. (Please note these may include incidents/complaints opened prior to this reporting period).	4 closed between 6th April 2025 and 5th April 2026 with 3 being reported during the period of this report.	16 closed between 6th April 2025 and 5th April 2026 7 reported during the period of this report.	There are no closed incidents reported during the period of this report.	0
Number of closed incidents/ complaints occurring when the nurse staffing level (planned roster) had not been maintained.	1	3	0	0
Number of those closed incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor.	0	3 • 2 reported during this reporting period with the post investigation level of harm reported as moderate harm. • 1 reported in 2023 (but closed during this reporting period) with the post investigation level of harm reported as severe harm	0	0
Number of closed incidents/complaints occurring when the	3	13	0	0

[3] Complaints received which have been closed during this reporting period, are being managed under NHS Wales complaints regulations (Putting things Right (PTR)), Have identified a breach in the duty of care and are relevant to nursing care.

nurse staffing level (planned roster) had been maintained				
Number of those closed incidents/complaints when the nurse staffing level was deemed to have been a contributing factor, even when planned roster had been maintained.	0	0	0	0

To note: Further to some work undertaken by the All-Wales Nursing Staffing Reporting group, the measure for complaints has been change to complaints received which have been closed during this reporting period, are being managed under NHS Wales complaints regulations (Putting things Right (PTR)), have identified a breach in the duty of care and are relevant to nursing care. Therefore, the number of complaints reported in this assurance report is significantly less than in previous assurance reports.

The data set out in the following table shows the number of closed incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor since "the Act" came into effect (it is noted that two of the measures were amended for the 2024/25 reporting period onwards and one for the 2025/26 reporting period so there is no comparable data from the previous reports for these measures).

	Number of closed incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor						
	Hospital acquired pressure damage (grade 3, 4 and unstageable)	**Falls resulting in serious harm or death (i.e., 4 and 5 incidents).**	**Falls resulting in moderate harm, serious harm, or death (i.e. level 3, 4 and 5 incidents).**	**Medication errors never events**	**Medication administration errors resulting in moderate harm, severe harm, death & never events (i.e. level 3, 4, 5 and never events incidents).**	**All complaints received about nursing care**	**Complaints received about nursing care identify a breach in the duty of care**
2020-21	0	1		0		0	
2021-22	1	2		0		4	
2022-23	0	0		0		0	
2023-24	0	0		0		0	
2024-25	0		1		1	0	
2025-26	0		3		0		0

	Section 25E (2c) Actions taken if the nurse staffing level is not maintained (or maintained but not appropriate *) Adult medical and surgical wards:

Actions taken if the nurse staffing level <u>was not</u> maintained (or maintained but not appropriate) in wards where section 25B applies (adult)	There were three falls (level 3, 4 and 5 incidents) closed during this reporting period where the nurse staffing level (i.e. the planned roster) was not maintained, and it was deemed that the failure to maintain the planned roster had been a contributory factor to the incident. The investigations showed that there was a high acuity of patients on the three wards at the time of the incident. The planned roster was not maintained (due to an existing deficit and staff sickness), although "baywatch" (where a member of staff is always present in the bay) was in place during these periods. Concerns around the staffing deficits were escalated to the site manager. The investigators concluded that the staffing deficits were a contributory factor to the incidents.

Section 25E(2b) Impact on care due to not maintaining the nurse staffing levels on paediatric inpatient wards[iii]

Incidents of patient harm with reference to quality indicators and complaints about nursing care (note: for all rows, only incidents that have been closed are included)	Avoidable hospital acquired pressure damage (grade 3, 4 and unstageable).	Falls resulting in moderate harm, serious harm, or death (i.e. level 3, 4 and 5 incidents).	Medication administration errors resulting in moderate harm, serious harm or severe harm, death & never events (i.e. level 3, 4, 5 and never events incidents).	Infiltration and extravasation injuries	Any complaints received about nursing care which identifies a breach in the duty of care[4]
Number of incidents/complaints closed during the current reporting period. (Please note these may include incidents/complaints opened prior to this reporting period).	0	0	0	0	1
Number of incidents/ complaints occurring when the nurse staffing level (planned roster) had not been maintained.	0	0	0	0	0
Number of those incidents/complaints where failure to maintain the nurse staffing level (planned roster) was	0	0	0	0	0

[4] Complaints received which have been closed during this reporting period, are being managed under NHS Wales complaints regulations (Putting things Right (PTR)), have identified a breach in the duty of care and are relevant to nursing care.

considered to have been a contributing factor					
Number of incidents/complaints occurring when the nurse staffing level (planned roster) had been maintained	0	0	0	0	1
Number of those incidents/complaints when the nurse staffing level was deemed to have been a contributing factor, even when planned roster had been maintained.	0	0	0	0	0

The data set out in the following table shows the number of closed incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor since "the Act" came into effect on the paediatric wards in Oct 2021 (it is noted that two of the measures were amended for the 2024/25 reporting period onwards and one for the 2025/26 reporting period onwards so there is no comparable data for these measures from the previous reports).

Number of closed incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor								
	Hospital acquired pressure damage (grade 3, 4 and unstageable)	**Falls resulting in serious harm or death (i.e., 4 and 5 incidents).**	**Falls resulting in moderate harm, serious harm, or death (i.e. level 3, 4 and 5 incidents).**	**Medication errors never events**	**Medication administration errors resulting in moderate harm, severe harm, death & never events (i.e. level 3, 4, 5 and never events incidents).**	**Infiltration and extravasation injuries**	**Any complaints received about nursing care**	**Complaints received about nursing care which identify a breach in the duty of care**
2020-21								
2021-22	0	0		0		0	0	
2022-23	0	0		0		0	0	
2023-24	0	0		0		0	0	

2024-25	0		0	0	0	0	0	
2025-26	0		0	0	0	0		0

	Section 25E (2c) Actions taken if the nurse staffing level is not maintained (or maintained but not appropriate *) – Paediatrics
Actions taken if the nurse staffing level <u>was not</u> maintained (or maintained but not appropriate) in wards where section 25B applies (Paediatrics)	There were no incidents during this reporting period for the two paediatric wards where the nurse staffing level (whether met or not met) was deemed to be a contributing factor.
	Section 25A: Duty to have regard to provide sufficient nurses
Requirements of Section 25A (Section 25A refers to the Health Boards/Trusts overarching responsibility to ensure appropriate nurse staffing levels in any area where nursing services are provided or commissioned, not only wards where section 25B applies)	While the primary statutory reporting requirements relate to wards where Section 25B of the Act applies, the Board can take assurance that the Health Board is actively discharging its duty under Section 25A. A consistent, evidence-based and professionally led approach is being applied across all nursing services, with clear governance, escalation and review arrangements where potential risks to care quality are identified in line with Policy 1310 Calculating, Maintaining and Reporting Nurse Staffing Levels Policy Framework which sets out the organisational responsibilities for S25A areas. While there is no statutory reporting requirement for areas covered by Section 25A, this section provides a summary of key activity undertaken during 2025/26 in relation to selected Section 25A services. Collectively, these arrangements provide assurance that the Health Board is actively discharging its duty under Section 25A of the Act by applying a consistent, evidence-based and professionally led approach to reviewing and maintaining nurse staffing levels across all services, with clear escalation and governance where potential risks to care quality are identified. **Calculating the nurse staffing levels:** The Senedd Health and Social Care Committee's report published in 2024 contained the following recommendation "R3. The Minister for Health and Social Services should bring forward clear operational guidance to support the consistent application of section 25A across health boards in Wales". A subgroup of the All-Wales Nurse Staffing Group has been set up with the aim of: • mapping available workforce planning tools and develop principles/guidelines to ensure a consistent approach to their application across Wales, and • to develop clear operational guidance to support consistent application of section 25A across NHS Wales organisations. The publication of any operational guidance for Section 25A areas may require changes to the process by which the nurse staffing levels are reviewed within the Health Board. Meanwhile, the triangulated methodology set out in the Act for those wards where S25B of the Act applies, forms the basis of the nurse staffing reviews for those areas where S25A of the Act applies, and includes:

- Consideration of any available service specific patient acuity/workforce planning tool data.
- Consideration of any available service specific quality indicator data (in addition to reviewing the data on falls, pressure damage, medication administration errors, and complaints) and
- The professional judgement of the nursing management structure of that service
- Consideration is also given to any national recommendations/ standards or best practice recommendations that exists around the service/specialty.

A timetable for the remaining 25A areas is currently being developed. The timetable will include:

- Community Nursing including District Nursing teams.
- Endoscopy units (planned for 2026/27)
- Pre- assessment units
- Same Day Emergency Care
- Day surgery units
- Medical Day Units
- Outpatients' departments (Adults) (planned for 2026/27)
- Outpatients' departments (Paediatrics) (planned for 2026/27)
- Systemic Anti-Cancer Treatment Units (planned for 2026/27)
- Health Visiting
- Rheumatology
- School Nursing
- Community Mental Health Teams
- Learning Disabilities
- Minor Injuries Unit in our community hospitals
- Radiology
- Clinical Nurse Specialist Teams

Below is a summary of the work undertaken during 2025/26.

- **S25A inpatient wards (Community and Integrated Medicine) –** for those wards where Section 25A of the Act a nurse staffing review has been undertaken during 2025/26 for the following areas: Mynydd Mawr Rehabilitation Unit PPH, Ward 12 WGH, Acute Frailty Unit (AFU) WGH, Sunderland Ward, South Pembs. It is not a requirement to undertake six monthly reviews on these wards, but the nurse staffing levels are reviewed periodically to ensure that there are no quality indicator concerns that would indicate a need to change the staffing requirements.

- **Cardiac Care Units (Community and Integrated Medicine) –** for those standalone cardiac care units (CCU GGH and CMU BGH) where Section 25B does not apply a nurse staffing review has been undertaken during 2025/26. It is not a

requirement to undertake six monthly reviews on these areas, but the nurse staffing levels are reviewed periodically to ensure that there are no quality indicator concerns that would indicate a need to change the staffing requirements.

- **Emergency and Urgent Care Centre, BGH (Community and Integrated Medicine) –** the outcome of the nurse staffing level review in EUCC, BGH was presented at the Formal Executive Team meeting on 12th November 2025, and it was agreed that the changes would be transacted in three phases, commencing as of Q4 2025/2026. Transacting the changes will mean:
  - The ED nursing requirements will reflect the standards set out in the Royal College of Emergency Medicine and Royal College Workforce Standards for Type 1 Emergency Departments (2020)
  - The recommendations linked to staffing set out by the NHS Executive Performance & Assurance Team following their visit in 2024 and the Peer review – Getting it Right First Time (GIRFT) Emergency Medicine report June 2024 would be addressed.

- **Mental Health inpatient wards (Mental Health & Learning Disabilities)–** the outcome of the nurse staffing review undertaken in 2024/25 has been transacted during 2025/26 with the recruitment of the additional nursing support workers which was identified as part of the review.

- **Theatres BGH and GGH (Planned & Specialist Care)** – the nurse staffing levels were presented to the Executive Director of Nursing during 2025/26, and it has been agreed that the additional requirements identified will be transacted during 2026/27.

- **Critical Care Units (Planned & Specialist Care)** – the nurse staffing reviews undertaken across the four units has been revisited during 2025/26 and the outcome presented to the Executive Director of Nursing during 2025/26. The workforce and financial implications of the review is being taken forward by the Clinical Care Group.

Maintaining the nurse staffing levels: while the statutory requirement to take “all reasonable steps” applies specifically to Section 25B wards, established organisational processes demonstrate that these principles are applied consistently across all services, including Section 25A areas.

Conclusion & Recommendations

During 2025/26, the Health Board continued to face challenges in consistently maintaining nurse staffing levels on adult medical and surgical wards; however, the data demonstrates improving oversight, increased use of professional judgement, and effective escalation where staffing was not appropriate. Paediatric inpatient wards maintained a high level of staffing appropriateness throughout the year.

There is clear evidence that all reasonable steps are being taken to maintain nurse staffing levels in line with the Nurse Staffing Levels (Wales) Act 2016, with established operational and governance arrangements supporting risk identification, escalation, and mitigation.

The priorities identified for the coming 12 months are linked to the areas where assurance is currently partial and where further strengthening is required. Delivery against these priorities will be monitored through established governance arrangements and will continue to support the Board in discharging its statutory responsibilities under the Nurse Staffing Levels (Wales) Act 2016.

Appendix 2 – Explanatory notes.

[i] NHS Wales is committed to utilising a national informatics system that can be used as a central repository for collating data to evidence the extent to which the nurse staffing levels have been maintained and to provide assurance that all reasonable steps have been taken to maintain the nurse staffing levels required. Extensive work has been undertaken across NHS Wales to implement a national informatics system to enable health boards/trust to meet the reporting requirements of the Act and follow the Once for Wales approach to ensure consistency.

Each health board/trust committed to implementing RL Datix (formally Allocates) Safecare system, with each organisation having implemented this system to their section 25B wards.

[ii] Based on a review of the Health Boards/Trusts first 3 yearly reports and feedback from operational leads on their experience completing the reports; an SBAR was presented to the Executive Nurse Directors (EDoNs) and the Chief Nursing Officer for Wales in 2021, which included a series of recommendations to improve and refine the reporting process. Following this a sub-group of the All-Wales Nurse Staffing Group was set up to improve and refine the reporting process to standardise reporting and be in line with the Duty of Candour set out in the Quality & Engagement Act (2020), with the aim of broadening the scope of incidences of harm to provide more meaningful data, by including moderate risk falls and medication administration error incidents.

The work of the Reporting Sub-Group included a review of the measures for the adult medical and surgical inpatient wards, and these were presented to the Executive Nurse Directors in August 2023. The changes to the adult wards' measures were agreed, with the intention that the amended measures come into effect at the beginning of the next reporting period i.e. April 2024.

Since the EDoNs agreed the recommendations in August 2023 it became apparent that the way data is being captured on Datix to meet the reporting requirements of the Duty of Candour (DoC), which came into force in April 2023, may impact our data collection under the duties of the NSLWA. Previously, we anticipated that the changes in the reporting criteria to include moderate levels of harm would increase overall reporting, however, following this clarification this anticipated increase may not be seen.

It must be noted that previous reports have reported on the actual harm sustained without validation, as opposed to the number of incidents found to be resulting from an act or omission when in receipt of NHS Care. To align with patient safety incident reporting to Welsh Government all future NSLWA reports, as from April 2024, will report on closed patient safety incidents which have been validated with a level of harm moderate or above (as per patient safety incident definition) and whether the nurse staffing levels contributed to the incident.

The quality indicators for the adults' in-patient wards will be as follows:

- Avoidable hospital acquired pressure damage (grade 3, 4 and unstageable).
- Falls resulting in moderate harm, serious harm, or death (i.e. level 3, 4 and 5 incidents).
- Medication administration errors resulting in moderate harm, severe harm, death & never events (i.e. level 3, 4, 5 and never events incidents).
- Any complaints received about nursing care (Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR))

The data to be reported for each of the above will be:

- Number of incidents/complaints closed during the current reporting period. (Please note these may include incidents/complaints opened prior to this reporting period).
- Number of incidents/ complaints occurring when the nurse staffing level (planned roster) had not been maintained
- Number of those incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor
- Number of incidents/complaints occurring when the nurse staffing level (planned roster) had been maintained
- Number of those incidents/complaints when the nurse staffing level was deemed to have been a contributing factor, even when planned roster had been maintained.

In late 2024, it became apparent that there is significant variation in the types of complaints that are being reported within each organisation's nurse staffing report due to local interpretation of the Operational Guidance. As a result, the Reporting Group presented an SBAR that outlined a proposed criteria for standardised complaint reporting to the DDoN Forum in February 2025. This criterion was agreed by the DDoN Forum on the basis that reports are reviewed later in 2025 to establish if the criteria is adequately sensitive and produces the right level of useful context as a quality indicator.

The agreed criteria are as follows:

- Complaints received by 25B areas that:
- Have been closed within this reporting period.
- Are being managed through PTR.
- Have identified a breach in the duty of care.
- Are relevant to nursing care (using the guidance document to support).

[iii] The work of the Reporting Sub-Group, mentioned above, included the measures for the paediatric inpatient wards and these were presented to the Executive Nurse Directors in August 2023, along with the amended measures for the adult medical and surgical wards. The changes to

the paediatric measures were agreed, with the intention that the amended measures come into effect at the beginning of the next reporting period i.e. April 2024.

As of 2024/25.the quality indicators for the paediatric inpatient wards will be as follows:

- Avoidable hospital acquired pressure damage (grade 3, 4 and unstageable).
- Falls resulting in moderate harm, serious harm, or death (i.e. level 3, 4 and 5 incidents).
- Medication administration errors resulting in moderate harm, severe harm, death & never events (i.e. level 3, 4, 5 and never events incidents).
- Infiltration and extravasation injuries
- Any complaints received about nursing care (Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR))

The data to be reported for each of the above will be:

- Number of incidents/complaints closed during the current reporting period. (Please note these may include incidents/complaints opened prior to this reporting period).
- Number of incidents/ complaints occurring when the nurse staffing level (planned roster) had not been maintained
- Number of those incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor
- Number of incidents/complaints occurring when the nurse staffing level (planned roster) had been maintained
- Number of those incidents/complaints when the nurse staffing level was deemed to have been a contributing factor, even when planned roster had been maintained.

The number of staff per shift needs to be entered. The information should reflect the information on the informing patient template.

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within the data for this report. Further information is provided within the annual assurance report [INSERT HYPERLINK] on the additional multi-professional staff that contribute to the coordination and delivery of patient care.

the Autumn 2025 cycle references Band 2 HCSW whilst the Spring 2026 cycle references NSW Band 3 -this is due to the recent Band 2/3 validation process.

Paediatric inpatient wards

The wards highlighted in yellow have seen a changed to either their planned roster and/or required establishment during this calculation cycle (autumn 2024cycle)

Name of Ward	Planned roster as stated within the annual presentation to the Board report - Autumn 2025				Required Establishment as stated within the annual presentation to the Board report (Autumn 2025) including uplift 26.9%		TOTAL WTE Band 7 supernumerary ward sister/Charge nurse	Planned roster as stated within the annual presentation to the Board report - Spring 2026				Required Establishment as stated within the annual presentation to the Board report (Spring 2026) including uplift 26.9%		TOTAL WTE Band 7 supernumerary ward sister/Charge nurse	Date designated person calculated the nurse staffing level	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of the biannual calculation cycle, and reasons for any changes made			
	Shift	RN (band 5 &6)	HCSW Band 4	HCSW Band 2	TOTAL WTE RN (bands 5 &6)	TOTAL WTE HCSW (bands 2,3 &4)		Shift	RN (band 5 &6)	HCSW Band 4	NSW Band 3	TOTAL WTE RN (bands 5 &6)	TOTAL WTE NSW (bands 2,3 &4)			Completed	changed	rationale	Completed (Yes/No)	Date	Changed	Rationale
WOMEN AND CHILDREN – PAEDIATRIC WARDS																						
Cilgerran/ HDU GGH	E	1			47.14	15.57	2	E	1			47.14	15.57	2	28.4.2026	yes	no					
	L	1						L	1													
	LD	8 M-W 9 T&F , 7 S+S	1	2				LD	8 M-W 9 T&F , 7 S+S	1	2											
	TW			1				TW			1											
	N	8	1	2 (1S&S)				N	8	1	2 (1S&S)											
Angharad Ward, BGH	E	2			12.79 (including 5.69 WTE Band 6)	4.26	1	E	2			12.79 (including 5.69 WTE Band 6)	2.84	1	28.4.2026	yes	yes	proportion of LD worked, removal of NSW at night (not required over the last 3 years)				
	L	2						L	2													
	LD			1				LD			1											
	TW							TW														
	N	2		1				N	2													
	Total	59.93				19.83	3					total	59.93		18.41	3						

The number of staff

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated S
planned roster. It is acknowledged that there is a range of additional healthcare professionals that contrib
the Autumn 2025 cycle references Band 2 HCSW whilst the Spring 2026 cycle references NSW Band 3 -thi

Adult inpatient Medical wards

The wards highlighted in yellow have

Name of Ward	Planned roster as stated within the annual presentation to the Board report -Autumn 2025				Required Establishment as stated within the annual presentation to the Board report (Autumn 2025) including uplift 26.9%		TOTAL WTE Band 7 supernumerary ward sister/Charge nurse	Planned roster the annual pres Board report	
	Shift	RN (band 5 &6)	HCSW Band 4	HCSW Band 2	TOTAL WTE RN (bands 5 &6)	TOTAL WTE NSW (bands 2,3 &4)		Shift	RN (band 5 &6)
Dyfi BGH Medical	E	1		1	14.45	17.06	1	E	1
	L	1		1				L	1
	LD	2		2				LD	2
	TW							TW	
	N	2		3				N	2
Meurig BGH Medical	E	1		1	14.45	11.61	1	E	1
	L	1		1				L	1
	LD	2		1				LD	2
	TW							TW	
	N	2		2				N	2
Ystwyth BGH Medical	E	1		2	19.9	19.54	1	E	1
	L	1		2				L	1
	LD	3		1				LD	3
	TW			1				TW	
	N	3		3				N	3
Cadog GGH Medical	E	1		2	11.73	23.45	1	E	1
	L	1		2				L	1
	LD	1	1	2				LD	1
	TW							TW	
	N	2		3				N	2
Dewi GGH Medical	E	1		1	14.45	19.9	1	E	1
	L	1		1				L	1
	LD	2		3				LD	2
	TW							TW	
	N	2		3				N	2
	E	1		1				E	1

Gwenllian GGH Medical	L	1		1	17.17	22.62	1	L	1
	LD	2	1	3				LD	2
	TW							TW	
	N	3		3				N	3
Padarn GGH Medical	E	1		1	19.9	17.17	1	E	1
	L	1		1				L	1
	LD	3		2				LD	3
	TW							TW	
	N	3		3				N	3
Steffan GGH Medical	E	1		2	14.45	19.95	1	E	1
	L	1		2				L	1
	LD	2		2 (1 S&S)				LD	2
	TW							TW	
	N	2		3				N	2
Towy GGH Medical	E	1		1	14.45	19.9	1	E	1
	L	1		1				L	1
	LD	2		3				LD	2
	TW							TW	
	N	2		3				N	2
Ward 1 PPH Medical	E	2		1	18.95	17.17	1	E	2
	L	1		1				L	1
	LD	2		2				LD	2
	TW							TW	
	N	3		3				N	3
Ward 3 PPH Medical	E	2		2	18	20.73	1	E	2
	L	2		2				L	2
	LD	1		2				LD	1
	TW							TW	
	N	3		3				N	3
Ward 4 PPH Medical	E	3		2	27	18	1	E	3
	L	3		2				L	3
	LD	2		1				LD	2
	TW							TW	
	N	4		3				N	4
Ward 5 PPH Medical	E	2	1 -m-f	2	20.73	27.44	1	E	2
	L	2		2				L	2
	LD	2		3				LD	2
	TW							TW	
	N	3		4				N	3
Ward 9 PPH Medical	E	2		3	20.73	28.9	1	E	2
	L	2		1				L	2
	LD	2	1	3				LD	2
	TW							TW	
	N	3		4				N	3

Ward 7 WGH Medical	E	2		2	20.73	20.73	1	E	2
	L	2		2				L	2
	LD	2		2				LD	2
	TW							TW	
	N	3		3				N	3
Ward 8/CCU WGH Medical	E	3		1	32.45	17.17	1	E	3
	L	3		1				L	3
	LD	3		2				LD	3
	TW							TW	
	N	5		3				N	5
Ward 10 WGH Medical	E	1		1	11.73	19.9	1	E	1
	L	1		1				L	1
	LD	1	1	2				LD	2
	TW							TW	
	N	2		3				N	2
Ward 11 WGH Medical	E	1		2	17.17	20.73	1	E	1
	L	1		2				L	1
	LD	2		2				LD	2
	TW							TW	
	N	3		3				N	3

Total	328.44	361.97	18

per shift needs to be entered. The information should reflect the information on the informing patient template.

Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom ute to the delivery and coordination of patient care and treatment. However, these staff are Not included within

s is due to the recent Band 2/3 validation process.

seen a changed to either their planned roster and/or required establishment during this calculation cycle.

as stated within entation to the -Spring 2026		Required Establishment as stated within the annual presentation to the Board report (Spring 2026) including uplift 26.9%		TOTAL WTE Band 7 supernumerary ward sister/Charge nurse	Date Designated Personcalculated the nurse staffing level	Biannual calculation cycl chan	
HCSW Band 4	NSW Band 3	TOTAL WTE RN (bands 5 &6)	TOTAL WTE NSW (bands 2,3 &4)			Completed	changed
	1	14.45	17.06	1	10.4.2026	Yes	No
	1						
	2						
	3						
	1	14.45	11.61	1	13.04.2026	Yes	No
	1						
	1						
	2						
	2	19.9	19.54	1	10.4.2026	Yes	No
	2						
	1						
	1						
	3						
	1	11.73	22.62	1	14.4.2026	Yes	No
	1						
1	3						
	3						
	1	14.45	19.9	1	16.04.2026 Assistant Director of Nursing on behalf of the Designated Person	Yes	No
	1						
	3						
	3						
	1						

	1						
1	3	17.17	22.62	1	30.4.2026Assistant Director of Nursing on behalf of the Designated Person	Yes	No
	3						
	1						
	1						
	2	19.9	17.17	1	14.4.2026	Yes	No
	3						
	2						
	2						
	2 (1 S&S)	14.45	19.95	1	24.4.2026 Assistant Director of Nursing on behalf of the Designated Person	Yes	No
	3						
	1						
	1						
	3	14.45	19.9	1	14.4.26	Yes	No
	3						
	1						
	1						
	2	18.95	17.17	1	21.4.2026 Assistant Director of Nursing on behalf of the Designated Person	Yes	No
	3						
	2						
	2						
	2	18	20.73	1	21.4.2026 Assistant Director of Nursing on behalf of the Designated Person	Yes	No
	3						
	2						
	2						
	1	27	18	1	29.4.2026 Assistant Director of Nursing on behalf of the Designated Person	Yes	No
	3						
1 -m-f	2						
	2						
	3	20.73	27.44	1	21.4.2026 Assistant Director of Nursing on behalf of the Designated Person	Yes	No
	4						
	3						
	1						
1	3	20.73	28.9	1	29.4.2026 Assistant Director of Nursing on behalf of the Designated Person	Yes	No
	4						

	2	20.73	20.73	1	29.4.2026 Assistant Director of Nursing on behalf of the Designated Person	Yes	No
	2						
	2						
	3						
	1	32.45	17.17	1	05.05.2026 Assistant Director of Nursing on behalf of the Designated Person	Yes	No
	1						
	2						
	3						
	1	14.45	17.17	1	05.05.2026 Assistant Director of Nursing on behalf of the Designated Person	Yes	Yes
	1						
	2						
	3						
	2	17.17	20.73	1	05.05.2026 Assistant Director of Nursing on behalf of the Designated Person	Yes	No
	2						
	2						
	3						

Total	351.89	358.41	18

n nursing duties have been delegated by a registered nurse - required to deliver the
n the data for this report. Further information is provided within the annual assurance

e reviews, and reasons for any nges made	Any reviews outside of the biannual calculation cycle, and reasons for any changes made			
rationale	Completed (Yes/No)	Date	Changed	Rationale
ward split June 2024				
In addition to the roster, Ward has 3 WTE Rehab Support Worker				
In additional to the roster ward has 3 WTE Frailty worker . Spring 2026 proportion of NSW LD worked				
propotion of hcsw LD spring 2025				

In addition to the roster, ward has 3 WTE Rehab Support Worker				
Spring 2022 - Changed to Service Model - 19 beds respiratory patients with up to 4 CPAP patients and procedure room (cost pressure) additonal RN 24/7 In addition to the roster there is 1 WTE Band 4 AP to support the treatment room. Autumn 2024 additional hcsw night				
additonal hcsw HCSW night spring 2024				

reduction of band LD , increase of RN LD				
in addition 3.0wte rehab assistant				

The numb

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated S
acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and

the Autumn 2025 cycle references Band 2 HCSW whilst the Spring 2026 cycle references NSW Band 3 -this i

Adult inpatient surgical wards

Name of Ward	Planned roster as stated within the annual presentation to the Board report - Autumn 2025				Required Establishment as stated within the annual presentation to the Board report (Autumn 2025) including uplift 26.9%		TOTAL WTE Band 7 supernumerary ward sister/Charge nurse	Planned roster as stated the annual presentation Board report - Spring		
	Shift	RN (band 5 &6)	HCSW Band 4	HCSW Band 2	TOTAL WTE RN (bands 5 &6)	TOTAL WTE HCSW (bands 2,3 &4)		Shift	RN (band 5 &6)	HCSW Band 4
Ceredig BGH Surgery	E	1		1	21.67	22.5	1	E	2	
	L	2		1				L	1	
	LD	3		3				LD	3	
	TW							TW		
	N	3		4				N	3	
Rhiannon BGH Surgery	E	1		1	11.61 PACU 4.77	11.61 PACU 4.77	1	E	1	
	L	1		1				L	1	
	LD	1		1				LD	1	
	TW							TW		
	N	2		2				N	2	
Teifi GGH Surgery	E	1		2	22.62	34.35	1	E	1	
	L	1		2				L	1	
	LD	3	1	4				LD	3	1
	TW							TW		
	N	4		5				N	4	
Cleddau GGH Surgery	E	1	1	1	12.67	18	1	E	1	1
	L		1	1				L		1
	LD	2		2				LD	2	
	TW							TW		
	N	2		2				N	2	
Derwen GGH Surgery	E	1		1	17.17	19.9	1	E	1	
	L	1		1				L	1	
	LD	2	1	2				LD	2	1

	TW							TW		
Merlin GGH Surgery	E	1		1	19.9	11.73	1	E	1	
	L	1		1				L	1	
	LD	3		1				LD	3	
	TW							TW		
	N	3		2				N	3	
Preseli GGH Surgery	E	1		1	11.73	11.73	1	E	1	
	L	1		1				L	1	
	LD	1		1				LD	1	
	TW							TW		
	N	2		2				N	2	
Picton GGH Surgery	E	1		1 +(1x9-5 Thu)	11.98	9.2	1	E	1	
	L	1		1				L	1	
	LD	1		1				LD	1	
	TW	1x 9-5 Thu						TW	1x 9-5 Thu	
	N	2		1				N	2	
Ward 6 PPH Surgery	E	1	1 M-F	2	13.67	14.99	1	E	1	1 M-F
	L	1		2				L	1	
	LD	2(1s+s)		1 M-F				LD	2(1s+s)	
	TW							TW		
	N	2		2 M-F 1 S-S				N	2	
Ward 7 PPH Surgery	E	1	1 M-F	1	14.45 ECU 10.9	15.72	1	E	1	1 M-F
	L	1		1				L	1	
	LD	2		2				LD	2	
	TW							TW		
	N	2		2				N	2	
Ward 1 WGH Surgery	E	1		1	17.17	19.9	1	E	1	
	L	1		1				L	1	
	LD	2		3				LD	2	
	TW							TW		
	N	3		3				N	3	
Ward 4 WGH Surgery	E	2		2	20.73	20.73	1	E	2	
	L	2		2				L	2	
	LD	2		2				LD	2	
	TW							TW		
	N	3		3				N	3	

Total	211.04	215.13	12

ber of staff per shift needs to be entered. The int

Statutory Guidance, the 'nurse staffing level' is
coordination of patient care and treatment. Hov
multi-professional staff that contrib

s due to the recent Band 2/3 validation process

The wards highlighted in yellow have seen a changed to eith

within to the 2026	Required Establishment as stated within the annual presentation to the Board report (Spring 2026) including uplift 26.9%		TOTAL WTE Band 7 supernumerary ward sister/Charge nurse
NSW Band 3	TOTAL WTE RN (bands 5 &6)	TOTAL WTE NSW (bands 2,3 &4)	
1	21.67	22.5	1
1			
3			
4			
1	11.61	11.61	1
1			
1	PACU	PACU	
	4.77	4.77	
2			
2	22.62	34.35	1
2			
4			
5			
1	12.67	18	1
1			
3			
2			
1	17.17	19.9	1
1			
2			

1 1 1 2	19.9	11.73	1
1 1 1 2	11.73	11.73	1
1 +(1x 9-5 Thu) 1 1 1	11.98	9.2	1
2 2 1 M-F 2 M-F 1 S-S	13.67	14.99	1
1 1 2 2	14.45 ECU 10.9	15.72	1
1 1 3 3	17.17	19.9	1
2 2 2 3	20.73	20.73	1

Total	211.04	215.13	12

formation should reflect the information on the informing patient template.

the establishment of registered nurses - and other staff to whom nursing duties have been
vever, these staff are not included within the data for this report. Further information is prov
ute to the coordination and delivery of patient care.

.

er their planned roster and/or required establishment during this calculation cycle

Date Designated Person calculated the nurse staffing level	Biannual calculation cycl char	
	Completed	Changed
10.4.2026	yes	yes
10.4.2026	yes	no
30.4.2026 JCW on behalf of the designated person	yes	no
24.04.2026JCW on behalf of the designated person	yes	no
16.4.2026JCW on behalf of the designated person	yes	no

16.4.2026 JCW on behalf of the designated person	yes	no
16.4.2026 JCW on behalf of the designated person	yes	no
28.4.2026	yes	no
21.4.2026 JCW on behalf of the designated person	yes	no
29.4.2026 JCW on behalf of the designated person	yes	no
5.5.2026 JCW on behalf of the designated person	yes	no
5.5.2026 JCW on behalf of the designated person	yes	no

delegated by a registered nurse - required to deliver the planned roster. It is
ided within the annual assurance report [INSERT HYPERLINK] on the additional

e reviews, and reasons for any nges made	Any reviews outside of the biannual calculation cycle, and reasons for any changes made			
rationale	Completed (Yes/No)	Date	Changed	Rationale
Late Rn chnaged to Early spring 2026				
proportion of RN LD spring 2025				
funded establishment is for 17 beds. Service Change for the ward to work at 21 beds + 2 triage spaces. Total WTE includes 3.55 WTE Band 4 See below comment entered for Derwen				
In additional to the roster ward has 3 WTE Frailty worker to work across Derwen & Cleddau				

service change NSW on nights post covid				

4

4 - Clinical Care Group Reports

4.1

4.1 - Mental Health and Learning Disabilities

Liz Carroll (Hywel Dda UHB - Service Director MH&LD Clinical Care Group), Rebecca Temple-Purcell (Hywel Dda UHB - Assistant Director of Nursing, Patient Safety, Quality and Experience)

Attachments

Quality Safety Experience Committee MHLD Report June 2026 FINAL for approval.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	11 June 2026
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Mental Health and Learning Disabilities Clinical Care Group Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Andrew Caruthers, Chief Operating Officer
SWYDDOG ADRODD: **REPORTING OFFICER:**	Liz Carroll, Service Director for the Mental Health and Learning Disabilities Clinical Care Group Becky Temple-Purcell, Assistant Director of Nursing, Quality, Patient Safety, Quality and Experience, Mental Health and Learning Disabilities Clinical Care Group

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report details the quality governance arrangements within the Mental Health and Learning Disabilities (MHLD) Clinical Care Group in relation to quality, safety and patient experience. It sets out achievements, progress and planned actions to meet our Duty of Quality, and is presented to the Quality, Safety and Experience Committee (QSEC) to provide assurance of the arrangements in place.

Cefndir / Background

The Clinical Care Group operates within the Health Board's quality governance framework and relevant legislation, including the Mental Health (Wales) Measure 2010, Mental Health Act 1983 and the Social Services and Well-being (Wales) Act 2014, underpinning a rights-based, person-centred approach aligned to principles of safe, timely, effective, efficient, equitable and person-centred (STEEEP) care.

There is strong local engagement with national policy direction, particularly the Welsh Government's Mental Health and Wellbeing (MH&W) Strategy (2024–2034) and the Suicide and Self-Harm Prevention Strategy. The Clinical Care Group is progressing demonstrator projects aligned to the Open Access Mental Health Support Model, with a strong emphasis on partnership working, system transformation and co-production with people who have lived experience. While initially led by the Health Board, these projects are being developed in collaboration with key stakeholders, with a clear ambition to strengthen shared ownership and oversight through the Dyfed Powys Partnership Board as the work evolves.

National frameworks, including the Quality Statement for Mental Health and Wellbeing and the National Mental Health Patient Safety Programme, are embedded within local governance and improvement activity to support consistent, high-quality care. In Learning Disabilities, services continue to align with the "Homes Not Hospitals" agenda, with an

established community-focused model that supports individuals to receive care closer to home wherever possible.

This context provides the foundation for the report, which goes on to outline how the Clinical Care Group is managing quality and safety, responding to current pressures, and delivering improvement across services.

Asesiad / Assessment

Quality Management System

The Clinical Care Group has now established and embedded its operational governance structures following the introduction of Clinical Care Groups.

This table summarises the key components of the MHLD Clinical Care Group's quality management system, demonstrating how planning, improvement, control and assurance work together to deliver safe, effective and person-centred care.

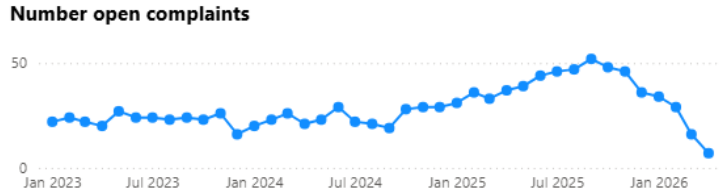
Quality Planning	Quality Improvement
• Alignment to the National Quality Statement with focus on safe, person-centred care and co-production. • Delivery of MH&W Strategy (Vision 4 – open access) and Suicide & Self Harm Strategy. • Service models focused on accessible, community-based care. • Commissioning of third sector services (e.g. Sanctuaries, Individual Placement Support). • Use of feedback, patient stories and complaints to inform improvement. • Partnership planning via Mental Health Partnership Board and demonstrator projects (including lived experience workforce).	• Enabling Quality Improvement in Practice (EQIiP) priorities: - Improving the patient experience within adult inpatient settings through nursing supported psychological interventions - Introducing One at a Time Approach in a rural Child & Adolescent Local Primary Mental Health Support Service - Reducing the amount of inappropriate Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions for adults with a Learning Disability within Hywel Dda • Participation in national improvement programmes for Neurodiversity, Dementia etc. • Delivery of National Patient Safety Programme. • Implementation of SAFEWARDS across adult acute wards.
Quality Control	**Quality Assurance**
• Oversight through MHLD governance groups aligned to Health Board structures. • Risk escalation and triangulation of data and intelligence. • Leadership Triumvirate site visits. • Implementation of national safety metrics. • Vanguard programme addressing out of area placements. • Clinical Audit & Effectiveness Framework with NICE benchmarking and audit plan. • Involvement in national discharge standards and inpatient safety guidance.	• Assurance through Ward and Community Manager forums. • Patient Reported Outcome Measures (PROMs) (Recovering Quality of Life (RQoL)) informing outcomes and improvement. • Regular review of audits, incidents, complaints and risks. • Oversight throught Mental Health Act Scrutiny Group and Mental Health Legislation Committee. • Serious Incident Learning Forum and audit framework. • Accreditation and external assurance processes.

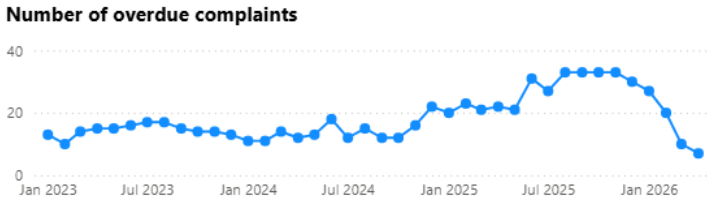
Quality and Governance Areas of Escalation

Areas of ongoing focus and improvement, identified through the Health Boards escalation framework relate to three areas; complaints management, incident management and specifically the timeliness of review and closure of Nationally Reported Incidents (NRIs).

Complaints Management

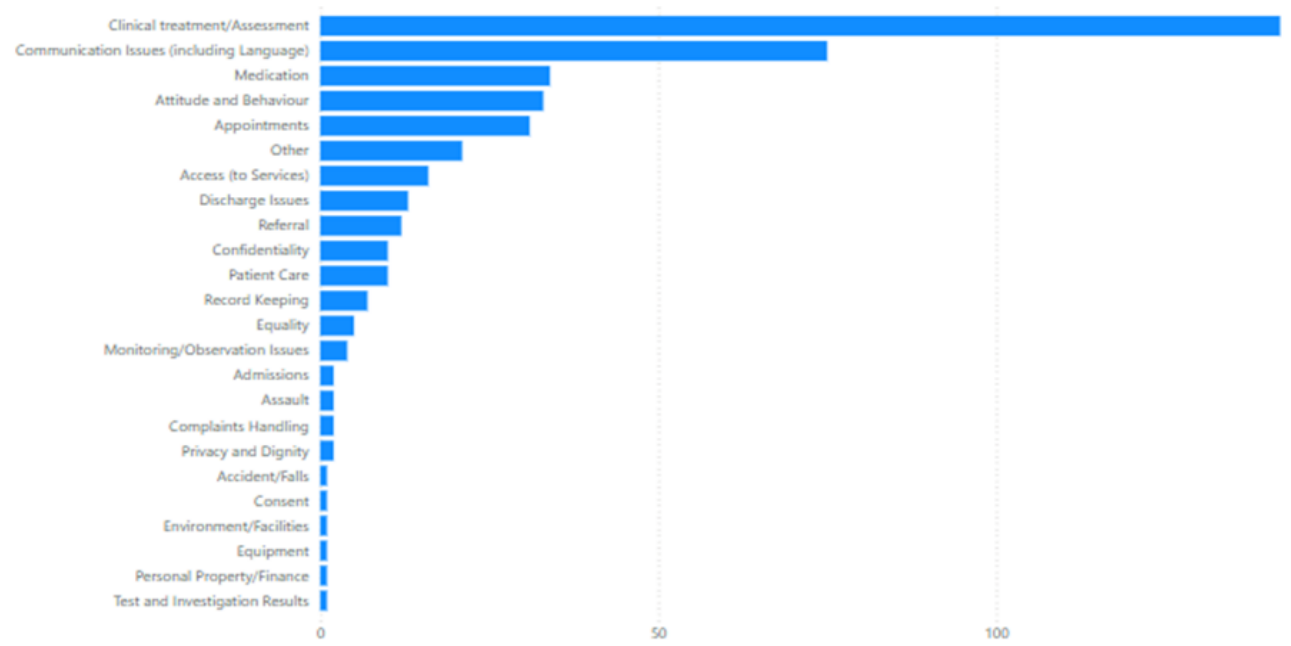
The number of complaints received by MHLD services show expected month-to-month variation, with a notable reduction in overall complaint volumes since October 2025, alongside improved performance in complaints management over the past six months. A focus on early resolution approaches, alongside the adoption of principles within the People's Experience Framework, has contributed to a reduction in formal complaints since 1 April 2026, supporting a more responsive and person-centred approach to concerns.





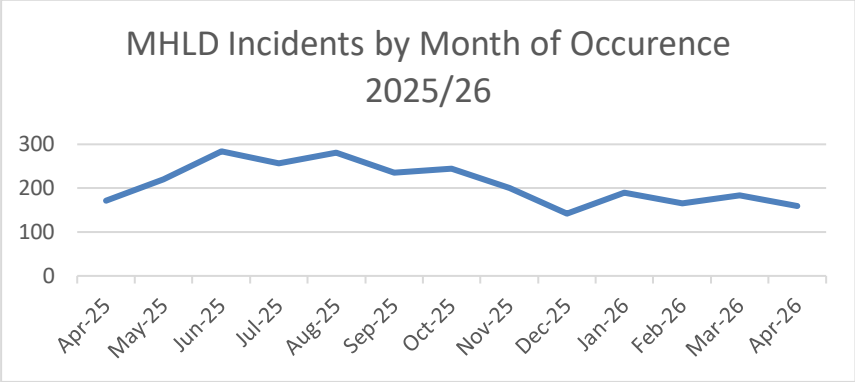
Longer open complaints are associated with cases linked to serious incidents, which involve a higher level of complexity and require detailed investigation. Extended timescales have been necessary to ensure thorough review, appropriate governance oversight, and alignment with parallel investigative processes.

Key themes remain consistent, primarily relating to communication, access and timeliness, care and treatment, and staff attitude. These reflect ongoing challenges within complex care pathways and continue to centre on patient experience rather than clinical safety concerns. Complaints are informing ongoing improvement activity, with emphasis on strengthening communication, managing expectations, and improving responsiveness.

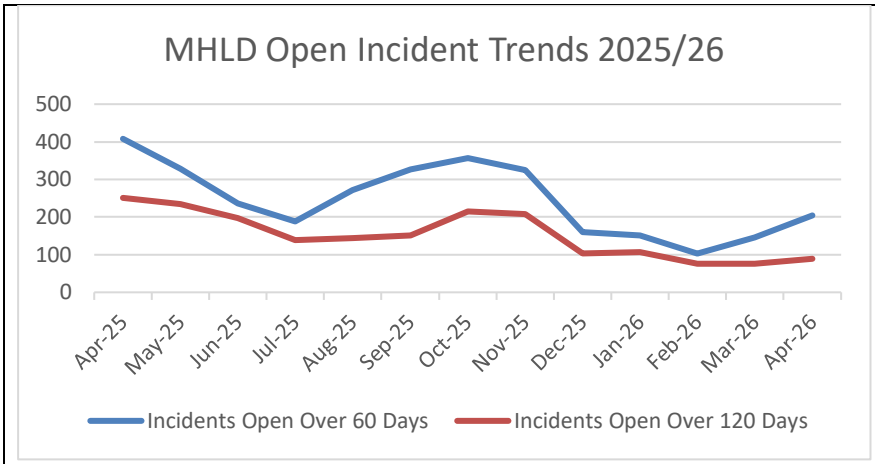


Incident Management

The chart below shows the last 12 months trends in numbers of incidents reported across the Clinical Care Group. The number of incidents reported has fluctuated throughout the period.



Work has been undertaken within the Clinical Care Group, in partnership with the Reducing Restrictive Practice Team, to refine how restrictive interventions are recorded. Restrictive interventions undertaken in response to an unexpected or unplanned incident are recorded as incidents on Datix. In contrast, planned restrictive interventions that form part of an individual's care plan have not been recorded as incidents on Datix since April 2026; instead, they are documented in clinical records and captured within local logs for monitoring and audit. If a planned intervention escalates into an incident, such as where harm occurs, it is reported on Datix. This approach is expected to impact future incident data. The Clinical Care Group has also piloted a nationally developed Datix module for restrictive interventions, now being rolled out across Wales.



The number of open incidents has reduced overall across the year, with both >60-day and >120-day backlogs falling significantly from April 2025 to early 2026. After an initial decline, there was a mid-year increase peaking around October 2025, followed by a sharp improvement into February 2026. A slight increase is evident in the final months, however, levels remain significantly below the position recorded at the start of the period.

Nationally Reported Incidents (NRIs)

As at 22 May 2026, there are 18 open Nationally Reported Incidents (NRIs), three of these are completed and awaiting receipt of an outcome form and one is due to be downgraded. All NRI's require proportionate review, stakeholder engagement and comment, prior to final approval. The outcome form must be received and acknowledged by NHS Performance and Improvement before the Datix can be closed at monthly Incident Management Group (IMG), which can extend the length of time from the completion of the review and final closure. All NRI's have expected closure dates, with most progressing towards expected closure over the coming months. While many are scheduled for completion between May and July, a small number are experiencing delays due to outstanding closure information.

There are a further 61 serious untoward incidents that are not NRIs also under proportionate review, 11 of these were due for closure in May 2026.

Actions in place to support improvement with complaints and incident management:

- Introduction of a Head of Nursing role for MHLD to strengthen leadership capacity, with a clear focus on improving quality and patient safety, including oversight of incident management and learning.
- Regular meetings established with Heads of Service to monitor progress on incident review and closure, alongside oversight of complaints to ensure timely learning and resolution.
- Implementation of workforce stabilisation plans within inpatient services to release ward leadership capacity, enabling greater focus on incident review, learning and closure.
- Plan for expansion of the pool of Reviewing Officers across services, supported by Quality Assurance and Practice Development (QAPD) training and guidance, to increase capacity, reduce delays and strengthen cross-service learning.
- Work underway to secure protected time for Reviewing Officers and strengthen support arrangements, recognising that operational pressures and limited capacity are key contributors to delays in completing reviews.

Serious Incident Learning Forum

The Clinical Care Group has established a Serious Incident Learning Forum (SILF), to strengthen both oversight of serious incident review processes and the way learning is identified, shared and embedded in practice. Early work has identified recurring learning themes including variability in documentation and decision-making, gaps in discharge planning and follow-up, inconsistent risk recognition and escalation, challenges in coordinating care for people with co-occurring needs, and variability in inter-service and multi-agency communication. These themes are not unique to the Health Board and align with wider national learning. In response, a coordinated programme of improvement is underway, closely aligned with the national patient safety programme for mental health, including implementation of national discharge standards, development of a national ligature risk policy, rollout of SAFEWARDS, and work to establish a more evidence-based, distributed approach to safety. This is supported by the development of mental health safety metrics and the introduction of ReQoL as a consistent patient-reported outcome measure across Wales.

Alongside this, SILF is overseeing targeted action to improve the timeliness and quality of serious incident reviews, including increasing review capacity, strengthening training and mentoring, and enhancing governance and accountability. There is a clear shift towards a more open, learning-focused and compassionate culture, supported by the use of patient and carer stories to inform learning and improvement. While the immediate priority is to stabilise and strengthen the serious incident review process, the longer-term ambition is to extend SILF into a broader forum for learning from all quality and safety intelligence, supporting continuous improvement at a whole-system level.

Key Risks across the Mental Health and Learning Disabilities Clinical Care Group

The Clinical Care Group currently has 28 open risks on its risk register. An overview of risk scores can be found below:

Open risks	Risks overdue	% overdue	Open actions	Actions overdue	% overdue
28	0	0%	59	0	0%

Risk heatmap

Likelihood

Impact	Rare 1	Unlikely 2	Possible 3	Likely 4	Almost Certain 5
Catastrophic 5		1376 139 1811			
Major 4			2021 1857 2010 839	971	2090 1032 1287 1290
Moderate 3		1896 1781	2011 2012 1455 138 1392	2191 2269 1249 1525	
Minor 2			1408 1365 1379	1375 1524	
Negligible 1					

100% of risks were reviewed within timeframe and 100% of risk actions were completed within timeframe in April 2026.

The Clinical Care Group's five highest scoring risks predominantly relate to the risk of service users not receiving timely access to services, where demand and clinical need exceed available capacity, often driven by or compounded by workforce gaps. Separately, there is a financial risk relating to the Clinical Care Groups ability to remain within allocated budgets. This risk is largely driven by sustained use of medical agency staffing and use of private out-of-area placements for adult mental health patients, alongside increased placement costs. Collectively, these risks impact the safety, timeliness, efficiency and effectiveness of service delivery.

Impacted areas are:

- children and adults waiting for assessment and diagnosis of autism spectrum disorder (ASD).
- adults waiting for assessment, diagnosis and treatment of attention deficit hyperactivity disorder (ADHD).
- adults seeking access to mental health services in North Ceredigion through both the Community Mental Health Team and Crisis Resolution Home Treatment Team.
- overall impact of risk of failure to remain within budget, which may reduce financial flexibility and challenge delivery of savings targets, limiting reinvestment and longer-term sustainability.

Risk 2228 Risk of patient safety affected due to discontinuation of the electronic prescribing system 'Vision' for Outpatient Department (OPD) clinics and services

The MHLD Clinical Care Group is also impacted by Risk 2228 (score 25), currently held by the Medicines Management Operational Group, which relates to the potential loss of electronic prescribing functionality following the planned discontinuation of the Vision system without a replacement. Although not yet a corporate risk, it is under consideration for escalation due to its significant impact on MHLD and Community Paediatric services reliant on Vision. The absence of a digital prescribing system presents a substantial patient safety risk, with increased potential for delays, errors, and disruption to treatment, particularly for vulnerable groups. The Clinical Care Group is working closely with pharmacy colleagues to

develop contingency arrangements for potential system outages, while Digital teams are progressing options to secure a replacement system.

Neurodevelopment Service Update

Waiting lists and demand for Neurodevelopmental Services remain a significant risk, with sustained increases in referrals for ASD diagnostic assessments across children and adult services, and for ADHD diagnostic assessments in adult services. In April 2026, referrals totalled 186 for children's ASD, 68 for adult ASD, and 180 for adult ADHD; however, current capacity remains insufficient, with adult ADHD services able to undertake approximately 10 assessments per month. Referral rates have risen significantly over the past five years, increasing by 125% for adult ASD and 492% for adult ADHD. While £567,000 of additional Welsh Government funding has been secured for children's ASD services, this will not fully address the backlog by 2026–27, and funding for adult services remains non-recurring.

In response, the service is progressing a range of developments, including demonstrations of digital platforms (Do-It Profiler, ThinkDivergent and Patient Knows Best) to support administrative efficiency and pre-assessment processes, plans to recommission outsourced assessment capacity, and implementation of an AI-supported documentation tool (Magic Notes). Work is also underway with the Communications Team to improve public information and manage demand, alongside engagement with primary care to strengthen shared care arrangements for ADHD prescribing and collaboration with other Health Boards to review pathways and share learning.

Ceredigion Community Mental Health Service Update

The Ceredigion Mental Health Pathway is in the early phase of embedding following Public Board approval on 26 March 2026, which endorsed both its permanent implementation within Ceredigion and a phased rollout to Carmarthenshire and Pembrokeshire. While the pathway is now established, uptake of the revised referral process by Primary Care remains variable, with key access routes not yet consistently utilised. Notwithstanding this, there has been positive progress with recruitment to non-medical roles which has supported improved performance against Part 2 of the Mental Health (Wales) Measure. Whilst this remains below target, close monitoring is in place with oversight through the Mental Health Legislation Committee.

There continues to be a strong focus on building trust and confidence with patients, service users and partners through active engagement. This includes a well-attended, full-day workshop held on 19 March 2026 facilitated by West Wales Action for Mental Health, bringing together third sector partners and service users to promote awareness and use of NHS 111 Option 2, identify service improvements, and strengthen public confidence, with positive feedback received. Collaborative work has also commenced with primary care partners, with an initial focus on improving understanding and use of the pathway within Ceredigion, recognising that current utilisation is not yet optimal.

Referral activity has stabilised overall, although variation remains and the expected shift in referral patterns has not yet been fully realised. Monthly planning meetings are in place to support a phased rollout to Carmarthenshire and Pembrokeshire, with a measured approach

to ensure the impact on NHS 111 Option 2 is closely monitored and that sufficient capacity is in place to respond to increased demand.

Out of Area Beds Update

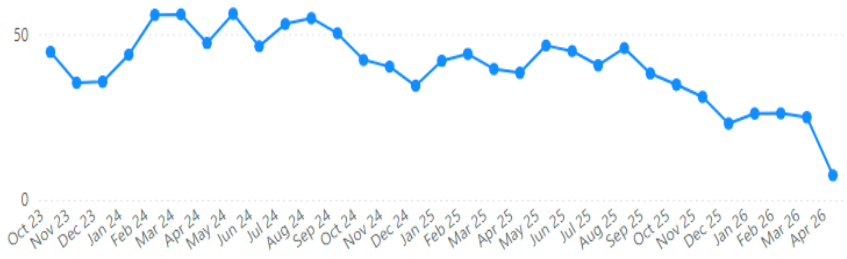
Local recovery and improvement actions within the Clinical Care Group has prioritised improving patient flow and reducing reliance on out of area placements. This includes a planned increase in bed capacity to support crisis admissions, alongside focused work to reduce delays in transfers of care and strengthen alternatives to admission through service redesign. These locally driven initiatives aim to support more timely, safe and effective pathways for patients.

This approach aligns with recent work led by the NHS Wales Performance and Improvement Team, which highlights variation in inpatient mental health provision across Wales and reinforces that out of area placements are a system-wide quality and safety issue, influenced by delayed discharges, workforce models and demand pressures rather than bed numbers alone. In response, a coordinated national programme is underway to improve flow, optimise use of existing capacity and strengthen community-based support which the Clinical Care Group is fully engaged with.

Inpatient Workforce Stabilisation

Revised staffing establishments have been approved and implemented across the majority of MHLD Inpatient areas**,** resulting in improved workforce stability and reduced reliance on temporary staffing. This has positively impacted continuity and quality of care delivery.

The chart below sets out the trend in combined agency and bank usage across the eight MHLD inpatient wards, expressed as whole-time equivalents (WTE), as at 12 April 2026.



While staffing levels have improved, they are currently operating at minimum accepted levels and therefore require ongoing monitoring to ensure sustainability. The changes have nevertheless enabled some strengthening of quality assurance processes, allowing clinical leads to increase focus on quality management system functions, although capacity remains constrained. This work represents progress in addressing historical staffing pressures and supports delivery of safer inpatient care**.**

Argymhelliad / Recommendation

The Committee is asked to TAKE ASSURANCE on the quality governance arrangements in place within the Mental Health and Learning Disabilities Clinical Care Group in relation to quality, safety and patient experience.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.10 Provide assurance to the Board in relation to its responsibilities for the quality and safety of mental health, primary and community care, public health, health promotion, prevention and health protection activities and interventions in line with the Health Board's strategies
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	All risks held on the Mental Health and Learning Disabilities Care Group risk register. Datix references contained within the main body of report.
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	5 Mental health and CAHMS 1 Workforce Stabilisation
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	8. Transform our communities through collaboration with people, communities and partners

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

Effaith: (rhaid cwblhau) **Impact: (must be completed)**

Ariannol / Gwerth am Arian: **Financial / Service:**	N/A
Ansawdd / Gofal Claf: **Quality / Patient Care:**	Initiatives described will promote more timely access to assessment.
Gweithlu: **Workforce:**	Initiatives described will promote staff wellbeing.
Risg: **Risk:**	Initiatives described will reduce documented risk.
Cyfreithiol: **Legal:**	No legal challenges anticipated.
Enw Da: **Reputational:**	N/A
Gyfrinachedd: **Privacy:**	N/A
Cydraddoldeb: **Equality:**	N/A

4.2

4.2 - Public Health

Bethan Lewis (Hywel Dda UHB - Assistant Director of Public Health Strategic Business and Operations)

Attachments

3 STEEP SBAR template for CCG to QSEC - Public Health Directorate 11 June 26.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	11 June 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Clinical Care Group Quality Report – Public Health Directorate
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Dr Ardiana Gjini, Executive Director of Public Health
SWYDDOG ADRODD: REPORTING OFFICER:	Ms Bethan Lewis, Assistant Director of Public Health Strategic Business & Operations

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report details the quality governance arrangements within the Public Health Directorate in relation to quality, safety and patient experience. It sets out achievements, progress and planned actions to meet our Duty of Quality, and is presented to the Quality, Safety and Experience Committee to provide assurance on the arrangements in place.

Cefndir / Background

The Public Health Directorate delivers and supports a range of operational services designed to protect health, prevent harm and improve wellbeing. These include statutory and core functions in health protection and communicable disease control, delivery and oversight of immunisation programmes, work to prevent and manage diseases of elimination, and prevention/intervention services including smoking cessation and health coaching. These services collectively support the Directorate's wider prevention, equity and population health agenda.

The aim of the Public Health Directorate in summary is to:

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

Meeting the Duty of Quality is the highest priority for the Directorate and its governance structures and oversight has developed significantly. The Assistant Director of Public Health and Head of Nursing lead the agenda, which is aligned to the six domains of quality as defined by the Duty of Quality Statutory Guidance 2023. This report is set out under each of these domains.

Asesiad / Assessment

Quality Assurance

The Public Health Directorate has established governance arrangements to oversee quality, safety and patient experience across its operational services and wider function. Oversight is provided through Directorate governance structures, including routine review of risks, incidents, service performance, complaints/concerns, workforce issues and improvement actions. This enables triangulation of intelligence across services and supports escalation where there are emerging concerns relating to capacity, access, safety or quality.

The Public Health Directorate Governance meetings are planned every month, and are well represented by senior and operational leads, as well as other multi-disciplinary colleagues from across the Health Board, all of which take an active part in the meetings and shape the overall agenda. Operational leads for Health Protection, Immunisation, Smoking Cessation and Health Coaching contribute to regular performance and quality discussions, with matters escalated through Directorate governance structures as required. Where services are delivered in partnership or with external interfaces, governance arrangements include attention to interdependencies, referral pathways and system coordination. The Group Terms of Reference and Work Plan are reviewed annually and has recently undergone a review to align to the Clinical Care Group (CCG) Integrated Governance approach. Due to the size of the Directorate, there are no large service sub-groups, instead Incident Scrutiny meetings meet monthly which provide report updates.

Safe Care

Although the Directorate's operational services are primarily preventative, there are clear safety implications associated with underperformance, delay or inconsistency. Within Health Protection, including diseases of elimination, safe care is linked to effective surveillance, timely response to incidents and outbreaks, robust case/contact management, and appropriate escalation where public health risks are identified. For immunisation services, safety includes safe vaccine delivery, cold chain assurance, incident reporting, workforce competence, and rapid action where uptake gaps may increase vulnerability to vaccine-preventable disease. For smoking cessation and health coaching, safety includes ensuring that interventions are delivered by appropriately trained staff, that clinical and safeguarding concerns are recognised and escalated, and that referral processes are safe and reliable.

Incident Reporting

The directorate currently has 11 incidents, of which 2 were recently closed. A monthly incident scrutiny meeting has been established led by the Head of Nursing, supported by the Senior Nurse for Health Protection & Immunisation Services, which ensures all incidents have timely management and enables focused discussion around opportunities for learning and the ability to focus on analysis of incident themes and drive improvement.

An Incident Management Review has taken place alongside Quality Assurance Team, Redress and Legal representatives with the advice to remain open as we awaiting information from follow up investigations to enable us to manage the incident appropriately. The Duty of Candour process has been completed for this incident.

Safeguarding

There are no current safeguarding cases relating to the directorate operational teams. Within the monthly Governance meetings Child Practice Reviews are shared to ensure key recommendations are shared to influence current practices across corporate functions of the directorate.

Infection Prevention and Control

Care homes across the Hywel Dda region experienced multiple outbreaks since late winter 2025, as outlined in table 3 below. These outbreaks highlighted challenges relating to ownership within care home settings, as well as difficulties in prescribing of antiviral medication and treatment of contacts in scabies incidents. The Directorate supported Incident Management Teams (IMT) for care homes outbreaks. Through these, epidemiology information was established, Infection, Protection and Control (IPC) guidance (including detailed audit reports follow face to face visits) was reinforced and treatment pathways were developed. This included access to treatment from the Out of Hours service, particularly where there was a reluctance from GP's to prescribe for contacts of residents and where secondary infections required escalation of treatment.

Table 3: Number of incidents reported in Hywel Dda UHB in 2026, by Local Authorities, setting and month

	Jan	Feb	Mar	^Apr	Total
Carmarthenshire	**5**	**2**	**1**	**1**	**9**
Care home	5	1			6
Hospital			1		1
Nursery		1			1
School				1	1
Ceredigion	**1**	**1**			**2**
Residential home	1	1			2
Pembrokeshire	**12**	**3**	**3**	**1**	**19**
Care home	4		1		5
Nursery	3	2	1		6
Restaurant/hotel/pub/take-away	1				1
School	4	1	1	1	7
Total	**18**	**6**	**4**	**2**	**30**

^ Incomplete month as of 20/04/2026

The Health Protection Team undertakes debriefs following outbreak incidents. Where challenges are identified, 'lessons learnt' reports are produced available to the Health Protection Operational Delivery Group.

A Scabies Quality Improvement Task & Finish Group has met recently to discuss ongoing issues with diagnosis and treatment pathways within the Health Board and initial action agreed to strengthen current provision as the group works towards a robust and effective pathway.

Mortality Reviews

The Directorate are not involved in mortality review however do ensure within its Governance meetings that key learning is shared from Drug and Alcohol related Death panels led by our Prevention & Population Health Improvement Manager. Key areas to note:

Harm Reduction and Overdose Prevention:
Significant progress has been made in harm reduction initiatives:

- Naloxone programme: 1,600 police staff trained, with 25 lives saved in the last year through overdose reversal.
- Innovative outreach models such as Spike on a Bike enhance rapid engagement with hard-to-reach populations.

Strategic Response and Intelligence:

- The Cocaine Summit has driven multi-agency collaboration and informed a subsequent market segmentation exercise, improving targeting of interventions.
- Work to embed routine alcohol screening in emergency departments and dentistry is progressing rapidly. This need is based on the findings of the Alcohol Death Review Group, one of only 2 that exist across the Welsh health boards.
- Excellent data systems now enable improved real-time surveillance, trend analysis, and targeted responses across the system.

Timely
Timeliness is a critical quality issue across all the services covered in this report. In Health Protection, timeliness affects outbreak management, contact tracing, risk communication and implementation of control measures. In immunisation, timeliness determines whether people are protected when they need to be, including infants, children, vulnerable adults and eligible groups during seasonal campaigns. In smoking cessation and health coaching, timely access to support is important because motivation to change health behaviours can be time-sensitive, and delays may reduce engagement or worsen outcomes.

The Directorate continues to monitor timeliness in relation to:

- access to immunisation appointments and follow-up of non-attenders
- responsiveness to communicable disease notifications and incidents
- referral-to-contact times for smoking cessation and health coaching services
- pathway responsiveness for people requiring more targeted or intensive support
- escalation where staffing or demand pressures affect service responsiveness.

Improvement actions remain focused on reducing avoidable delay, improving data visibility, and ensuring operational capacity is aligned to demand. Consideration is given to whether certain population groups experience disproportionate barriers to timely access, including rural communities, deprived communities, digitally excluded individuals, or those requiring outreach and tailored engagement.

Effective

The Directorate's operational services contribute to effectiveness by delivering interventions known to reduce morbidity, mortality and long-term demand on health services. Effectiveness is supported through:

- use of recognised pathways, models and national guidance
- quality improvement activity aimed at improving uptake, engagement and pathway performance
- targeted work to reach underserved groups
- multidisciplinary collaboration to strengthen referral and escalation routes
- service review to identify what is working well and where outcomes can be improved.

An internal audit in 2025 of the Immunisation Service identified areas for strengthening governance, data quality and equity of uptake. A structured action plan has been implemented and is being monitored through Directorate governance arrangements. Key actions taken include a refresh of the vaccine equity plan, key delivery plans across all immunisation programmes, and the involvement of Primary Care on each of the vaccine subgroups with Assistant Director level membership at the oversight level.

The Directorate has completed a Smoking Cessation Audit over the past 2 years as part of the Health Board audit cycle. There is a plan to re-audit in 2026 with a start date to be confirmed.

Evidence based

The Directorate's operational model is grounded in established public health evidence and national expectations. Immunisation delivery, communicable disease management, disease elimination work, smoking cessation and behaviour change interventions all require adherence to current guidance, standard operating procedures and evidence-informed practice. The Directorate therefore places importance on aligning services with national policy, recommended pathways and recognised models of good practice.

Areas of evidence-based assurance include:

- alignment of immunisation delivery with national programme requirements
- health protection practice informed by current communicable disease guidance and escalation arrangements
- smoking cessation interventions delivered using evidence-based approaches
- health coaching practice informed by recognised behaviour change methodologies and professional competencies
- review of service design and targeting in light of available evidence on what improves uptake, engagement and outcomes.

Equitable

Equity is central to the quality of Public Health operational services. Those at greatest risk of poor outcomes are often the least likely to access preventative interventions without proactive outreach and tailored approaches. This is relevant across immunisation, where uptake can vary by deprivation, geography or community group; in diseases of elimination, where vulnerable populations may face barriers to prevention or follow-up; and in smoking cessation and health coaching, where people with the highest need may face structural, cultural, practical or psychological barriers to engagement.

The Directorate continues to focus on equitable delivery through:

- targeted approaches to populations with lower uptake or higher risk
- partnership working to improve reach and acceptability
- consideration of rurality, deprivation and inclusion health needs in service delivery
- accessible communication and, where possible, tailored support models
- monitoring of whether service models unintentionally disadvantage particular groups.

Person Centred
Although a number of public health services operate at population scale, person-centredness remains essential. For immunisation, this includes clear information, informed choice, respectful contact and support for people who are hesitant or anxious. In smoking cessation and health coaching, person-centred care is fundamental to engagement, trust and sustained behaviour change. In health protection, person-centred practice includes clear communication, culturally appropriate advice, support for those affected by incidents or outbreaks, and sensitive handling of confidential or anxiety-provoking situations.
The Directorate's person-centred quality considerations include:

- the quality and accessibility of communication with patients and the public
- patient experience and feedback where available
- responsiveness to concerns, complaints and learning from lived experience
- ensuring interventions are tailored to individual circumstances and readiness to engage
- maintaining dignity, respect and compassion in all interactions.

Further strengthening of patient voice in operational services is a key focus within the Directorate to ensure all operational patient-facing services are capturing patient feedback through CIVICA with the Smoking Cessation team leading this approach.

Argymhelliad / Recommendation

The Quality, Safety and Experience Committee is asked to RECEIVE ASSURANCE on the quality governance arrangements in place within the Public Health Directorate in relation to quality, safety and patient experience.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.10 Provide assurance to the Board in relation to its responsibilities for the quality and safety of mental health, primary and community care, public health, health promotion, prevention and health protection activities and interventions in line with the Health Board's strategies.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	4. The best health and wellbeing for our individuals, families and communities

Amcanion Cynllunio Planning Objectives	10 Population health
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	4. Improve Population Health through prevention and early intervention, supporting people to live happy and healthy lives

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Our Performance Dashboard
Rhestr Termau: Glossary of Terms:	As noted within body of report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	Public Health Senior Leadership Team

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	The services covered in this report are integral to the delivery of prevention, protection and early intervention. Effective delivery reduces avoidable demand associated with infectious disease, smoking-related harm and preventable deterioration.
Ansawdd / Gofal Claf: Quality / Patient Care:	This report is directly related to patient care, population outcomes and effective delivery of operational services. Effective delivery of these operational services improves protection from infectious disease, supports healthier behaviours, reduces avoidable harm and contributes to a better patient experience.
Gweithlu: Workforce:	The delivery of safe and effective services depends on a skilled and resilient workforce.
Risg: Risk:	Key risks are detailed in report and are aligned to the Directorate risk register with ongoing monitoring and mitigation through Directorate governance arrangements.
Cyfreithiol: Legal:	Some services covered in this report operate within statutory or nationally mandated frameworks, particularly in relation to communicable disease control and immunisation programme delivery.

Enw Da: **Reputational:**	Any failure in immunisation delivery, outbreak management, or equitable access to prevention services may attract public, partner or regulatory concern. Strong governance and transparent improvement action help mitigate this risk.
Gyfrinachedd: **Privacy:**	Public health operational services involve the use of confidential patient and population information. Information governance requirements are applied to ensure safe handling, sharing and storage of data.
Cydraddoldeb: **Equality:**	The services in this report have significant equality and health equity implications. Positive impact is achieved where services proactively reduce barriers and improve access for underserved populations.

4.3

4.3 - Community and Integrated Medicine

Peter Skitt (Hywel Dda UHB - Clinical Care Group Service Director - Community & Integrated Medicine), Anna Chiffi (Hywel Dda UHB - Assistant Director of Nursing, Patient Safety, Quality)

Attachments

CIMCCG to QSEC June 2026 v2.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	11 June 2023
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Community and Integrated Medicine Clinical Care Group Quality Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Andrew Carruthers, Chief Operating Officer
SWYDDOG ADRODD: **REPORTING OFFICER:**	Peter Skitt – Community and Integrated Medicine Care Group Director Anna Chiffi – Assistant Director of Nursing

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report details the quality governance arrangements within the Community and Integrated Medicine Clinical Care Group in relation to quality, safety and patient experience. It sets out achievements, progress and planned actions to meet our Duty of Quality, and is presented to the Quality, Safety and Experience Committee to provide assurance on the arrangements in place.

Community & Integrated Medicine continues to operate within a highly complex and pressurised environment, characterised by sustained workforce challenges, increased demand across both acute and community settings, and ongoing flow constraints. As a result, the Clinical Care Group remains at Level 3 governance escalation, reflecting the need for enhanced organisational oversight and support.

Whilst governance frameworks are embedded and functioning, there remain significant pressures affecting delivery. These are most evident in relation to incident and complaint backlogs, compliance with audit and national standards, and the resilience of clinical pathways.

In addition, whole-system flow challenges are increasingly influencing the quality and safety of care delivery, including the use of non-designated clinical areas to manage capacity pressures.

The overall position is therefore one of a Clinical Care Group with established governance processes but experiencing operational strain, with continued focus required to strengthen delivery, compliance, and patient outcomes.

Cefndir / Background

Community & Integrated Medicine encompasses a wide portfolio of services across acute, community and primary care settings, delivering care across Pembrokeshire, Carmarthenshire and Ceredigion systems. Governance is delivered through a structured framework of Clinical

Care Group, system and service-level quality and safety arrangements, bringing together intelligence from incidents, complaints, audit, infection prevention, safeguarding and patient experience.

The Clinical Care Group operates in line with the statutory requirements of the Duty of Quality (2023), with a clear focus on embedding quality across all aspects of care delivery. A key component of this approach is the Clinical Care Group's commitment to a learning culture, with a particular emphasis on the systematic identification and analysis of thematic trends across incidents, complaints and audit findings, ensuring that learning is triangulated, shared effectively, and translated into measurable service improvement.

Whilst governance maturity has developed significantly, the scale of operational pressures continues to impact the ability to achieve consistent compliance and sustained improvement across all domains.

Asesiad / Assessment

Quality Assurance

The Clinical Care Group Quality Governance meetings are planned every month, and are well represented by medical, nursing and managerial staff across all Service Groups, as well as other multi-disciplinary colleagues from across the Health Board, all of which take an active part in the meetings and shape the overall agenda.

Each Service Group holds monthly Quality and Safety meetings, and further work is underway to strengthen this structure and reporting to the Clinical Care Group Quality Governance meeting.

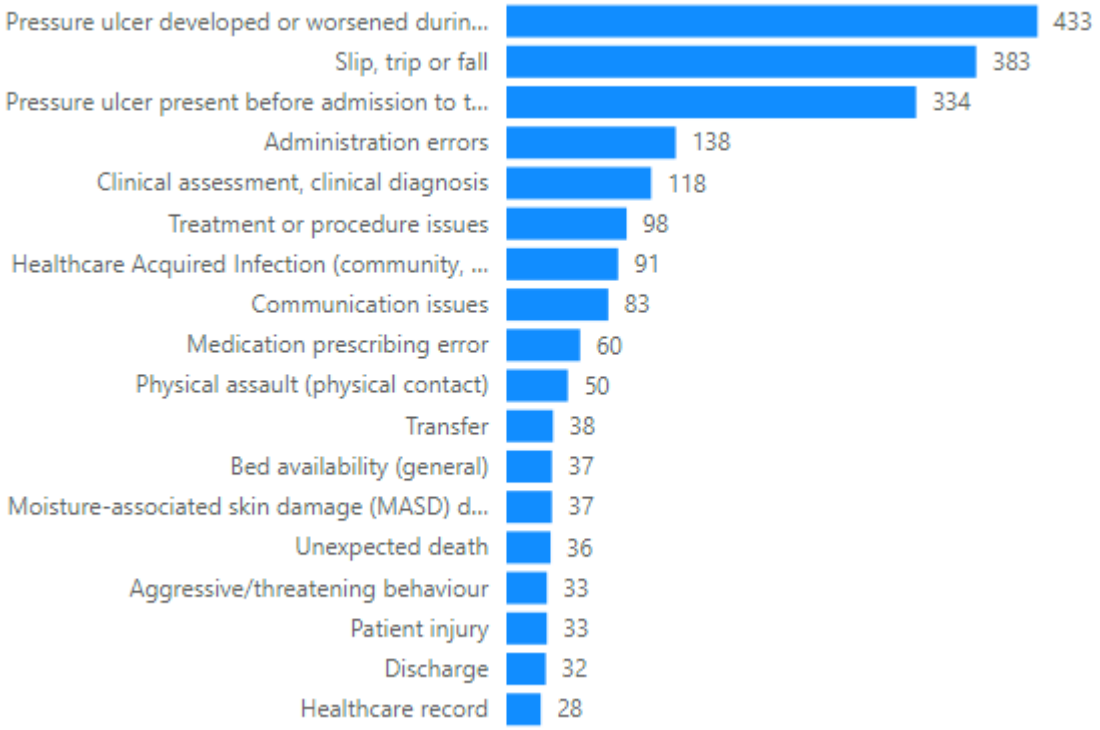
This assessment has been undertaken within the context of the Health Board's Quality Management System, drawing on a triangulated range of intelligence including incidents, complaints, audit, risk and patient experience. The Clinical Care Group's approach reflects the core components of quality management, including quality planning (through defined governance structures and improvement priorities), quality control (via monitoring of key standards, performance and compliance), quality improvement (through targeted programmes and service redesign), and quality assurance (through oversight, reporting and escalation mechanisms). The assessment is structured against the STEEEP domains to provide a comprehensive and balanced view of care delivery, recognising that quality is multidimensional and interdependent. It therefore considers both current performance and the robustness of the systems in place to identify, manage and mitigate risk, with a particular focus on how effectively the Clinical Care Group is translating intelligence into sustained improvement and demonstrable impact.

Safe Care

The Clinical Care Group continues to experience a number of significant patient safety risks, largely driven by workforce fragility, service pressures and challenges in pathway resilience. The Non-Invasive Ventilation pathway at Withybush Hospital remains a key concern, with identified risks relating to unclear clinical ownership and variation in adherence to agreed pathways.

Incident management continues to present a challenge, with high volumes of open incidents and delays in investigation and closure limiting the ability to demonstrate timely organisational learning. Infection prevention risks remain, particularly in relation to delayed review processes and environmental factors. The table below gives a thematic overview of the open incidents within the care group.

Thematic Overview of open incidents across the care group:



Encouragingly, there has been sustained progress in reducing the volume of aged incidents, with those open greater than 60 days reducing from 2050 in February to 1772 in April 2026, and incidents open greater than 120 days reducing from 1533 to 1369 over the same period. This demonstrates a clear and focused progress across systems to address historical backlogs, supported by strengthened oversight and targeted trajectories. Whilst this improvement reflects positive momentum and increased organisational grip, the residual volume remains significant and continues to impact the timeliness of learning and assurance. Continued focus is therefore required to sustain this trajectory, further reduce backlog volumes, and ensure that improvements are translated into timely investigation, closure and embedded learning. This is represented in the table below.

<u>Reduction in Incident Backlog and Ongoing Position</u>

Topic	Measure	Feb 26	Mar 26	Apr 26	Trend (Apr 22 - Apr 26)
Incidents	Incidents open >60 days	2050	1823	1772	
	Incidents open >120 days	1533	1402	1369	
	Patient safety incidents closed with moderate or above harm	6	23	10	

This improvement has been achieved through targeted actions including weekly incident trajectory reviews at system and Clinical Care Group level, strengthened oversight through Quality Governance meetings, and the introduction of focused review sessions to support timely closure. These actions have improved organisational grip and accountability; however, the residual backlog continues to pose a risk to timely learning and assurance, and further trajectory improvement is required.

Boarding and care within non-designated clinical areas: A further and increasingly significant safety concern relates to the use of boarding and care within non-designated clinical areas, arising from system-wide capacity and flow constraints.

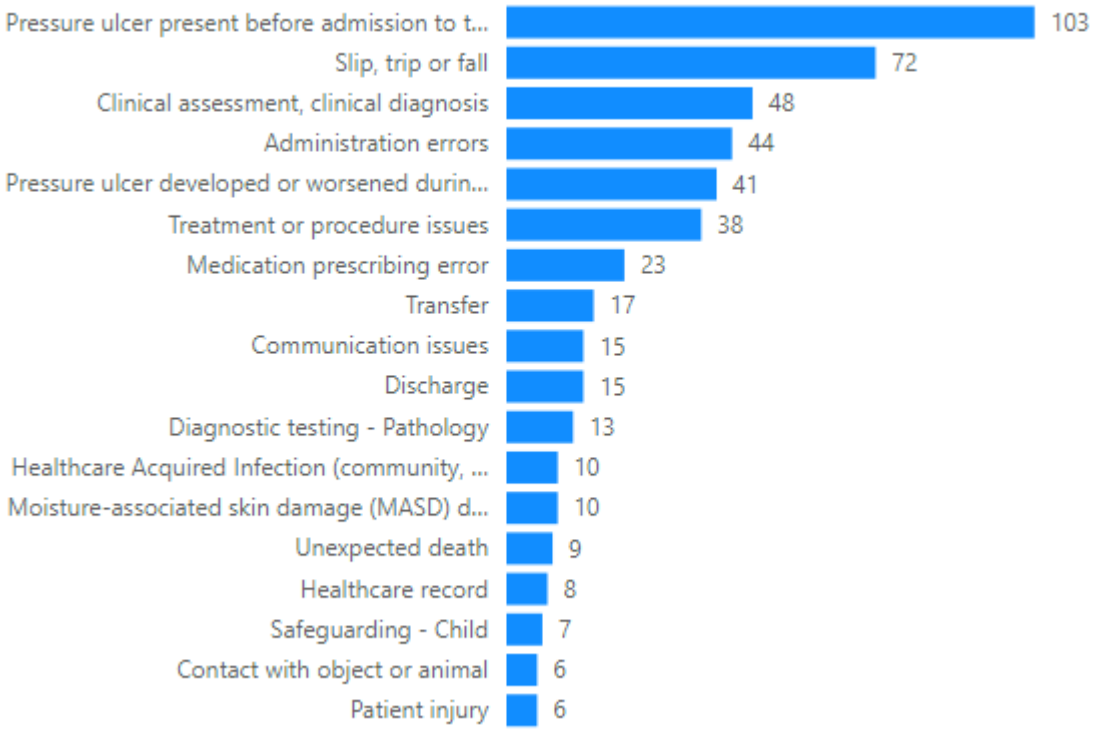
Patients continue to be cared for in escalation areas, corridor spaces or environments not designed for their clinical needs. This presents a heightened risk to patient safety, including reduced visibility for monitoring, challenges in maintaining appropriate staffing levels, delays in clinical decision-making, and limitations in infection prevention and control.

These environments are not configured to support the safe management of patients with complex or acute conditions and often require staff to adapt care delivery in ways that increase clinical risk. There is also potential for deterioration in patient condition to be identified later than expected due to environmental constraints.

This risk profile is increasingly reflected within incident reporting and patient experience feedback. Incidents associated with care in non-designated areas frequently cite factors such as reduced observation capability, delays in escalation of care, communication challenges, and environmental limitations impacting safe delivery of care. In parallel, complaints and concerns raised by patients and families often highlight issues relating to dignity, privacy, and overall patient experience, particularly where care is delivered in corridor spaces or areas not designed for inpatient care.

The graph shows the current profile of open incidents attributed to Urgent and Emergency Care (UEC). This is used as the baseline to track progress, supported by a monthly run chart of total open incidents and key themes to evidence trajectory and control. Risk assessment is used operationally alongside escalation and flow controls to mitigate known risks, particularly where congestion and boarding increases. Handover, 45 reporting evidences improved handover performance, with acknowledged displacement of pressure into surge and boarding; therefore tracking access alongside safety balancing measures (UEC incidents and harm themes) to demonstrate whether improved access is being achieved without unacceptable harm, is required.

Open incidents attributed to urgent and emergency care settings



Whilst escalation processes are in place and actively managed, the sustained reliance on non-designated areas indicates underlying system pressure and represents a significant safety and governance concern. The emerging themes from incidents and complaints further reinforce the impact on patient safety and experience, and underline the need for continued organisational focus, mitigation, and system-level action to reduce reliance on such environments.

Actions and risk management:

The risks associated with boarding and care in non-designated areas are actively managed through the Health Board's escalation framework, with daily operational command structures reviewing capacity, risk and patient placement decisions. Risk assessment is embedded within these processes, with clinical teams undertaking dynamic risk assessments to inform patient allocation, observation requirements and escalation thresholds.

Targeted system actions are in place to reduce reliance on escalation spaces, including:

- Progression of system flow initiatives (including streaming and assessment models)
- Strengthened discharge coordination and oversight of Delayed Pathways of Care (DPOC)
- Increased senior clinical decision-making at the front door

These actions are monitored through daily operational calls, system escalation reviews and Clinical Care Group governance structures, ensuring that risks are both visible and actively managed.

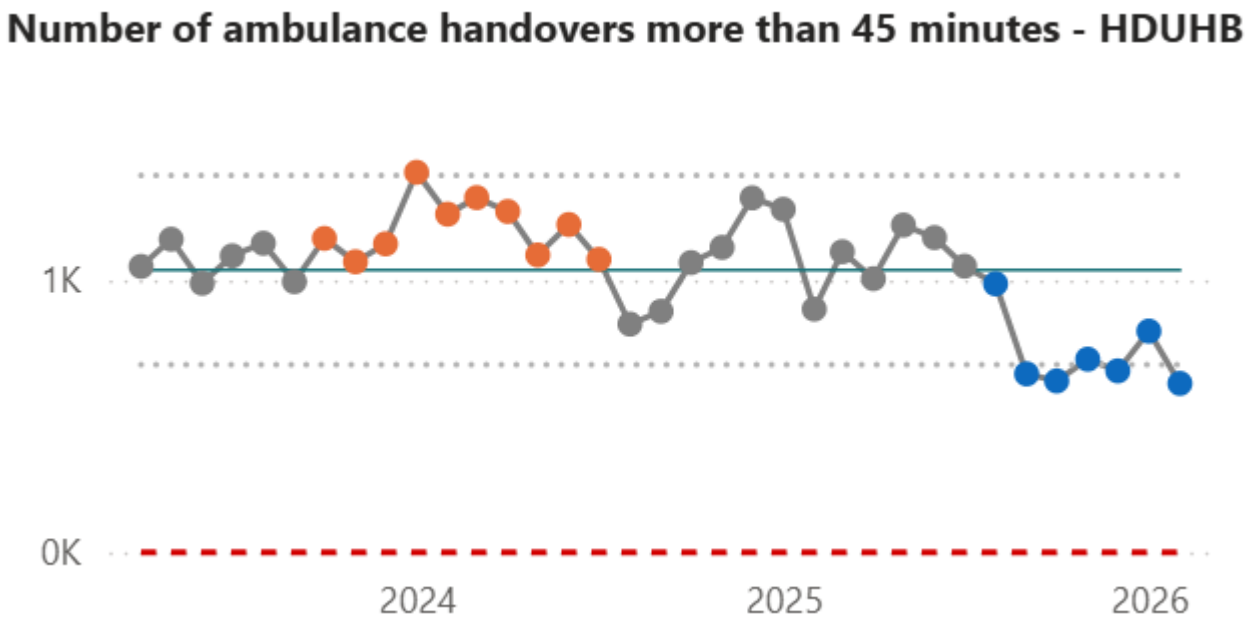
Impact:
Whilst reliance on non-designated areas remains, there is early evidence of improved system flow indicators (including ambulance handover performance as outlined below), demonstrating a positive trajectory. However, this has not yet translated into a sustained reduction in boarding, and the risk profile remains significant. Continued system focus is required to deliver measurable reduction and to ensure improvements are sustained.

Timely

Timeliness of care delivery remains variable across the Clinical Care Group, with delays evident in key processes including incident management and complaints handling. A significant proportion of complaints exceed required response times, and delays in incident investigation impact the timeliness of learning and improvement.

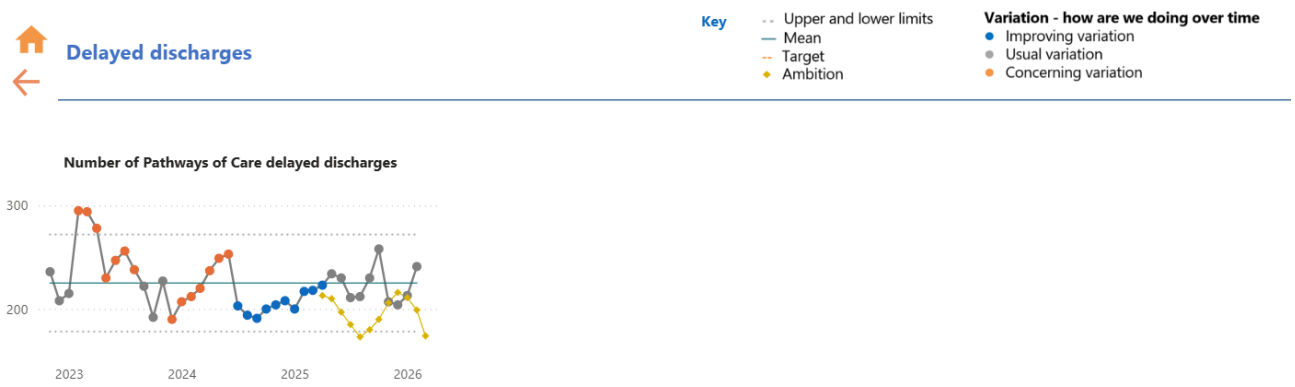
System flow challenges are also contributing to delays in care delivery. Corridor care, patient boarding and service capacity constraints create inefficiencies in patient movement and contribute to delays in assessment, treatment and discharge. Boarding in non-designated areas further exacerbates these issues, as patients may be reviewed later than required or experience fragmented care coordination due to unclear clinical ownership.

Actions are in place to improve timeliness, including implementation of the “Listening to People” framework and strengthened monitoring of complaint and incident performance. However, system pressures continue to impact the ability to deliver timely care consistently.



Performance in relation to 45-minute handover has remained consistently high, reflecting sustained system pressure. More recently, there is a clear improvement, with delays reducing indicating a positive trajectory from system actions. However, performance remains above expected levels, and continued focus is required to sustain and embed improvement.
The reduction in ambulance handover delays indicates an improvement in system responsiveness and access at the front door. However, this improvement must be considered within the wider system context. Whilst access has improved, there remains a displacement of risk into the hospital setting, particularly through increased boarding and use of non-designated care areas.

Analysis of incident themes and patient experience feedback indicates that improvements in handover timeliness have not yet translated into a proportional improvement in overall patient safety and experience, reflecting ongoing constraints in downstream flow and capacity. This reinforces the need for whole-system actions to ensure that gains in access are matched by improvements across the patient pathway.



DPOC continue to demonstrate variability, with early improvements not sustained. Performance remains inconsistent against ambition, reflecting our ongoing system pressures, particularly within community capacity and discharge pathways. However, there is clear system focus and oversight in place, with discharge processes, escalation, and pathway management actively monitored, providing assurance that risks are understood and actions are being taken. Overall, variability remains the key challenge, with further work required to achieve sustained improvement.

Effective and Efficient Care

There is ongoing evidence of quality improvement activity across the Clinical Care Group, including implementation of programmes aimed at improving patient outcomes and strengthening governance arrangements. However, effectiveness is impacted by the position of the clinical audit programme, with a number of audits remaining non-compliant and associated action plans either delayed or incomplete. There is an identified gap in the consistent translation of audit findings into demonstrable improvements in clinical practice. This limits assurance that care delivery is fully aligned to evidence-based standards.

The impact of boarding and non-designated care areas also affects effectiveness, as patients are often cared for outside of their specialty pathways, leading to fragmented clinical oversight, potential duplication of work, and delays in senior clinical decision-making. This reduces the overall effectiveness of care delivery and contributes to extended lengths of stay.

Efficiency continues to be challenged by financial pressures, workforce constraints and operational demand. Workforce limitations, including vacancies, sickness absence and reliance on temporary staffing, impact productivity and increase cost pressures.

Flow inefficiencies across the system, including delayed discharges and limited step-down capacity, contribute to escalation and the need to utilise non-designated care areas. Boarding patients outside of appropriate clinical environments further reduces efficiency, as it creates additional coordination demands, increases staff workload, and disrupts standard care pathways.

Work is underway to address these issues through workforce planning, recruitment and service redesign, including community-based models of care aimed at improving flow and reducing reliance on escalation spaces.

Evidence based

Compliance with national standards and guidance remains variable across the Clinical Care Group. Whilst there are areas of progress, a number of requirements remain outstanding or overdue, impacting overall assurance and contributing to the escalation position.
Delays in implementation of national guidance and Welsh Health Circulars highlight the need for strengthened oversight and accountability. There is a continued focus on improving compliance through governance processes and structured monitoring.

The challenges associated with boarding and non-designated care areas also highlight a deviation from best practice standards, reinforcing the need to address underlying system pressures to ensure care is consistently delivered in appropriate clinical environments.

Equitable

Variation in access to care is evident across the Clinical Care Group, influenced by differences in service capacity, workforce and system pressures. Patient experience and access to timely care can vary depending on location and service demand.

The use of non-designated care areas also introduces inequity, as patients may receive care in environments that do not meet expected standards, with impacts on both safety and experience. This variation highlights the need for continued focus on equitable access and consistency of care delivery across all settings.

The Clinical Care Group is addressing this through analysis of complaints and incident data, enabling targeted improvement in areas where inequity is identified.

Person Centred

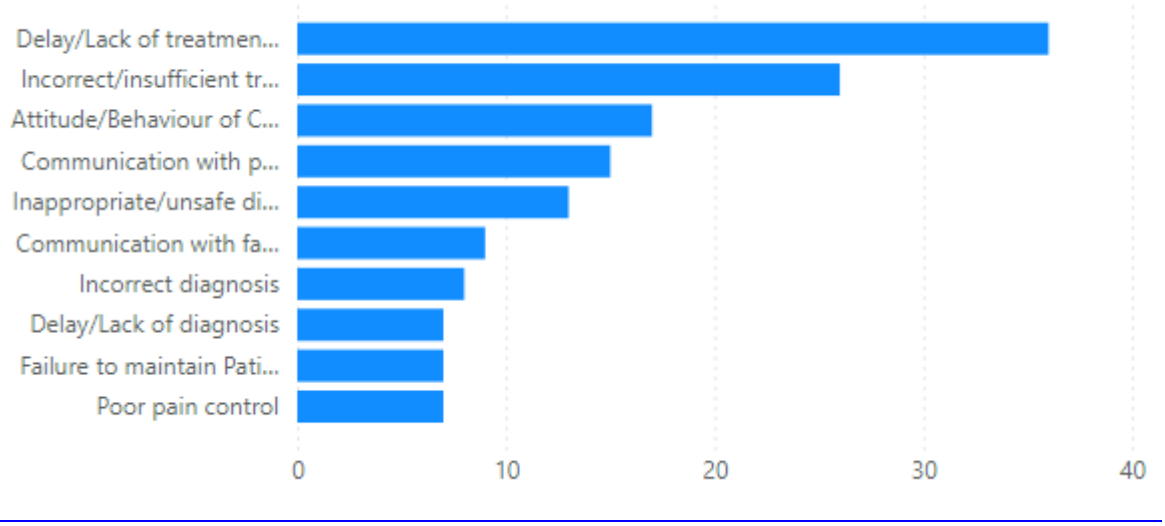
Patient feedback highlights examples of compassionate care and positive staff engagement; however, there are consistent themes in complaints relating to communication, delays and unmet expectations.

The use of boarding and care in non-designated areas has a notable impact on person-centred care. Patients cared for in these settings may experience reduced privacy, dignity and comfort, particularly where care is delivered in open or corridor environments. Communication with patients and families can be more difficult, and there are increased challenges in meeting the needs of vulnerable groups, including those requiring end-of-life care or additional support.

Complaints and patient experience data:

Complaints data indicates sustained pressure within the system, with increasing volumes and ongoing challenges in meeting response times. The graph below details the themes and number of complaints between 1 January and 28 April 2026.

Total Complaints by Theme



Thematic analysis highlights recurring concerns relating to:

- Communication with patients and families
- Delays in care and discharge
- Environment and dignity, particularly in escalation areas

Patient experience feedback aligns with incident themes, particularly in relation to care delivered in non-designated areas.

Actions and impact:

The “Listening to People” framework is being implemented to strengthen the systematic use of feedback in service improvement, with improved triangulation of complaints, incidents and experience data. Early impact includes improved visibility of themes and targeted improvement actions; however, measurable improvement in response timeliness and patient experience metrics is not yet consistently demonstrated.

Quality Assurance Overview

The Clinical Care Group remains at Level 3 governance escalation, with risks actively managed through the Health Board’s escalation policy and supporting governance structures.
Risks relating to patient safety, flow and workforce are formally recorded within the Datix risk register and are reviewed through:

- Monthly Care Group Quality Governance meetings
- System-level Quality and Safety forums
- Operational escalation and command structures

Risk mitigation actions are clearly defined and monitored, with trajectories in place for key areas such as incident backlog reduction and flow improvement. This ensures that risks are not only identified but are actively managed with demonstrable oversight and accountability.

The Clinical Care Group has well-established governance structures that provide a comprehensive framework for oversight of quality, safety and performance. These arrangements are multidisciplinary and operate across all levels of the organisation.

However, there remain challenges in delivering full compliance with governance requirements. Backlogs in incidents, complaints, risks and audit actions continue to impact the ability to demonstrate timely learning and improvement. In addition, system pressures, including workforce fragility and flow constraints, continue to influence delivery.

The sustained use of non-designated care areas presents a significant cross-cutting risk and is indicative of the level of system pressure currently being experienced. Whilst managed within escalation processes, this remains an area requiring ongoing scrutiny and action.

The continued Level 3 escalation position is noted, together with the key risks impacting the Clinical Care Group, including patient safety risks, workforce fragility, audit and compliance challenges, and system flow pressures.

Particular attention is drawn to the risks associated with boarding and care in non-designated areas, and the need for sustained system-wide focus on reducing reliance on escalation spaces through improved flow, capacity management and workforce resilience.

There is assurance that robust governance and escalation processes are in place and are functioning effectively. Key risks are clearly identified, actively managed and subject to ongoing monitoring, with targeted actions being implemented to address system pressures, including incident backlog reduction, flow improvement and the strengthening of patient experience. Whilst there is evidence of improved grip and early positive trajectories in key areas, including incident backlog reduction and ambulance handover performance, the impact of these actions is not yet consistently realised across all domains.

Continued organisational focus and system-wide action remain necessary to deliver sustained improvement and reduce reliance on escalation measures, particularly in relation to boarding and care in non-designated areas.

Argymhelliad / Recommendation

The Quality, Safety and Experience Committee is asked to take assurance on the governance arrangements in place across Community & Integrated Medicine Clinical Care Group, noting the progress made in strengthening oversight and improvement activity.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1 Provide advice to the Board on the adoption of a set of key indicators of quality of care against which the University Health Board's performance will be regularly assessed and reported on.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	1. Safe 2. Timely 3. Effective 6. Person-Centred
Galluogwyr Ansawdd: Enablers of Quality:	1. Leadership 2. Culture and valuing people 3. Data to knowledge

Quality and Engagement Act (sharepoint.com)	5. Whole systems persepctive
Amcanion Strategol y BIP: UHB Strategic Objectives:	1. Putting people at the heart of everything we do 2. Working together to be the best we can be 3. Striving to deliver and develop excellent services 4. The best health and wellbeing for our individuals, families and communities
Amcanion Cynllunio Planning Objectives	3 Transforming Urgent and Emergency Care programme 6 Clinical services plan 7 Primary and community strategic plan
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	2. Develop a skilled and flexible workforce to meet the changing needs of the modern NHS 5. Offer a diverse range of employment opportunities which support people to fulfill their potential 8. Transform our communities through collaboration with people, communities and partners 9. All HDdUHB Well-being Objectives apply

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	The current escalation position and system pressures are contributing to increased cost pressures, including the use of escalation areas, extended length of stay and reliance on temporary staffing, with ongoing actions focused on improving flow and value for money.
Ansawdd / Gofal Claf: Quality / Patient Care:	System pressures and the use of non-designated care areas continue to impact the consistency of patient safety and experience; however, targeted actions are in place to strengthen governance, reduce incident backlogs and improve quality outcomes.

Gweithlu: **Workforce:**	Workforce fragility, including vacancies and operational pressures, continues to impact service delivery and resilience, with ongoing workforce planning and management actions in place to mitigate risk and support safe care delivery.
Risg: **Risk:**	Key risks relating to patient safety, system flow, workforce and compliance are clearly identified, recorded and actively managed through established governance and escalation processes, with defined mitigation actions and ongoing monitoring.
Cyfreithiol: **Legal:**	There are no new legal issues identified; however, ongoing pressures on compliance with national standards and statutory requirements are being actively managed through established governance and oversight arrangements.
Enw Da: **Reputational:**	There is a risk of adverse reputational impact associated with ongoing system pressures, patient experience challenges and escalation measures, which is being mitigated through transparent reporting and focused improvement activity.
Gyfrinachedd: **Privacy:**	N/A
Cydraddoldeb: **Equality:**	N.A

5

5 - Escalation Report

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

Attachments

Escalation Report - June QSEC.pptx

Targeted intervention escalation update

June 2026

Lead executive: Mrs Sharon Daniel

Report author: Mr Shaun Ayres

Hospital acquired infections

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Improvement in hospital acquired infections is not yet sustained

The tracker shows a material Quarter 4 improvement in 2025/26, but April 2026 returned to the Q3 baseline level and none of the three formal de-escalation tests has been met.

18

April 2026 cases

combined threshold is 13 per month

0 of 3

Maintenance tests met

each measure breached at least once in Feb to Apr 2026

+28

More cases in 2025/26

205 cases compared with 177 in 2024/25

+49

Above target equivalent

2025/26 annual comparator: 205 versus 156

The issue is control, not simply volume.

A quarter can look acceptable in aggregate while the monthly de-escalation rule is still failed. That is the position here: the combined Quarter 4 total was below the aggregate threshold equivalent, but individual monthly breaches remain visible.

The safest reading is targeted and cautious.

The data supports a clear conclusion that improvement has not yet become reliable. It does not, on its own, explain causation, site variation or preventability. Those questions need denominator-based and ward-level analysis.

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Hospital acquired infections

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

The formal de-escalation test has not been met

The criteria require each measure to remain at or below its monthly threshold for three consecutive months. A three-month average alone is therefore insufficient.

Measure	Baseline	Threshold	Apr 2026	Feb to Apr 2026	3-month avg	Breaches	Test result
C. difficile	8	**<=6**	**8**	8 / 1 / 8	5.7	**2 of 3**	**Not met**
S. aureus bacteraemia	3	**<=2**	**5**	3 / 4 / 5	4	**3 of 3**	**Not met**
E. coli bacteraemia	7	**<=5**	**5**	6 / 4 / 5	5	**1 of 3**	**Not met**

Reading the table

C. difficile and E. coli look closer to threshold when averaged over three months, but the rule is stricter than that. Both have a breach in the latest three months. S. aureus is materially above threshold in every month from February to April 2026.

Committee Consideration

The current evidence does not support de-escalation. The correct assurance question is whether the Quarter 4 improvement can be repeated and held.

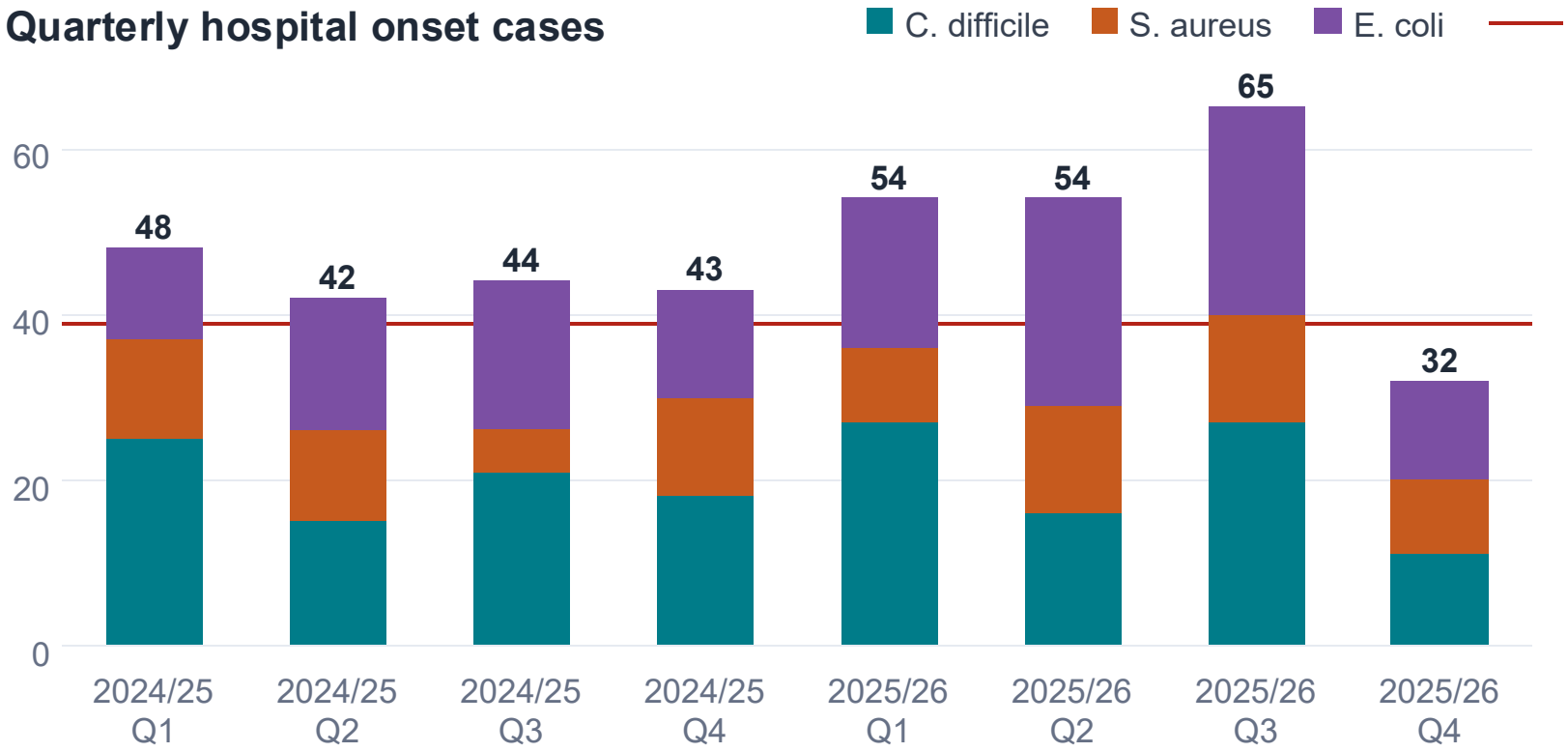
Hospital acquired infections

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Quarter 4 improved sharply, but April 2026 is an early warning

The combined count fell to 32 in Quarter 4 2025/26, below the aggregate threshold equivalent. April then returned to 18 cases, which is five above the monthly threshold equivalent and equal to the tracker baseline.

Quarterly hospital onset cases



The improvement was real.
Quarter 4 fell by 33 cases from Quarter 3 2025/26. This is the strongest quarterly position in the period shown.

It was not yet reliable.
The formal test is monthly and organism-specific. February breached for C. difficile and E. coli, and S. aureus breached throughout February to April.

April matters.
April 2026 was back to 18 cases, the same as the Q3 2023/24 baseline.

Hospital acquired infections

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

The monthly pattern is volatile rather than steadily improving

The latest 13 months show alternating improvement and deterioration. The April 2026 position is particularly important because it follows a better January to March period.

Monthly compliance view, April 2025 to April 2026

Measure	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26
C. difficile threshold <=6	8	8	11	7	4	5	11	8	8	2	8	1	8
S. aureus bacteraemia threshold <=2	3	3	3	4	5	4	3	4	6	2	3	4	5
E. coli bacteraemia threshold <=5	6	5	7	10	6	9	10	7	8	2	6	4	5
Combined total threshold <=13	17	16	21	21	15	18	24	19	22	6	17	9	18

At or below threshold

Above threshold

C. difficile

April returned to 8 cases after a low March position. Two of the latest three months were above threshold.

S. aureus

The most consistent concern. All latest three months were above threshold and April reached 5 cases.

E. coli

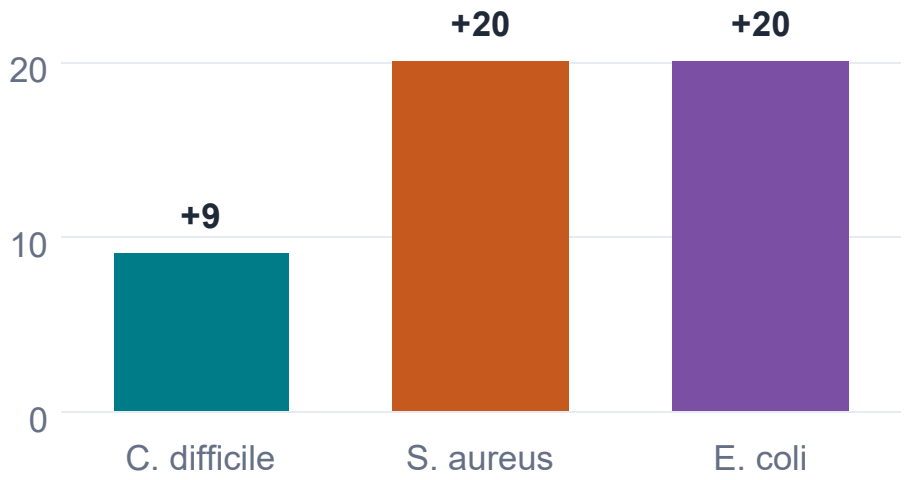
April was at threshold, but February was above threshold. The maintenance test is therefore not met.

Hospital acquired infections

2025/26 moved in the wrong direction, with E. coli the main driver

The full-year comparison avoids over-reading a single month. On that basis, total cases increased by 28 in 2025/26, with E. coli accounting for most of the year-on-year deterioration.

Excess cases above annual target equivalent, 2025/26



Annual target equivalent is the monthly threshold multiplied by 12. It is used here only as a comparator.

Measure	2024/25	2025/26	Change	Target eq.	Above target
C. difficile	79	81	+2	72	+9
S. aureus bacteraemia	40	44	+4	24	+20
E. coli bacteraemia	58	80	+22	60	+20
Combined	**177**	**205**	**+28**	**156**	**+49**

E. coli increased by 22 cases year on year. S. aureus remained persistently above its lower threshold. C. difficile was broadly flat, but still above the target equivalent.

Hospital acquired infections

The assurance response should now focus on reliability and explanation

The data is sufficient to show that the position is not yet controlled. It is not sufficient to explain the drivers. The next step is therefore a tighter evidence pack, not a broader set of assumptions based on the current IPC plans for 26/27.

What the tracker shows

The de-escalation thresholds are not being sustained. April 2026 was above the combined monthly threshold and two of the three organism measures were above threshold.

What it does not show

The TI tracker does not include occupied bed days, admissions, ward or site attribution, case-mix, source reviews or preventability assessment. It should not be read as a rate of avoidable harm.

What should happen next

Validate April, explain the February to April breaches, and add site and denominator analysis so improvement can be assessed as a rate and not only as a count.

Recommendation for the Committee

The Committee should recognise the Quarter 4 improvement but not treat it as sufficient assurance. A focused improvement response is required, with particular attention to persistent S. aureus breaches, the year-on-year increase in E. coli and the volatility in C. difficile. The next report should show whether the April rebound is an isolated month or the start of renewed deterioration?

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Criteria 10, 11, 13, 14: Fragile services

Fragile services arrangements are improving, but are not yet fully embedded

The Health Board has established the core framework, governance route and early oversight mechanisms, but the approach is not yet consistently applied across all services, and a consolidated Board-level view is still developing

What the current position shows

A **Fragile Services Framework** is in place, supported by **heat-map assessments**, early pilots in diabetes and ultrasound, a **Fragile Services Oversight Group**, and **Executive Improving Together Sessions** to strengthen monitoring and governance.

What remains incomplete

Not all services are completing fragility assessments to the same standard, project-management and transformation capacity remain variable, and **clinical leads are not yet formally identified for all fragile services**. A **consolidated Board-level view of fragile service scores and trajectories** is still in development and is not yet routinely reported to QSEC.

What should happen next

Embed a consistent triangulation method across all services, establish a **single central fragile services register**, confirm named clinical and operational leads for each fragile service, and implement routine QSEC / Board reporting on fragility scores, improvement trajectories and outstanding external recommendations. This aligns with the gaps identified in the existing fragile services slide.

Recommendation for the Committee

The Committee should recognise that the foundations of a more robust fragile services approach are now in place, including the framework, oversight arrangements and early improvement activity. However, the evidence also shows that the approach is not yet fully embedded across all services, and further work is required to standardise assessments, strengthen leadership and support, and provide a consolidated Board-level view. Status remains **Advise**

Cross cutting risks and next steps

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

The current position shows that improvement is emerging but not yet reliable across infection control and fragile services, with risks relating to consistency, leadership, and system grip.

What the current risks show

- Infection performance remains variable and not sustained, with S. aureus consistently above threshold and E. coli showing fragile improvement
- Training compliance below standard (IPC and ANTT), limiting impact of improvement actions
- Complaint timeliness below target, reducing organisational learning and responsiveness
- Fragile services approach not yet consistently embedded, with variation in assessment and oversight

What this means

- Improvement is real but not yet reliable, with risk of regression (as seen in April)
- System grip is not yet consistent, particularly in fragile services and workforce/leadership alignment
- Board visibility is improving but incomplete, with no single consolidated view of risk and trajectory

What should happen next

- Strengthen infection prevention reliability, focusing on S. aureus and E. coli driver
- Deliver and sustain training compliance (ANTT ≥95%, IPC ≥90%)
- Implement a single fragile services register with clear scores, risks and trajectories
- Confirm clinical and operational leadership for all fragile services
- Embed routine QSEC and Board reporting on fragile services and improvement delivery

Recommendation for the Committee

The Committee should recognise that improvement is emerging across both infection control and fragile services, but performance remains variable and not yet fully embedded. A continued focus on reliability, leadership, and consolidated oversight is required to ensure that recent improvements can be sustained and translated into demonstrable system control.

Recommendation

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

The Committee is asked to:

Note

- the current position that infection performance has shown periods of improvement but not sustained compliance
- fragile services arrangements are established but not yet fully embedded
- that further work is required to:
  - embed a consistent fragile services approach
  - provide a consolidated Board-level view of risk and trajectory

Discuss and scrutinise

- the ongoing variability in:
  - hospital acquired infections (criteria 22–24)
  - fragile services (criteria 10–14) recognising that system reliability and consistency have not yet been achieved

Support / consider

- strengthening infection prevention reliability
- improving training compliance

6

6 - For Approval

6.1

6.1 - Extension of ‘Service User Access Policy – Psychological Therapies.’ Policy number: 1133

Andrew Homfray (Hywel Dda UHB - Interim Service Delivery Manager), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)

Attachments

Quality, Safety Experience Committee SBAR extension 1133 Access Policy.pdf

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	11 June 2026
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Extension of 'Service User Access Policy – Psychological Therapies.' Policy number: 1133
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Andrew Curruthers, Chief Operating Officer
SWYDDOG ADRODD: **REPORTING OFFICER:**	Andrew Homfray, Interim Service Delivery Manager

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Quality, Safety and Experience Committee is asked to approve the extension of the Patient Access Policy. This report provides the required assurance that Policy 190 – Written Control Documentation (WCD) has been adhered to in the development and review of the above mentioned written control document and that therefore the document is in line with legislation/regulations, available evidence base and can be implemented within the Health Board.

Policy 1133 'Service User Access Policy – Psychological Therapies', is overdue a review, however in the past 12 months the NHS Performance and Improvement Team have advocated an All-Wales document which has been agreed across Wales but has yet to be given the final agreement through their governance processes.

Due to the expectation of the All-Wales document, it is proposed that our current local policy is extended for 6 months in readiness for the introduction of the All Wales 'Guidance for Managing planned Mental Health Waiting Times'.

Cefndir / Background

The Integrated Psychological Therapies Service (IPTS) is committed to providing high quality and timely care, supporting the vision to reduce waiting list times in line with Welsh Government (WG) targets.

The Policy standardises arrangements for each service user taking into consideration their individual circumstances ensuring that all patients requiring access to Psychological Therapies in Hywel Dda University Health Board (HDdUHB) are managed equitably and consistently, in line with national waiting time standards. This includes the management of patient referrals, waiting lists, appointments, and therapeutic interventions. This policy details Welsh Government (WG) targets that the Service aspires to deliver for psychological interventions. All waiting lists are weighted fairly to ensure consistent provision dependent upon wait and need.

Asesiad / Assessment

The policy continues to be utilised and meets the needs of the service and its delivery of psychological therapies across the Health Board. The author has attended the WCD Group to discuss the challenge and proposal and the Group has supported the extension of 6 months to allow the new All-Wales document to be accepted and implemented.

Argymhelliad / Recommendation

The Committee is requested to approve extension of Policy 1133 by a further 6 months to allow the All-Wales document to be taken through the relevant governance and implemented across Wales. If, however the All-Wales policy isn't implemented within that time frame, the current policy will be reviewed updated and processed through the WCD Group.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	9.1 Although the Board has delegated authority to the Committee for the exercise of certain functions, as set out in these Terms of Reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens, through the effective governance of the organisation.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	1. Safe 2. Timely 5. Equitable 6. Person-Centred
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	3. Data to knowledge 5. Whole systems persepctive
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	4. Improve Population Health through prevention and early intervention, supporting people to live happy and healthy lives

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Legislation and National Policy
Rhestr Termau: Glossary of Terms:	Contained within the document
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	Written Control Document Group

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

7

7 - For Information

7.1

7.1 - QSEC Work Plan 2026-27

Attachments

Draft QSEC Work Programme 2026 27.pdf

QUALITY SAFETY & EXPERIENCE COMMITTEE WORK SCHEDULE APRIL 2026– MARCH 2027

Currently, Quality Safety & Experience Committee (QSEC) meets bi-monthly. Based on this, the following table represents a proposal to incorporate the duties as outlined in the Committee's Terms of Reference into a basic work programme April 2026 – March 2027.

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2026	11 June 2026	11 August 2026	9 October 2026	3 December 2026	9 February 2027
Governance								
Welcome and Apologies	**Chair**	**All**	✓	✓	✓	✓	✓	✓
Declarations of Interests	**Chair**	**CSO**	✓	✓	✓	✓	✓	✓
Minutes from Previous Meeting and Matters Arising not on Agenda	**Chair**	**CSO**	✓	✓	✓	✓	✓	✓
Table of Actions (ToA)	**Chair**	**CSO**	✓	✓	✓	✓	✓	✓
Review of Terms of Reference (TORs)	**Chair**	**CSO**						✓
Annual Review of Sub Committees TORs	**Chair**	**CSO**						✓
Assurance and Risk Report • Corporate Risks • Operational Risks • Internal and External Audit Reports • Monitoring of Ministerial Directions • Monitoring of Welsh Health Circulars (WHCs)	**Executive Leads**	**RW**	✓	✓	✓	✓	✓	✓

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2026	11 June 2026	11 August 2026	9 October 2026	3 December 2026	9 February 2027
Self-Assessment - Six month review of actions August 2026	**Chair**	**JW**			✓ update on actions			✓outcome report
Patient/Staff Story	**SD**	**LOC/ Service Leads**	✓	✓	✓	✓	✓	✓
Policies for Approval (as required)	**All**	**All**		✓	✓	✓	✓	✓
Targeted Intervention Progress Report	**SA**	**Executive Leads**	✓	TBC				
Assurance								
Annual Report on Committee's Activity	**AL/SD**	**All**	✓					
Annual Report from Sub-Committees	**SD**	**LOC**		✓				
A report on the impact of revised governance arrangements	**SD/ AC/ JS/ MH**		✓					
Clinical Audit Programme for Approval	**MH**	**IB**		✓				

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2026	11 June 2026	11 August 2026	9 October 2026	3 December 2026	9 February 2027
Duty of Quality Assurance Report incorporating: • External Inspection and peer reviews *(TI34 & 52)* • Nurse Staffing Act Assurance (every 6 months) • Walkrounds (a thematic review on 6 month basis) • Quality Improvement outcomes *(TI 53)* • Quality Impact Assessments *(TI 32, 33)* • Putting things right *(TI 51)* • HCAI *(TI 50)* • Duty of Candour *(TI 54)* • Learning from significant events • Speaking Up reports on quality themes (every 6 months) • WHC's overview *(every other meeting) (TI 52)*	**SD**	**CS**	✓	✓	✓	✓	✓	✓
Safeguarding Assurance Report	**SD**	**CW**			✓			✓
Infection Prevention Control Report	**SD**	**RR**	✓			✓		
Duty of Candour Annual Report 2025/26	**SD**	**CS**		✓				

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2026	11 June 2026	11 August 2026	9 October 2026	3 December 2026	9 February 2027
Duty of Quality Annual Report 2025/26	**SD**	**CS**			✓			
Nurse Staffing Levels (Wales) Act: Assurance Reports (as required) –Annual Report and Spring Calculation Cycle	**SD**	**HH**		✓				
Cleanliness Standards Audit report and Action Plan	**JS**	**SC/ EB**			✓			
A review of the implementation of the community Mental Health referral pathway	**AC**	**AD**		TBC				
Fuller Inquiry assurance of progress of recommendations	**JS**	**CB**	✓					
First Contact Physiotherapist Report	**JS**	**JB**	✓				Learning from investigation to be shared via LLSC report	
Sleep Apnea- Action from Board on patients who have not been followed up correctly	**JS**				✓			
Epilepsy in Learning Disabilities Update	**AC**	**DS**			✓			
Ceredigion Community Mental Health Referral Pathway	**AC**	**LC**			✓			
Quality Assurance Report for Commissioned Services	**LD**	**AS**		✓				
Listening to People Initiative	**SD**	**LOC**		✓				
Deep Dives								
Ophthalmology	**AC**					✓		

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2026	11 June 2026	11 August 2026	9 October 2026	3 December 2026	9 February 2027
Urology	**AC**					✓		
Clinical Care Group Updates								
Mental Health and Learning Disabilities	**AC**	**RTP**		✓		✓		✓
Community and Integrated Medicine	**AC**	**ACh**		✓	✓		✓	
Allied Health Services	**AC**	**SQ**			✓			✓
Planned and Specialist Care	**AC**	**PG**	✓			✓		
Estates and Facilities	**JS**	**EB/ SC**			✓			✓
Public Health	**AG**	**BL**		✓			✓	
Listening and Learning Sub Committee Update Report	**MH**	**LOC**	✓	✓	✓	✓	✓	✓ TOR for review
POLICIES			**EXPIRY DATE**					
1133 Service User Access Policy - Psychological Therapies	**AC**	**Andrew Homfray**	5-Mar-26 Extended whilst full review is finalised	✓				
429 Management and Distribution of Safety Alerts and Notices Policy	**SD**	**Cathie Steele**	13-Jun-26					
004 Claims Management Policy	**SD**	**Louise O'Connor**	5-Oct-26					
894 Putting Things Right Management	**SD**	**Louise O'Connor**						

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2026	11 June 2026	11 August 2026	9 October 2026	3 December 2026	9 February 2027
and Resolution of Concerns Policy (Incidents, Complaints and Claims)			5-Oct-26					
63 Use of Patient and Carers Stories Guideline	**SD**	**Louise O'Connor**	13-Feb-27					
307 Production of Patient and Carer Information Policy	**SD**	**Louise O'Connor**	21-Mar-27					
892 Incidents Near Miss and Hazard Reporting procedure	**SD**	**Cathie Steele**	31-Jul-27					
18 Inquest guidance	**SD**	**Louise O'Connor**	15-Aug-27					
309 - Continuing NHS Healthcare Operational Policy to Support Framework for Implementation	**AC**	**Tracy Devantier**	15-Aug-27					
568 Production and Use of Surveys Guideline	**SD**	**Louise O'Connor**	4-Dec-28					
1097 Corporate Safeguarding Policy	**SD**	**Charlotte Westacott**	11-Aug-26					
Listening and Learning Sub Committee Update Report	✓	✓	✓	✓	✓	✓	✓	✓ TOR for review
For Information								
HIW Annual Report	**N/A**	**N/A**					✓	
JCC Quality Safety Outcomes Sub Committee	**N/A**	**N/A**	✓	✓	✓	✓	✓	✓
Work plan 2026/27	**N/A**	**N/A**	✓	✓	✓	✓	✓	✓
Patient Experience Report	**N/A**	**N/A**	✓	✓	✓	✓	✓	✓
Agenda setting meeting with Chair and Exec Lead to include discussion	**CSO**	**CSO**	✓	✓	✓	✓	✓	✓

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2026	11 June 2026	11 August 2026	9 October 2026	3 December 2026	9 February 2027
on deep dives on new risks (at least 6 weeks before the meeting)								
Draft agenda to go to Executive Team prior to being issued.	**CSO**	**CSO**	✓	✓	✓	✓	✓	✓
Call for papers (at least 4 weeks before the meeting to receive papers at least 14 days before the meeting)	**CSO**	**CSO**	✓	✓	✓	✓	✓	✓
Disseminate agenda and papers 7 days prior to the meeting	**CSO**	**CSO**	✓	✓	✓	✓	✓	✓
Type up minutes and TOA within 7 days of the meeting	**CSO**	**CSO**	✓	✓	✓	✓	✓	✓
Circulate minutes and TOA to Committee for comments, points of accuracy and matters arising within 10 days of the meeting	**CSO**	**CSO**	✓	✓	✓	✓	✓	✓
Check and send final version of minutes to the Committee Chair following comments received.	**CSO**	**CSO**	✓	✓	✓	✓	✓	✓
Chase updates on TOA before the next meeting and RAG rate	**CSO**	**CSO**	✓	✓	✓	✓	✓	✓
Record and track the TOA as part of the decision tracker	**CSO**	**CSO**	✓	✓	✓	✓	✓	✓
Produce written update report for Board	**CSO**	**CSO**	✓	✓	✓	✓	✓	✓
Prepare schedule of meetings	**CSO**	**CSO**					✓	
QSEC Annual Work Programme	**CSO**	**CSO**	✓	✓	✓	✓	✓	✓

Initials

SD- Sharon Daniel	CSO-Katie Lewis	MP- Marilize Preez	LOC- Louise O'Connor	MH- Mark Henwood

AC- Andrew Carruthers	BL- Bethan Lewis	CS- Cathie Steele	AG- Ardiana Gjini	JS- James Severs
HH- Helen Humphreys	SA- Shaun Ayres	MD- Mandy Davies	RW- Rachel Williams	IB- Ian Bebb
RTP- Rebecca Temple Purcell	ACh- Anna Chiffi	SC- Simon Chiffi	AS- Ann Simpson	LD- Lee Davies
EB- Elin Brocke				

8

8 - Date of Next Meeting : 11 August 2026

9

9 - In Committee Session

In accordance with the Committee's Terms of Reference, which permit the Committee to operate an in-committee function for the consideration of sensitive and/or confidential information, the next part of the meeting will be held in private session. Attendance will be restricted to Committee Members and those individuals (or their nominated deputies) identified in the Terms of Reference.

This session will consider the following items:

1. *Withybush Hospital Emergency Department*

A summary of matters considered will be reported to the next appropriate Committee meeting.