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

Assurance and Risk Report

Quality, Safety & Experience Committee – 12 February 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 risks 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 April 2026.

Principal Risks:
4
Under Review

Operational Risks
467

Audit and Inspection Reports
31

Risk Management - Overview

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

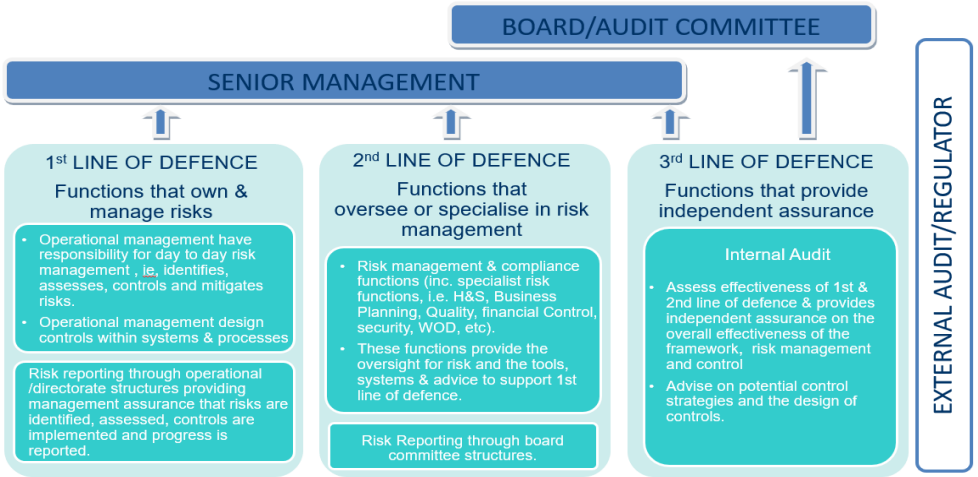
The Health Board's risk management process is recorded via the Datix Risk Register module, and enables risks to be recorded at either Principal, Corporate or Operational level. An escalation process is in place to ensure that risks which require escalation or de-escalation are done via appropriate approval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

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

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

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

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



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.

Refreshed principal risks will be discussed at Board seminar in June 2026 ahead of presentation 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

Of the 467 operational risks aligned to QSEC, 412 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 Goverance Group (CCG IGG) is provided with an Assurance and Risk Report, with any issues escalated to the Integrated Quality, Finance and Performance Delivery Group 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.

Operational Risks assigned to QSEC

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

Measures to assess against the Governance Domain (risks)

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). 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. Evidence where known risks are not articulated on the function's risk register. **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 original action dates, limited evidence of reduction in current risk score).* **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

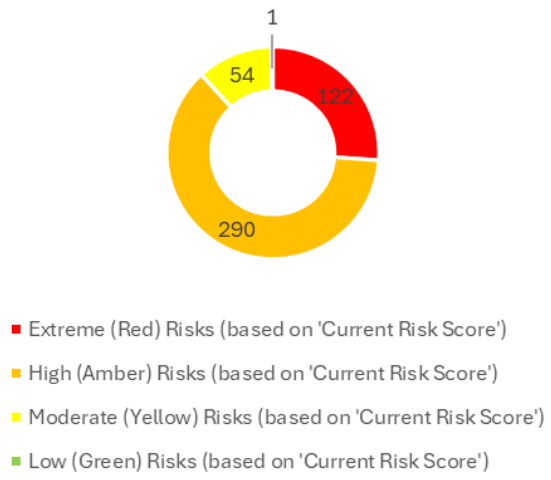
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Of the 467 operational risks aligned to QSEC (an increase from the 389 previously reported to the Committee in October 2025), a summary of the 39 operational risks with a current risk score of >20 is provided over the next slides.

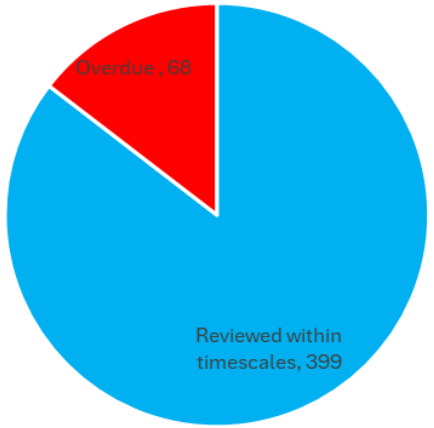
Details related to target risk scores (TRS) became mandatory fields on Datix as of 1 July 2025, and therefore for the 10 risks which do not currently have this detail (noted as 'Unable to Assign TRS date'), risk leads will be asked to provide this detail by the next report to QSEC.

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?).

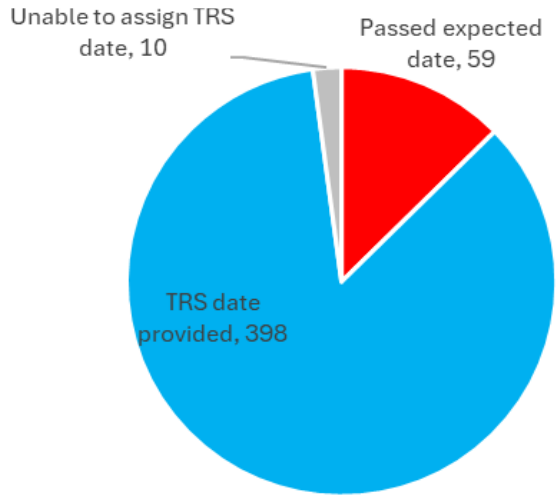
Current Level of Risks Aligned to QSEC



Operational Risks Aligned to QSEC



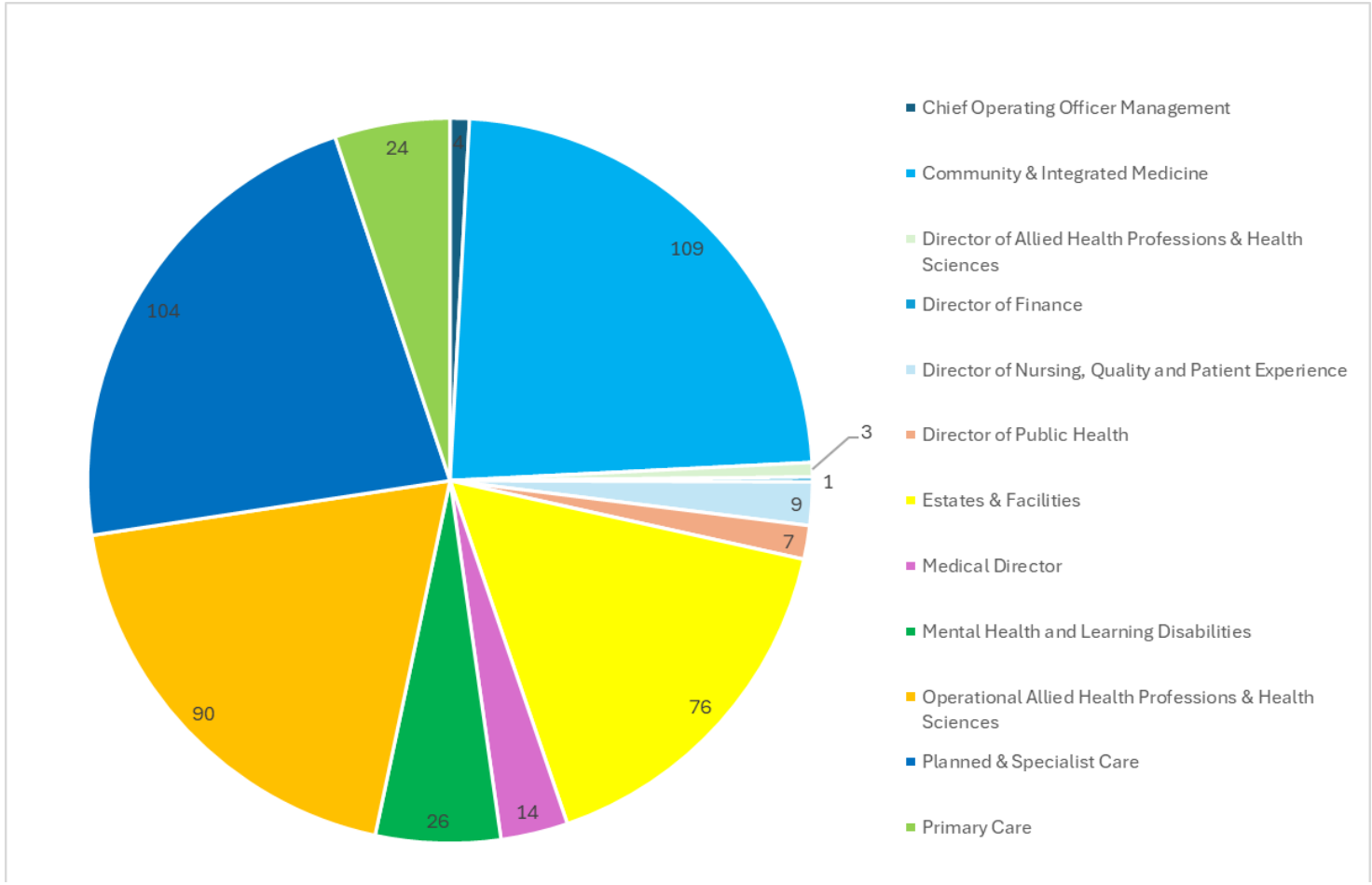
Target Risk Score Status



Operational Risks assigned to QSEC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risks Split Out By Clinical Care Group/Executive Function



Extreme Level Operational Risks
(Page 1 of 5)

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

Risk Reference & 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
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	25	10	30/04/2027	29/12/2025
2228 - Risk of patient safety affected due to discontinuation of the electronic prescribing system Vision for Outpatient Department (OPD) clinics and services	Medicines Management	Medical Director	25	4	01/05/2026	27/11/2025
1349 - Risk of being unable to deliver ultrasound services at Withybush General Hospital (WGH) due to a lack of appropriately trained obstetric staff	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	25	4	31/03/2028	17/12/2025
1256 - Risk to safety and management of hip fracture patients due to lack of Orthogeriatric service at Glangwili General Hospital (GGH)	Planned & Specialist Care	Chief Operating Officer	25	4	30/06/2026	05/01/2026
2264 - Inconsistent delivery of urgent and emergency care	Community & Integrated Medicine	Chief Operating Officer	20	5	31/12/2026	07/01/2026
2141 - Risk of harm to patients, staff and public due to insufficient physical security measures in place at Bronglais General Hospital (BGH)	Community & Integrated Medicine	Chief Operating Officer	20	5	03/08/2025	17/12/2025
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	31/08/2025	15/12/2026
2113- Risk of patient harm in Emergency department WGH due to demand exceeding capacity	Community & Integrated Medicine	Chief Operating Officer	20	12	30/04/2026	15/12/2025
2102- The risk of radiology service delivery due to leadership fragility	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	10	01/12/2026	17/12/2025

Extreme Level Operational Risks
(Page 2 of 5)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & 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
1547 - There is a risk to timely and safe radiology provision as capacity does not match demand	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	8	30/03/2029	17/12/2025
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	29/12/2025
1115 - Risk of increased time in Accident and Emergency due to lack of inpatient beds, GGH.	Community & Integrated Medicine	Chief Operating Officer	20	12	31/10/2025	12/02/2026
750 - Risk of delays at Emergency Department due to lack of substantive middle grade doctors	Community & Integrated Medicine	Chief Operating Officer	20	12	15/01/2026	15/12/2025
2265 - Risk of failure of ceiling mounted operating ophthalmic microscope	Planned & Specialist Care	Chief Operating Officer	20	2	31/03/2026	08/01/2026
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	22/12/2025
2219 - Backlog in triaging dermatology referrals	Planned & Specialist Care	Chief Operating Officer	20	2	31/03/2027	30/12/2025
2170 - Risk of harm to patients due to insufficient capacity to meet demand for occupational therapy in acute hospitals	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	8	30/09/2027	29/12/2025
2156 - Risk of patient harm within the bone health service due to lack of clinical capacity across HDdUHB	Community & Integrated Medicine	Chief Operating Officer	20	4	31/03/2026	15/12/2025

Extreme Level Operational Risks
(Page 3 of 5)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & 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
2151- Risk of poorer outcomes due to delayed prescribing for those with complex co-morbid Obesity	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	9	31/08/2026	29/12/2025
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	31/12/2026	02/01/2026
2118 - Risk of harm to physiotherapy patients due to inadequate medical service capacity at GGH	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	12	31/03/2026	29/12/2025
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	31/12/2025	30/12/2025
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	29/12/2025
2028 - Harm to patients/staff due to extreme theatre workforce shortages at GGH affecting ability to provide safe/essential care	Planned & Specialist Care	Chief Operating Officer	20	6	30/06/2026	24/12/2025
1996 - Risk of reduced workforce recruitments and developments due to lack of funding	Planned & Specialist Care	Chief Operating Officer	20	8	31/07/2026	24/12/2025
1968- Risk of closure of wards and departments due to failure of roof structure of PPH	Estates & Facilities	Chief Operating Officer	20	5	31/03/2030	18/12/2025

Extreme Level Operational Risks
(Page 4 of 5)

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

Risk Reference & 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
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	31/03/2026	02/01/2026
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	31/03/2026	05/01/2026
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	31/03/2026	29/12/2025
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	29/12/2025
1706 - Risk of loss of Nuclear Medicine Service due to decline in condition of equipment and failure to comply with Natural Resources Wales compliance.	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	2	30/07/2027	17/12/2025
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	29/12/2025
1517 - Risk of poor outcome 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	29/12/2025
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	24/12/2025
1308 - Risk of Urgent Treatment Delays for Stone Patients in Urology due to backlog outweighing capacity	Planned & Specialist Care	Chief Operating Officer	20	6	31/03/2026	22/11/2025

Extreme Level Operational Risks
(Page 5 of 5)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & 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
1290 - Risk of increased Adult Attention Deficit Hyperactivity Disorder (ADHD) waiting list due to referrals exceeding service capacity.	Mental Health and Learning Disabilities	Chief Operating Officer	20	16	26/04/2030	09/12/2025
1287 - Risk of clients not being provided with timely interventions due to waiting lists for assessment & diagnosis of Autism Spectrum Disorder (ASD).	Mental Health and Learning Disabilities	Chief Operating Officer	20	16	30/04/2026	09/12/2025
834 - Risk of clinical deterioration due to reduced service resilience within the Clinical Haematology sub-specialty	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	8	30/09/2026	29/12/2025
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	31/10/2025	14/01/2026

Risk Themes (1 of 2)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk owners can assign 'themes' to risks on Datix, allowing risk information to be shared on specific areas with relevant subject matter experts within the Health Board. They in turn can offer specific support and guidance to risk owners in the management of risk and identify trends and areas of concern. Each risk theme is aligned to a specific and relevant committee or sub-committee to provide assurance that processes are in place to deliver a holistic approach to risk management. 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 following themes are currently aligned to QSEC as of January 2026:

Risk Theme	Definition	Number of risks
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.	110
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
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
Fragile Services	A fragile service is one where there is a risk of a diminished service being delivered, or a service being unable to be delivered	178
Infection Control	An incident 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	27

Risk Themes (2 of 2)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Theme	Definition	Number of risks
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.	30
Medication	A risk that involves the prescribing, dispensing or supply, administration or monitoring of medicines.	20
NICE / National Guidance	Risks related to the Health Board's ability to comply with evidence-based guidance for health and care.	43
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.	22

The Assurance and Risk Team are working with the Interim Assistant Director of Nursing, Assurance and Safeguarding to review existing risk themes to re-align 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.

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 (NEW)	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 (NEW)	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 (NEW)	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 5)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

There are currently 31 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).

For those recommendations that are overdue by more than 6 months, meetings have been scheduled during Q4 of 2025/26 with relevant Executive Leads and CCG/Function leads to review and to identify whether the recommendations have been fully implemented or if additional support or escalation is required to further progress.

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	Director of Nursing, Quality and Patient Experience	May-25	~~May-25~~ ~~Dec-25~~ N/K	6	2	0	4	0	0	0	0	No barriers noted
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	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	Mar-26	9	1	0	4	3	1	0	0	No barriers noted
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

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

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Date of report	Report Issued By	Report Title	Clinical Care Group/ Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommend-ations in original report	Overdue	In progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Barriers to Completion
Feb-24	HIW	Children and Young People Mental Health Review	Mental Health and Learning Disabilities	Chief Operating Officer	Feb-26	Feb-26	9	2	2	4	0	0	0	1	Insufficient staffing resource to facilitate this forum at present.
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	9	1	1	7	0	0	0	0	No barriers noted
May-23	HIW	Mental Health Discharge Review	Mental Health and Learning Disabilities	Director of Nursing, Quality and Patient Experience	Mar-24	~~Apr-24~~ ~~Dec-24~~ ~~Mar-25~~ ~~Oct-25~~ Mar-26	40	2	0	35	0	3	0	0	Awaiting publication of national standards
Sep-23	NHS Wales Executive	Children and Young Person's Neurodevelopmental Services All Wales Review	Planned and Specialist Care	Chief Operating Officer	Nov-24	~~Nov-24~~ ~~Oct-25~~ Mar-26	9	1	0	8	0	0	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
Apr-23	Peer Review	Out of Hours Peer Review, issued April 2023	Primary Care, Community Strategy & Long Term Care	Chief Operating Officer	Dec-23	~~Mar-24~~ ~~Mar-25~~ ~~Dec-25~~ Jun-26	17	3	0	0	13	0	0	1	Lack of Urgent Primary Care Centre in HB.
Jun-23	Peer Review	Follow Up: Congenital Heart Defect Provider, Assessment Return, issued June 2023	Planned and Specialist Care	Chief Operating Officer	Nov-22	~~Nov-24~~ N/K	10	0	0	9	1	**0**	0	**0**	No barriers noted

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

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Date of report	Report Issued By	Report Title	Clinical Care Group/ Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommend-ations in original report	Overdue	In progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Barriers to Completion
Oct-23	HIW	St Non, St Caradog, Canolfan Bro Cerwyn WGH	Mental Health and Learning Disabilities	Director of Nursing, Quality and Patient Experience	Oct-24	~~Oct-24~~ ~~Oct-25~~ Jan-26	19	1	0	18	0	0	0	0	Fragility of current medical workforce capacity.
Jun-24	Welsh Risk Pool	Welsh Risk Pool Concerns Assessment (December 2024)	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	Mar-25	~~Mar-25~~ ~~Jul-25~~ Mar-27	11	1	0	8	2	0	0	0	Organisational pressures and re-organisations, in addition to pending restructure of investigation framework and learning arrangements have impacted the delivery of this recommendation.
Oct-24	HIW IRMER	IRMER Regulations	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	Jul-25	~~Jul-25~~ Jan-26	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	Director of Allied Health Professions and Health Sciences	Oct-25	~~Oct-25~~ N/K	6	1	0	5	0	0	0	0	No barriers noted

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

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

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Jan-25	Internal Audit	Reinforced Autoclaved Aerated Concrete – Withybush General Hospital Final Internal Audit Report 2024/25	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Mar-26	Mar-26	6	0	1	5	0	0	0	0	No barriers noted
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	Director of Nursing, Quality and Patient Experience	Sep-25	~~Sep-25~~ ~~Dec-25~~ N/K	3	2	0	1	0	0	0	0	No barriers noted
Mar-25	HIW	Joint Inspection of Child Protection Arrangements (Pembrokeshire)	Director of Nursing, Quality and Patient Experience	Chief Operating Officer	Mar-26	Mar-26	21	5	4	10	2	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	14	10	1	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	6	1	15	2	0	0	0	No barriers noted
Sep-25	HIW	Derwen Ward, Glangwili General Hospital	Community & Integrated Medicine	Chief Operating Officer	Nov-25	~~Nov-25~~ N/K	9	6	0	3	0	0	0	0	No barriers noted

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

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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Oct-25	Internal Audit	Human Tissue Authority Final Internal Audit Report 2025/26	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	Dec-25	Dec-25	6	0	0	0	6	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	Mar-26	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	Mar-26	2	0	2	0	0	0	0	0	No barriers noted
Oct-25	HIW	HIW Inspection BGH Emergency Department October 2025	Community & Integrated Medicine	Chief Operating Officer	Mar-27	Mar-27	29	13	3	12	1	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
Nov-25	HIW IRMER	Significant Accidental or Unintended Exposures Notifications (IRMER Dec 2025)	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	Feb-26	Feb-26	4	0	4	0	0	0	0	0	No barriers noted
Dec-25	Internal Audit	Patient Experience Final Internal Audit Report 2025/26	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	Jun-26	Jun-26	5	0	5	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	0	15	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 identified controls are in place and working effectively; and
- **RECEIVE ASSURANCE** that all planned actions are credible and deliverable, and in line with agreed plans, and will be implemented within stated timescales and will reduce risks further and/or mitigate the impact should risks materialise.

Audits, Inspections and Regulatory Reports

- **RECEIVE ASSURANCE** from the lead Executive Director or Supporting Officer on the management of recommendations raised in audit, inspection and regulatory reports within their area of responsibility, particularly in respect of confirming the full implementation of recommendations with any barriers to delivery noted.

DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG

SAFE | SUSTAINABLE | ACCESSIBLE | KIND

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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	Comments/Updates
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.	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	
HIW Children and Young People Mental Health Review	Health boards must reflect on the feedback from CAMHS referrers, parents, and carers to enhance transparency regarding the criteria and thresholds for accessing CAMHS assessments and interventions. This process should involve revising the outcome letter templates used to communicate decisions following the Single Point of Access (SPOA) and CAMHS assessments, ensuring that they clearly convey the rationale behind decisions and improve overall understanding and communication.	1.T&F group will review and establish standard letters for SPOA & Secondary S-CAMHS: Initial contact letters & follow up letters to include a clear rationale for clinical decision.	Mental Health & Learning Disabilities	Chief Operating Officer	03/11/2025	03/11/2025	05/11/25 UPDATE - SPoC letters have been signed off and are now in use. - Secondary CAMHS letters have been drafted and are out for feedback with team leads and team secretaries. These will be completed and implemented by the end of November. Previous update: We believe our capacity to provide clarity in relation to criteria and thresholds is hampered by the lack of sufficient clarity nationally in relation to this. Further clarity at a national level would support enhanced transparency by allowing us to provide additional detail and to define terms such as mild, moderate and severe. 25/11/2025: Work underway. Revised completion date of 31st December 2025.
HIW Children and Young People Mental Health Review	Health boards must reflect on the feedback from CAMHS referrers, parents, and carers to enhance transparency regarding the criteria and thresholds for accessing CAMHS assessments and interventions. This process should involve revising the outcome letter templates used to communicate decisions following the Single Point of Access (SPOA) and CAMHS assessments, ensuring that they clearly convey the rationale behind decisions and improve overall understanding and communication.	T&F group will review and establish standard letters for SPOA & Secondary S-CAMHS: Service user information leaflet outlining criteria of NHS S-CAMHS and CAPA model	Mental Health & Learning Disabilities	Chief Operating Officer	03/11/2025	03/11/2025	UPDATE 5/11/2025: A leaflet has been drafted and updated based on initial feedback. It has gone out for further feedback and will be completed and sent out for use by the end of November. Previous update: We believe our capacity to provide clarity in relation to criteria and thresholds is hampered by the lack of sufficient clarity nationally in relation to this. Further clarity at a national level would support enhanced transparency by allowing us to provide additional detail and to define terms such as mild, moderate and severe. 25/11/2025: Work underway. Revised completion date of 31st December 2025.
HIW Children and Young People Mental Health Review	Health boards must reflect on the feedback from CAMHS referrers, parents, and carers to enhance transparency regarding the criteria and thresholds for accessing CAMHS assessments and interventions. This process should involve revising the outcome letter templates used to communicate decisions following the Single Point of Access (SPOA) and CAMHS assessments, ensuring that they clearly convey the rationale behind decisions and improve overall understanding and communication.	Service User Forum will be involved in reviewing and co -production of leaflets	Mental Health & Learning Disabilities	Chief Operating Officer	03/11/2025	03/11/2025	05/11/2025 Leaflet drafted and provided to three team leads to gather feedback from CYP and parents/carers. 25/11/2025: Work underway. Revised completion date of 31st December 2025.
HIW Children and Young People Mental Health Review	Health boards must explore the options available within their local CAMHS teams to facilitate a strengthened approach for communication and partnership working with GP clusters and/ or directly with GP practices.	S-CAMHS will discuss with GP Clusters to discuss an agreed approach to partnership working and improving communication, including the suggestion of a regular (bi-monthly) forum	Mental Health & Learning Disabilities	Chief Operating Officer	04/08/2025	04/08/2025	28/10/2025: Awaiting confirmation of cluster meeting dates from Cath Burrell (Clinical Director, Primary Care Services). Further information re GP leads is being sought to move this forward. Revised completion date 31/12/2025.
HIW Derwen Ward 04054	The health board must ensure that checks of the drug refrigerator in the clinical room are monitored and recorded daily.	•To further sharing and dissemination of learning within wider Health Board forum: 2.Senior Nurse Management Team (SNMT),	Community & Integrated Medicine	Chief Operating Officer	17/11/2025	17/11/2025	

HIW Derwen Ward 04054	The health board must ensure that sufficient domestic staff are available to clean the ward to maintain appropriate infection prevention and control (IPC)	To undertake spot checks of domestic staff compliance with hand hygiene and PPE when in clinical areas. Findings and remedial actions to be reported to the Infection Prevention Strategic Steering Group.	Community & Integrated Medicine	Chief Operating Officer	31/10/2025	31/10/2025	To note: the Facilities Team will be implementing a new model of cleaning provision 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. A Task & Finish (T&F) Group will be established to support the Facilities and Nursing Teams during the implementation phase of the new cleaning and catering model. The group will meet monthly to review progress, identify challenges, and coordinate solutions. Membership will include representatives from both teams, with meeting outcomes documented and shared. The group will remain active until full implementation is achieved. Interviews for a Facilities Manager (Band 8a) to support the Facilities Team during the implementation phase of the new cleaning and catering model will start week commencing 22nd September 2025. The recruitment process to fill the 8.63 WTE vacancies in the domestic team has commenced. The Hotel Services Manager will provide fortnightly updates on recruitment progress, including shortlisting, interview dates, and onboarding timelines. Full staffing levels are expected to be achieved by 30 November 2025, with impact on service delivery reviewed monthly thereafter.
HIW Derwen Ward 04054	The health board must ensure that multi patient use items such as BP cuffs, are appropriately decontaminated between use and that clean equipment is correctly labelled.	To review training attendance and requirements of staff for IPC e-learning module. Training compliance will be monitored via Carmarthenshire System Infection Prevention and Control Locality Meeting.	Community & Integrated Medicine	Chief Operating Officer	29/10/2025	29/10/2025	
HIW Derwen Ward 04054	The health board must ensure that multi patient use items such as BP cuffs, are appropriately decontaminated between use and that clean equipment is correctly labelled.	To undertake spot checks of the results to ensure sustained compliance.	Community & Integrated Medicine	Chief Operating Officer	31/10/2025	31/10/2025	
HIW Derwen Ward 04054	The health board must ensure that patient records are stored securely at all times.	To review the training attendance and requirements of staff for Information Governance e-learning and report the findings to the Carmarthenshire Integrated Performance and Business Management Care Group, with a clear plan for improvement if required.	Community & Integrated Medicine	Chief Operating Officer	31/10/2025	31/10/2025	
HIW Derwen Ward 04054	The health board must ensure that all staff have received training and complete patient risk assessments appropriately and take the relevant action in line with local or national guidance, and document this in patient records. This includes: •Taking appropriate action when NEWS scores are 3 or above •Completing and documenting Sepsis Screening for those at risk of sepsis, such as a NEWS score of 5 or above •Completing and documenting VTE risk assessments on admission and thereafter in line with local and national guidance.	To review the current training compliance of staff for NEWS 2 e-learning module and develop a plan to ensure timely completion of the e-learning module. Training compliance will be monitored via RADAR scrutiny meeting.	Community & Integrated Medicine	Chief Operating Officer	13/11/2025	13/11/2025	
HIW Derwen Ward 04054	The health board must ensure that all staff have received training and complete patient risk assessments appropriately and take the relevant action in line with local or national guidance, and document this in patient records. This includes: •Taking appropriate action when NEWS scores are 3 or above •Completing and documenting Sepsis Screening for those at risk of sepsis, such as a NEWS score of 5 or above •Completing and documenting VTE risk assessments on admission and thereafter in line with local and national guidance.	To review the current training compliance of staff for classroom ILS/BLS and develop a plan to ensure timely completion of the learning. Training compliance will be monitored via RADAR scrutiny meeting.	Community & Integrated Medicine	Chief Operating Officer	13/11/2025	13/11/2025	

HIW Derwen Ward 04054	The health board must ensure that all staff have received training and complete patient risk assessments appropriately and take the relevant action in line with local or national guidance, and document this in patient records. This includes: •Taking appropriate action when NEWS scores are 3 or above •Completing and documenting Sepsis Screening for those at risk of sepsis, such as a NEWS score of 5 or above •Completing and documenting VTE risk assessments on admission and thereafter in line with local and national guidance.	To arrange additional training to support the early recognition of a deteriorating patient.	Community & Integrated Medicine	Chief Operating Officer	15/09/2025	15/09/2025	Completed prior to AMAT upload- The dates for the additional training are 25th, 27th and 29th September 2025) Staff have been reminded of the requirement to document all risk assessments and associated actions in the patient record, as per Monitoring, Recording of Adult Physiological Observations and Response to Physical Deterioration Policy. This includes initial assessments, reassessments, and any interventions taken. This will be reinforced through staff meetings and training. Review training attendance and requirements of staff for NEWS 2 e-learning module. Review training attendance and requirements of staff for classroom ILS/BLS Additional training arranged to support the early recognition of a deteriorating patient. Weekly spot checks will be conducted by the senior ward manager or designated team member to ensure compliance with accurate NEWS scoring and escalation of sepsis as per guidance. Implementation of E-Observations (Electronic NEWS recording) throughout the hospital site. Pharmacy/Nursing to reinforce the need for Medical Colleagues to complete and document the VTE Risk Assessment. VTE Site Improvement plan in place. Preventing Thrombosis and VTE showcase event. Hospital Acquired Thrombosis SharePoint page available with current resources and information. Monthly spot checks of VTE risk assessments on Surgical, Medical and Trauma & Orthopaedic ward areas. Review of VTE risk assessment compliance findings to be discussed within the Carmarthenshire System Quality and Safety Governance meeting
HIW Derwen Ward 04054	The health board must ensure that all staff have received training and complete patient risk assessments appropriately and take the relevant action in line with local or national guidance, and document this in patient records. This includes: •Taking appropriate action when NEWS scores are 3 or above •Completing and documenting Sepsis Screening for those at risk of sepsis, such as a NEWS score of 5 or above •Completing and documenting VTE risk assessments on admission and thereafter in line with local and national guidance.	To reinforce to medical staff the requirement to complete and document the VTE Risk Assessment.	Community & Integrated Medicine	Chief Operating Officer	30/09/2025	30/09/2025	
HIW Derwen Ward 04054	The health board must ensure that all staff have received training and complete patient risk assessments appropriately and take the relevant action in line with local or national guidance, and document this in patient records. This includes: •Taking appropriate action when NEWS scores are 3 or above •Completing and documenting Sepsis Screening for those at risk of sepsis, such as a NEWS score of 5 or above •Completing and documenting VTE risk assessments on admission and thereafter in line with local and national guidance.	To promote the Hospital Acquired Thrombosis SharePoint page which is available with current resources and information.	Community & Integrated Medicine	Chief Operating Officer	30/09/2025	30/09/2025	
HIW Derwen Ward 04054	The health board must ensure that all staff have received training and complete patient risk assessments appropriately and take the relevant action in line with local or national guidance, and document this in patient records. This includes: •Taking appropriate action when NEWS scores are 3 or above •Completing and documenting Sepsis Screening for those at risk of sepsis, such as a NEWS score of 5 or above •Completing and documenting VTE risk assessments on admission and thereafter in line with local and national guidance.	To review the VTE Site Improvement plan currently in place to ensure it covers the findings of HIW.	Community & Integrated Medicine	Chief Operating Officer	15/09/2025	15/09/2025	Completed prior to AMAT upload- Monthly spot checks of VTE (Venous Thromboembolism) risk assessments are carried out on the Surgical, Medical, and Trauma & Orthopaedic ward areas by the Quality Improvement VTE Lead or designated clinical lead. Findings are reported to the governance team and any gaps in compliance will be addressed through targeted staff feedback and re-education. The VTE site improvement plan has been uploaded. Quality improvement work continues to improve VTE risk assessment compliance in accordance with the action plan
HIW Derwen Ward 04054	The health board must ensure that all staff have received training and complete patient risk assessments appropriately and take the relevant action in line with local or national guidance, and document this in patient records. This includes: •Taking appropriate action when NEWS scores are 3 or above •Completing and documenting Sepsis Screening for those at risk of sepsis, such as a NEWS score of 5 or above •Completing and documenting VTE risk assessments on admission and thereafter in line with local and national guidance.	To review of VTE risk assessment compliance findings to be discussed within the Carmarthenshire System Quality and Safety Governance meeting (feeding into our Clinical Care Group)	Community & Integrated Medicine	Chief Operating Officer	30/09/2025	30/09/2025	

HIW Derwen Ward 04054	The health board must ensure that all the findings in this immediate improvement plan are not systemic across all other wards within the hospital and the wider health board.	To share the immediate actions through the Community and Integrated Medicine Professional Nurse Forum.	Community & Integrated Medicine	Chief Operating Officer	31/10/2025	31/10/2025	
HIW Derwen Ward 04054	The health board must ensure that all the findings in this immediate improvement plan are not systemic across all other wards within the hospital and the wider health board.	To support with individual ward review to monitor and ensure compliance with actions. Where compliance is found to not be in place, immediate remedial activity to commence.	Community & Integrated Medicine	Chief Operating Officer	01/10/2025	01/10/2025	
HIW Derwen Ward 04054	The health board must ensure that all the findings in this immediate improvement plan are not systemic across all other wards within the hospital and the wider health board.	To present the Quality Improvement audit results for all wards (inclusive of actions at the Care Group Quality and Safety Group for assurance.	Community & Integrated Medicine	Chief Operating Officer	16/10/2025	16/10/2025	All ward areas audit added as evidence.
HIW Derwen Ward 04054	The health board must ensure that all the findings in this immediate improvement plan are not systemic across all other wards within the hospital and the wider health board.	CB to ensure all actions complete prior to closure	Community & Integrated Medicine	Chief Operating Officer	31/10/2025	31/10/2025	
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	Update 23/11/23 added to risk register Requirement escalated in exception report to OQSEC 09/01/2024 6/9/24- Update: This action cannot be completed at this time as it requires additional investment. I will be escalating this in my next QSEG report. 13/12/24- Update- presented to QSEG- on annual plan to employ quality radiographer. Have considered document from other services. Remains ongoing. On risk register Feb 2025- Update need for document control system and quality lead Radiographer included in Radiology annual plan March 2025 update- HB annual plan approved by the Board on 28/03/2025 which has included the Quality Lead Radiographer and document control system. Steps will be put in place shortly to recruit to the post and procure a document control system. April 2025- Currently wiring the JD for this post which will be advertised May 2025. Recruitment expected August 2025 September 2025 - OCP starting - expected to be advertised in December 25 - post filled May 26 - unable to complete action until Dec 26 (post needs to be filled before document control system can be purchased)
HIW GGH IRMER Inspection (Nov 2022)	The employer is required to provide an update on the action taken to ensure the employer's written procedure is adhered to by entitled referrers making a referral prior to exposures performed during surgical theatre cases.	CB to ensure all actions closed and evidence uploaded prior to closure of report	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	03/02/2025	03/02/2025	
HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within	The health board must ensure that full and comprehensive mental health assessments and physical health assessments are always being completed in a timely manner, in line with the Mental Health (Wales) Measure 2010 under the Mental Health Act 1983.	CB to ensure all actions closed and evidence uploaded prior to closure of report	Mental Health & Learning Disabilities	Chief Operating Officer	05/05/2025	05/05/2025	
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	Director of Nursing, Quality and Patient Experience	30/11/2023	30/11/2023	Update 24/05/24 Delay in updates to this action due to delay in publication of Welsh levels of care guidance for inpatient mental health and pause of All Wales Mental Health Workstream for Nurse Staffing. Extraordinary MH Workstream Group meeting scheduled for 4th June 2024 where practical application of Welsh Levels of Care within SAFECARE will be reconsidered. Local capacity being scoped within the Hywel Dda Nurse Staffing Team in anticipation of being able to work towards implementing a local pilot of SAFECARE across one mental health inpatient ward. Timescale for completion therefore revised to 31/12/2024. Update -07/01/2025 - Executive meeting did not go ahead on 18/12/2025 therefore meeting has been rescheduled - revised completion date 31/01/2025 Update 23/05/25 - Inpatient Workforce Stabilisation Paper, including recommendation for roll out of SafeCare across mental health wards presented to Executive Team on 07/05/25 - paper uploaded as evidence. Confirmation now received of commitment and support to this. SafeCare Pilot to be undertaken in Older Adult Mental Health Services ahead of full roll out scheduled by the Nurse Staffing Team to take place in October 2025. Action remains in progress with revised timescale of 31/10/2025. 25/11/2025: Senior Nurse for Older Adult Inpatient Wards has advised that whilst there had been an issue with Bryngolau staff accessing Safecare (since the day it was made live) this was resolved on 24/11/2025. The staff have been completing paper records in the meantime however they are now in a better position to continue inputting the data accurately on the Safecare system. Update requested from Nurse Staffing Programme Team. Revised completion date 31/03/2026. 30.12.25 Update: Safecare is in pilot stage usage on Bryngolau Ward. Technical glitches remain with staffs log-ins (manual collection in place). Anticipating to be operational for March deadline prior to full roll-out.

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	Director of Nursing, Quality and Patient Experience	30/11/2023	30/11/2023	Update 22/11/23 Training Needs Analysis tool developed by Learning and Development Team to be piloted across MHLD services. Update 24/05/24 Update. Progress with action delayed due to directorate capacity to facilitate pilot of TNA tool. Directorate to re engage with Learning and Development to agree a plan to progress. Completion date therefore revised to 30/09/24. Update 30/06/2025: Capacity has remained a challenge and the CCG to re-engage with Learning and Development to agree a plan to progress. To also progress appointment of Head of Nursing, and an additional post. Revised completion date 31st October 2025. 25/11/2025: Recent bid for HEIW Funding has been approved which incorporates funding to support completion of this piece of work. Next steps to be agreed with Assistant Director of People Planning. Revised completion date 31/03/2026. Update 30/12/25 Meeting planned to take place on 05/01/26 with Clinical Education Manager to plan delivery of TNA. Revised completion date remains as 31/03/26.
HIW Inspection BGH Emergency Department	HIW requires details on how the health board will ensure that measures are in place to ensure that medication storage fridge temperatures are checked and recorded on a daily basis.	To complete checks of medication storage fridge temperature alongside the daily checks of the resuscitation trolley	Community & Integrated Medicine	Chief Operating Officer	02/10/2025	02/10/2025	As of 02/08/25, this is now part of the daily resus checklist and is being actively completed. In addition, senior nurse management team will undertake regular spot checks to ensure ongoing compliant
HIW Inspection BGH Emergency Department	HIW requires details on how the health board will ensure that measures are in place to ensure that medication storage fridge temperatures are checked and recorded on a daily basis.	To notify all staff of change.	Community & Integrated Medicine	Chief Operating Officer	02/08/2025	02/08/2025	Notified by A&E Ward sisters across usual communication channels. Paper copy record kept in dept. Evidence to be uploaded
HIW Inspection BGH Emergency Department	HIW requires details on how the health board will ensure that measures are in place to ensure that medication storage fridge temperatures are checked and recorded on a daily basis.	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	HIW requires details on how the health board will ensure that the paediatric emergency trolley is checked regularly and an accurate record of checks maintained.	To discuss with EUCC team and ensure that they are aware that the paediatric emergency trolley is to be included in the daily checks of the resuscitation trolley. To issue reminder also to be given regarding record keeping of checks.	Community & Integrated Medicine	Chief Operating Officer	05/08/2025	05/08/2025	This was already part of the daily resus checklist and is actively completed. It is recognised that the paeds checklist originally issued is for a ward and different equipment is utilised in a resus area. Discussions held and confirmed to continue with daily resus checklist but to ensure everything is recorded. All staff notified and aware. In addition, senior nurse management team will undertake regular weekly spot checks to ensure ongoing compliance and submit assurance to System GM
HIW Inspection BGH Emergency Department	HIW requires details on how the health board will ensure that the paediatric emergency 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	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.	To utilise whiteboard in main theatres with checklist so that any gaps easily identifiable.	Community & Integrated Medicine	Chief Operating Officer	04/08/2025	04/08/2025	
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.	To issue reminder also to be given regarding record keeping of checks.	Community & Integrated Medicine	Chief Operating Officer	04/08/2025	04/08/2025	
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 evaluate and enhance security measures to ensure the safety of both staff and patients.	To progress implementation of the recovery plan which is in place and supports ongoing compliance and reinforces key competencies. To establish a programme of regular monitoring and refresher training to maintain standards and ensure continued readiness across the team.	Community & Integrated Medicine	Chief Operating Officer	31/12/2025	31/12/2025	From Rachel Wood: I had confirmation that my name had been allocated to this in error. That was from Louise Cullum. The recovery plans need to be authored by operational leads. I have explained this to them, I can support them to do this but I can't be responsible for this.
HIW Inspection BGH Emergency Department	The health board must review the mental health assessment room and ensure that it is fit for purpose and safe to use.	To review the risk assessment for the room in question.	Community & Integrated Medicine	Chief Operating Officer	31/12/2025	31/12/2025	
HIW Inspection BGH Emergency Department	The health board must review the mental health assessment room and ensure that it is fit for purpose and safe to use.	To arrange site visit to advise on the call alarm system.	Community & Integrated Medicine	Chief Operating Officer	31/12/2025	31/12/2025	Charles will take a look at the call alarm system when on site in w/c 10/11/2025.
HIW Inspection BGH Emergency Department	The health board must review the mental health assessment room and ensure that it is fit for purpose and safe to use.	To seek advice from Mental Health teams in relation to the alarm system.	Community & Integrated Medicine	Chief Operating Officer	30/09/2025	30/09/2025	Work is in progress to do necessary works on this room. Review 31st March 2026

HIW Inspection BGH Emergency Department	The health board must ensure that the paediatric emergency trolley and difficult airway trolley are appropriately sealed when not in use.	To address the risk of essential equipment being removed from the paediatric emergency and difficult airway trolleys, tamper-evident security tabs have now been sourced and implemented. These tabs seal the trolleys between checks, providing assurance that equipment remains intact and ready for use in the event of an emergency. Compliance with sealing and checking procedures will be monitored through regular audits and reviewed at local assurance meetings to ensure sustained safety and readiness.	Community & Integrated Medicine	Chief Operating Officer	30/09/2025	30/09/2025	Complete however ongoing checks remain in place. 31st March 2026
HIW Inspection BGH Emergency Department	The health board must ensure that staff are reminded of the need to maintain good hand hygiene in order to reduce the risk of cross infection.	To remind staff of the importance of complying with good hand hygiene practices to reduce the risk of infection and support safe patient care and to reinforce this message through safety huddles and visual prompts in clinical areas.	Community & Integrated Medicine	Chief Operating Officer	31/10/2025	31/10/2025	
HIW Inspection BGH Emergency Department	The health board must ensure that staff are reminded of the need to maintain good hand hygiene in order to reduce the risk of cross infection.	To ensure 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 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 the paediatric area is kept secure and that adult patients are not accommodated within this area when children are accommodated.	To undertake a site visit with the security team to discuss and address additional security measures for the paediatric area.	Community & Integrated Medicine	Chief Operating Officer	31/12/2025	31/12/2025	Paediatric area is part of the minor injuries unit and it is a open communal aera. it would be very difficult to implement additional security measures in the department. The Security Adviser will visit site in w/c 10/11/2025.
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 remind staff of the importance of completing timely and accurate pressure area risk assessments to prevent avoidable harm.	Community & Integrated Medicine	Chief Operating Officer	31/12/2025	31/12/2025	
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 support this, to introduce regular spot checks and documentation audits, with results reviewed through existing local assurance meetings. To continue to monitor trends in incident reporting related to pressure damage through the meetings and escalate to the Care Group's Quality, Health and Safety Meeting for oversight, ensuring ongoing vigilance, learning, 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 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 remind staff of the importance of completing timely and accurate falls risk assessments to prevent avoidable harm.	Community & Integrated Medicine	Chief Operating Officer	31/12/2025	31/12/2025	
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 support this, to introduce regular spot checks and documentation audits, with results reviewed through existing local assurance meetings. Trends in falls related incidents will be monitored through these meetings and escalated to the Care Group's Quality, Health and Safety Meeting for oversight if required, ensuring ongoing vigilance, learning, 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 remind staff of the importance of accurate and complete assessments	Community & Integrated Medicine	Chief Operating Officer	31/12/2025	31/12/2025	
HIW Inspection BGH Emergency Department	The health board must ensure that patient assessments are fully completed and documented.	To support this, to introduce regular spot checks and documentation audit, with results reviewed through existing local assurance meetings. Trends will be monitored through these meetings and escalated to the Care Group's Quality, Health and Safety Meeting for oversight, ensuring ongoing vigilance, learning, 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 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 remind staff of the importance of accurate and complete assessments	Community & Integrated Medicine	Chief Operating Officer	31/12/2025	31/12/2025	
HIW Inspection BGH Emergency Department	The health board must ensure that fluid intake and output balance charts are being completed consistently.	To support this, to introduce regular spot checks and documentation audit, with results reviewed through existing local assurance meetings. Trends will be monitored through these meetings and escalated to the Care Group's Quality, Health and Safety Meeting for oversight, ensuring ongoing vigilance, learning, 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 remind staff of the importance of accurate and complete assessments.	Community & Integrated Medicine	Chief Operating Officer	31/12/2025	31/12/2025	

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 support this, to introduce regular spot checks and documentation audit, with results reviewed through existing local assurance meetings. Trends will be monitored through these meetings and escalated to the Care Group's Quality, Health and Safety Meeting for oversight, ensuring ongoing vigilance, learning, 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 Inspection BGH Emergency Department	The health board must ensure that the GP Out of Hours Service provides consistent and effective support to the ED when this is required.	We acknowledge and appreciate the ongoing efforts of the GP Out of Hours service in helping to reduce demand at the EUCC front door. During periods of operational pressure, the Silver On-Call Manager has the ability to liaise directly with the Out of Hours team to explore capacity for additional support. However, this is dependent on the level of demand within their own service at the time. This collaborative approach is part of our wider system response to managing flow and ensuring patients receive timely and appropriate care.	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 the action taken to revise and update the employer's written procedure and flow chart for pregnancy enquiries for staff must be updated to ensure it includes reference to the circumstances when a pregnancy test should be considered and how the result will be effectively communicated	CB to ensure all actions closed and evidence uploaded prior to closure of report	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	05/05/2025	05/05/2025	
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	13/12/24- presented to QSEG- ongoing review and remains on risk register. Feb 2025- Update need for document control system and quality lead Radiographer included in Radiology annual plan March 2025 update- HB annual plan approved by the Board on 28/03/2025 which has included the Quality Lead Radiographer and document control system. Steps will be put in place shortly to recruit to the post and procure a document control system. April 2025- Quality Manager recruitment should be complete by Aug 2025 and an immediate must do within the workplan will be sourcing the quality control system. September 25 - OCP starting in Oct 25 - three month process. Expected to advertise post in Dec/Jan 26 - in post May 26. Post needs to be filled before action can be closed - expected Dec 2026
HIW IRMER Diagnostic Imaging x-ray department Withybush Hospital January 2024	Employer must provide HIW with details of action taken to manage entitlement of all duty holders (medical, non-medical and third party across the site). They must provide an action plan detailing when this process will be completed and the mitigation in place in the meantime to promote patient safety.	2.All Medical/third party referrers to be identified by implementation of the new PACS and RIS system which will move entirely to electronic referrals.	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	31/12/2025	31/12/2025	13/12/24- System go live Sept 25
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	Mental Health and Learning Disabilities	Director of Nursing, Quality and Patient Experience	05/05/2025	05/05/2025	
HIW St Non, St Caradog, Canolfan Bro Cerwyn WGH	The health board must ensure that safe holds are described in detail and that patient observations are recorded post any restraint or medical intervention in patient notes	To undertake a Directorate wide audit of Rapid Tranquilisation against standards for physical health monitoring within the Health Boards Rapid Tranquilisation Policy.	Mental Health and Learning Disabilities	Director of Nursing, Quality and Patient Experience	31/03/2024	31/03/2024	Update 23/05/24 Progress with this action has been delayed due to limited medical capacity. Plans to develop a rapid tranquilisation audit will be discussed at the newly formed Clinical Audit and Effectiveness Group meeting taking place in June 2024. Timescale for completion revised to 30th September 2024. Update 04/09/25 Rapid Tranquilisation Audit identified as a priority audit within MHLD Clinical Audit and Effectiveness Forward Audit Plan presented to MHLD CCG Integrated Governance Group 19/08/25. Timescale for completion revised to 31/12/25. Update 30/12/25 Clinical audit underway and is currently in the data review stage; reviewers have a deadline of 8th of January to ensure all cases are reviewed. Final audit report expected to be completed by 31/01/26. Evidence uploaded.
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	16/12/24 - Initial meeting held with Exec Director of Nursing, Exec Director of Public Health, Exec Director of Allied Health Professionals to agree outline of strategy and next steps. Aim to provide an overarching strategy including prevention through to inpatient fall management encompassing a preventive strategy aligned to health ageing / social model for health- change of narrative 'promoting independence' . Paper being developed on proposed strategy for discussion with exec team. 04/02/2025 - Working group established to review development of a Promoting Independence and Falls Strategy. 1st meeting held on 4/2/25 and actions agreed. 17/03/2025 - Further meetings planned for 14/04/2025 - responsible person amended to Mandy Davies as Ceri Griffiths leaving healthboard. 25/04/2025: Meetings held between Executive Directors (JS and AG) and Anna Llewellin to discuss strategic direction of the Falls Strategy Group. Executive Group is currently looking at promoting an independence framework which will include a falls strategy and work remains ongoing. . Anna will take this forward in the coming weeks/months, now that she is in post. Revised completion date of 31st December 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	18/06/2025: Revised completion date of December 2025.
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	11/04/25 - Following discussion with both Health Board legal and governance teams, the MOU approved in May 2024 Boards (and minuted as such) cannot be signed retrospectively. However, the transitional MOU is not yet ready to move to 'final' stage as originally planned from April 2025. Therefore, a paper is going to both Boards in March 2025 to seek approval to the continue the Transitional MOU. If this is approved, then signatures can be added (and the evidence provided) 14/07/25 - awaiting signed transitional MOU
Internal Audit - Mortuary Services Final Internal Audit Report 2024/25 Swansea Bay University Health Board Hywel Dda University Health Board (Limited)	R3. (External) Financial Responsibilities The Transitional MoU details in respect of the ODN that the "Health Boards agree to share the costs and expenses arising in respect of the Project between them in accordance with the Contributions Schedule set out in Annex D," and that the Schedule will be approved within three months of the date of the Transitional MoU (May 2024). We note that the development of the ODN has been impacted by capital funding and the delivery plan is behind schedule, however, the ODN Service Specification and commissioning arrangements have not been finalised. This would assist in determining how the ODN, including leadership roles, will be financed. In relation to the regional mortuary service provision, there is a spreadsheet that details the basis for the sharing of staffing costs between the health boards. However, current arrangements need to be more explicit to confirm the basis of the recharge	(External) We will formally document the agreement between the health boards of shared costs for the provision of the regional mortuary service and ODN.	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	31/03/2025	31/03/2025	Dec 2024 – Meeting organised between both operational and financial teams within both SBU and HD to discuss financial arrangements with regards to Di and regional APT's. Dec 2024 – Initial draft SLA constructed and circulated for review and comment. Final draft SLA to be attached to Mortuary MOU. This is still ongoing and being finalised and further meetings are scheduled for March and April 2025. Awaiting further decisions to be made by SBU and HD board meetings. 15/05/25 - Paper submitted to Public board meeting 27th March where a 12 month extension was requested. Awaiting meeting minutes 02/06/25 - further meeting set up for 08/07/25 to discuss draft SLA with the intention to finalise it. Awaiting signed SLA. Draft uploaded
Internal Audit - Nursing Management Final Internal Audit Report 2025/26 (Limited)	R2. Escalation / Approval of Agency Requests Escalation to agency requires approval by the Head of Service/Nursing. Sample testing of 25 shifts escalated to agency since implementation of the new SOP in April 2025 identified that only 16% of agency shifts reviewed had been escalated to agency on Allocate (i.e., 'approved') by the Head of Nursing. The SOP permits approval by a 'nominated deputy,' although there is ambiguity about which role(s) this could or should be, and it contradicts the intention of the SOP which is to ensure tight grip and control over agency use through senior management approval. In keeping with this it would be prudent to escalate rather than delegate approval, in the absence of the Head of Nursing.	The SOP will be updated to require, in the absence of the Head of Nursing, delegated approval by the Deputy Head of Nursing or escalation to the Assistant Director of Nursing, Quality & Patient Experience, emphasising that this should be the exception rather than the norm.	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	30/09/2025	31/12/2025	Discussions with the Assistant Directors of Nursing who are in agreement with the revised wording. SOP to be updated to reflect the wording change. Revised completion date 30/11/2025 23/10/2025: Gareth Heaven has requested that the due date be changed to 31st December 2025. Copy of email (as evidence of this request) uploaded to file.
Internal Audit - Nursing Management Final Internal Audit Report 2025/26 (Limited)	R3. Absence Management Sample testing identified widespread non-compliance with the key requirements of the NHS Wales Managing Attendance at Work Policy, including: • Absence of any documentation in support of some episodes • Failure to undertake Return to Work interviews, or significant delays in completion • Absence of sufficient self-certificates and/or fit notes covering the whole of the absence • Failure to identify and act on review prompts	The good practice identified at PPH Ward 9 will be process mapped into a guidance document and shared with all Heads of Service/Nursing for implementation within their respective areas.	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	30/09/2025	30/09/2025	Revised completion date 31/12/2025
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	10/06/2025- This report is a follow up from the previous report - HDU-2425-13 Discharge Management Internal Audit Report 2024/25 (Recommendation 4 in the previous report was not implemented)
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	Update 3.9.25- All Wales approach – FO taking to AWIQF for update and progress. revised target date 31.1.26

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	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 EIRMER is added as mandatory.
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.	CB to ensure all actions complete to allow for closure	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	30/06/2025	30/06/2025	unable to complete until earlier actions have been completed
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	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.
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	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	Director of Nursing, Quality and Patient Experience	Chief Operating Officer	30/09/2025	30/09/2025	As this action 'sits' within Nursing, Medical Quality, Safety & patient Experience the ADoN Olwen Morgan will be the overall action lead, assisted by Mr. Ihab Abassi, AMD. 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	Director of Nursing, Quality and Patient Experience	Chief Operating Officer	30/09/2025	30/09/2025	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	Director of Nursing, Quality and Patient Experience	Chief Operating Officer	30/11/2025	30/11/2025	
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	
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	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, Mr. Ihab Abassi.
Joint Inspection of Child Protection Arrangements (Pembrokeshire)	The reliance on CP medicals being completed by acute paediatricians in an out-of-county hospital, due to the lack of a service in Pembrokeshire, presents a long-standing and unresolved challenge to all agencies involved. The Health Board should consider how best to resolve theses issues to ensure a more timely and seamless service, both for agencies and for the children and families involved.	Work with Local Authority partners to agree an escalation process when health assessments are delayed.	Director of Nursing, Quality and Patient Experience	Chief Operating Officer	30/09/2025	30/09/2025	There is no agreement from consultants on a unified way forward at present. Further meeting due Nov 12th. This will require funding to implement a new rota. 12/11/2025 - meeting held. The community paediatric service would not be able to support this without considerable investment. Options for delivering a 5 day service are being scoped.
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	A review planning group has been established.
Joint Inspection of Child Protection Arrangements (Pembrokeshire)	Partners should ensure timely information sharing about emerging safeguarding themes and work together to disrupt and reduce such risks within the population and for individual children.	Prevention & emerging risks: HV and Midwifery to draft a Free Birth policy for consultation with regional multi-agency partners.	Director of Nursing, Quality and Patient Experience	Chief Operating Officer	30/09/2025	30/09/2025	A draft policy has been developed for health visiting and internal health board consultation with Midwifery has taken place. In addition to this discussions have been had with the policy lead for the Health Board as well as bench marking with another Health Board. Children's Commissioner has also been consulted. When all is complete policy to be shared with multi -agency partners for further consultation before finalising, also taking into account the National perspective and progress on the management of Free birthing. This process near finalisation waiting for SBAR to be completed and policy taken to SNMT for sign off. 11th Dec 2025 update: It has been decided that this policy will be a stand alone policy for Health Visiting, the literature review is complete, EQIA is being completed along with SBAR and then will be progressed. Evidence of SBAR and EQIA to be uploaded once completed.

Joint Inspection of Child Protection Arrangements (Pembrokeshire)	Partners should ensure timely information sharing about emerging safeguarding themes and work together to disrupt and reduce such risks within the population and for individual children.	Prevention & emerging risks: Review strategies across the multi-agency partnership to reduce substance ingestion by young children	Director of Nursing, Quality and Patient Experience	Chief Operating Officer	31/12/2025	31/12/2025	To be discussed at the Safeguarding Leads regional meeting.
Mynydd Mawr Ward, Prince Philip HospitaL 03921	Implement robust measures to maintain clinic room temperatures within recommended guidelines for safe medication storage.	The monitoring chart link requires to be embedded within the medicine policy for ease of access. This action has been requested and is underway.	Community & Integrated Medicine	Chief Operating Officer	30/09/2025	30/09/2025	Link embedded but awaiting ratification- update 1.10.25 (expected completion Dec 2025) Copy of the daily temperature log has been cascaded to all Heads of Nursing. Medicines policy is under review with no clear time scale on completion. A request has been made to extend the review for a further 6 months. (updated on the 7/10/25) Medicines Policy is being review. The Daily temperature log templates are being imbedded into the policy as links. I have no definitive date of when this will be approved. (updated 29:12:25)
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	Temperature Controlled Medicines Task and finish group September 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	All Wales Group are updating this work underway, working with HIW for editing to ensure capability with ESR This is an All Wales piece of work that is underway. No clear time scale on completion. Group to meet in the next month. Updated 7/10/25 No new update to give .Work remains to be done on this. Working with HEIW on this piece of work. (updated 29:12:25)
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	Currently remains under review - Aim is January 2026 Policy is being updated. No definitive date of completion(updated 29:12:25)
Mynydd Mawr Ward, Prince Philip HospitaL 03921	The health board must urgently review the physiotherapy provision on the ward, to ensure patients receive timely and appropriate assessments, along with suitable therapeutic support during the interim period.	To embed a robust and structured approach to patient rehabilitation on the ward.	Community & Integrated Medicine	Chief Operating Officer	30/11/2025	30/11/2025	To note: the recruitment process to fill the 3.5 vacancies commenced in June 2024. Initial attempts at recruitment in July 2024 were unsuccessful and, alongside the increased site pressures to support patient flow, this impacted on the ability to deliver consistent rehabilitation. In December 2024, three band 6 physiotherapists were appointed, however start dates were delayed due to notice periods, completion of band 5 rotations and maternity leave. Recruitment in March 2025 and June 2025 has been successful. Further recruitment is to commence in October and November 2025.
Mynydd Mawr Ward, Prince Philip HospitaL 03921	The health board must ensure that all staff are compliant with Duty of Candour training and are appropriately supported to understand and apply its principles in their roles.	To undertake a weekly (for a period of four weeks) validation of manager's interim harm assessment for patient safety incidents reported on Mynydd Mawr This will be in addition to the established monthly validation of all patient safety incidents closed in the month.	Community & Integrated Medicine	Chief Operating Officer	30/11/2025	30/11/2025	
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	The Dermatology Consultant Capacity currently remains at 2.0 WTE this is due to the available core budget. There is currently an advert out to recruit for one WTE Dermatology Consultant. Completion date set to 30/06/2026 to allow ample time for recruitment for a Dermatology Consultant.
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	To date the Health Board has experienced difficulty in recruiting a suitably trained doctor to carry out patch testing. There are currently two job advertisements for a Consultant Dermatologist and a Locum Consultant Dermatologist. The Health Board are also experiencing a shortage of clinical space for the patch testing to be carried out. 3 rooms have been identified at DSU PPH for the Dermatology Service, however practicalities around air handling, reception cover and medical records support need to be agreed before these rooms can be utilised for the Dermatology Service. Further space is also required and this is being supported via the CSP. At present, patients are being referred to SBUHB for patch testing.
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	The recommendation relates to the initial clinical space within the outpatients department at Glangwili General Hospital (GGH) that was earmarked for Dermatology back in 2019. However due to the COVID-19 Pandemic that clinical space was utilised by the Minor Injuries Unit (MIU) at GGH. MIU have since returned to their original location and another service has used that space as the Dermatology Service moved to Prince Phillip Hospital (PPH) during the COVID-19 pandemic. 3 rooms have been identified at DSU PPH, however practicalities around air handling, reception cover and medical records support need to be agreed before the space can be utilised by the Dermatology service. Further space is required in order to carry out the service to patients and this is currently being supported via the CSP. The service continues not to have a dedicated department as mentioned in the report. Revised date April 2028
NHS Wales Executive Children and Young Person's Neurodevelopmental Services All Wales Review	Arrangements for transition of CYP between children's and adult ASD and ADHD assessment should be clarified and strengthened to ensure that CYP are not disadvantaged in relation to waiting time or access to age-appropriate expertise.	Review current transition arrangements for older YP people waiting diagnostic assessments of ASD and ADHD	Planned and Specialist Care	Chief Operating Officer	30/11/2024	30/11/2024	02/12/2025: Meetings held between ASD and ADHD teams, awaiting final confirmation of agreement from Adult ADHD team to agree transition arrangements. Revised Date: February 2026

NHS Wales Executive Children and Young Person's Neurodevelopmental Services All Wales Review	Arrangements for transition of CYP between children's and adult ASD and ADHD assessment should be clarified and strengthened to ensure that CYP are not disadvantaged in relation to waiting time or access to age-appropriate expertise.	Develop an all age Transition policy/pathway for Neurodivergent Children & Young People.	Planned and Specialist Care	Chief Operating Officer	30/11/2024	30/11/2024	11th April. Series of meetings held to date and on-going Assigned lead on Action Plan is Angharad Davies, therefore re-assigned on AMat for updating purposes 4th Dec 2024 Initial document approval form and EQIA screening complete. HB Transition policy now under development in collaboration with Policies team, to be taken to Women and Childrens Written Clinical Documentation Group on the 31.01.25. All age transition pathway for Neuro-divergent Children and Young people to be included within HB policy. 31/10/2025: Work is ongoing surrounding this policy/pathway. Revised completion date 31.12.2025 02/12/2025: Transition policy pathway is still being developed and will likely to be agreed in the new year. Policy has been drafted and sent to MH&LD CCG leads for approval, awaiting outcome. Revised Completion date: March 2026.
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	Identified opportunities, however, implementation is a challenge. SDM's from both directorates are working on these challenges. Planned meeting with relevant colleague to support referral/s advice/ signposting liaison meeting to discuss relevant cases is in hand. Evidence to be added 04/12/2024 - Update requested via Email from TH. Awaited. 02/12/2025: Lead Nurse for Children Community and Lead for Psychology and SCAHMS are working together to explore opportunities to share expertise. Ongoing meetings are in place for further discussions. There is a B8a Child Health Psychology post due to go to FCSG for approval and this post has already received CCG approval. Due to the small size of the Paediatric psychology team we are unable to progress this matter further until this post is in place. Revised Date: December 2026 (this takes into account approval from FCSG, recruitment and embedding into the post)
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	Benchmarking document has been produced as a hard copy and will be scanned and uploaded.
Nuclear Medicine IRMER WGH 03909	The employer should consolidate the two procedures on the referral process into one.	Review relevant Employers Procedures to amalgamate EP5 and EP25.	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	01/01/2026	01/01/2026	
Nuclear Medicine IRMER WGH 03909	The employer must ensure that: •All IR(ME)R entitlement and training competency documentation is completed in full, with the appropriate signatures, in a timely manner and before entitlement is granted •The employer's procedure contains reference to the correct titles of staff.	Develop new entitlement document which reflects all duty holders under IR(ME)R.	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	01/01/2026	01/01/2026	
Nuclear Medicine IRMER WGH 03909	The employer must ensure that: •All IR(ME)R entitlement and training competency documentation is completed in full, with the appropriate signatures, in a timely manner and before entitlement is granted •The employer's procedure contains reference to the correct titles of staff.	Review all job titles within Employers Procedures	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	01/01/2026	01/01/2026	
Nuclear Medicine IRMER WGH 03909	The employer must ensure that the employer's procedure includes the correct duty holder to justify nuclear medicine procedures, for pregnant or breastfeeding individuals.	Review Employers Procedure 8 to amend the duty holder required to justify Nuclear Medicine procedures.	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	01/01/2026	01/01/2026	
Nuclear Medicine IRMER WGH 03909	The employer must ensure that the relevant employer's procedure includes: •Details on the formal process and responsibilities of identifying and conducting both clinical and IR(ME)R audits •Reference to the audit report templates that should be used •Specific terminology to ensure clarity between clinical and IR(ME)R audits.	Employers Procedure 21 to be reviewed and amended to include: •Details on the formal process and responsibilities of identifying and conducting both clinical and IR(ME)R audits •Reference to the audit report templates that should be used and included as an appendix. •Specific terminology to ensure clarity between clinical and IR(ME)R audits.	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	01/01/2026	01/01/2026	

Nuclear Medicine IRMER WGH 03909	The employer must ensure that the relevant employer's procedure is updated to include: •Clarity on the circumstances of informing or not informing patient •Making it clear that the relevant practitioner, referrer and operator should always be informed of any CSAUEs •The process in place for recording and analysing accidental or unintended exposures including near misses •References to nuclear medicine equipment.	Employers Procedure 19 to be reviewed and updated to include: •Clarity on the circumstances of informing or not informing patient	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	01/01/2026	01/01/2026	
Nuclear Medicine IRMER WGH 03909	The employer must ensure that the relevant employer's procedure is updated to include: •Clarity on the circumstances of informing or not informing patient •Making it clear that the relevant practitioner, referrer and operator should always be informed of any CSAUEs •The process in place for recording and analysing accidental or unintended exposures including near misses •References to nuclear medicine equipment.	Employers Procedure 19 to be reviewed and updated to include: Making it clear that the relevant practitioner, referrer and operator should always be informed of any CSAUEs	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	01/01/2026	01/01/2026	
Nuclear Medicine IRMER WGH 03909	The employer must ensure that the relevant employer's procedure is updated to include: •Clarity on the circumstances of informing or not informing patient •Making it clear that the relevant practitioner, referrer and operator should always be informed of any CSAUEs •The process in place for recording and analysing accidental or unintended exposures including near misses •References to nuclear medicine equipment.	Employers Procedure 19 to be reviewed and updated to include: The process in place for recording and analysing accidental or unintended exposures including near misses	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	01/01/2026	01/01/2026	
Nuclear Medicine IRMER WGH 03909	The employer must ensure that the authorisation guidelines and the employer's procedure is updated to correctly reflect the process and ensure there is clarity on who is authorising the exposure to carers and comforters.	The Employer's Procedure will be amended to offer specific guidance to staff, and including recording of authorisation following advice from MPE.	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	28/10/2025	28/10/2025	Meeting with RPE delayed due to DHoS unexpected leave and service pressures. - updated date 31.12.25
Nuclear Medicine IRMER WGH 03909	The employer must ensure that: •The adjuvant drugs used in nuclear medicine are part of the formulary •The nuclear medicine protocols are ratified and approved to ensure compliance with regulation 240 of the Human Medicines Regulations 2012.	Nuclear Medicine protocols to be reviewed, amended and ratified appropriately by Head of Radiology Services Manager, in consultation with the ARSAC licence holders and MPE to ensure compliance with regulation 240 of the Human Medicines Regulations 2012.	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	01/01/2026	01/01/2026	Draft documents have been developed by NM team and MPE. Meeting to discuss with all stakeholders to be scheduled.
Nuclear Medicine IRMER WGH 03909	The employer must ensure that: •A document list of relevant IR(ME)R theoretical training is introduced and completed by staff •The relevant employer's procedure states the process for the review of training records and how the review of training records is recorded.	Process added to Employers Procedure around review of training records.	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	01/01/2026	01/01/2026	

Peer Review Out of Hours Peer Review, issued April 2023	R6. The Advanced Paramedic Practitioner role within OOH has not been formalised but is working well. The APPS would like to do more shifts.	Review the formalisation of the APP role within the OOH MDT and possibly joint roles with Urgent Primary Care.	Primary Care	Chief Operating Officer	30/06/2023	30/06/2023	26/04/2023- WAST APP pilot has been in place since October 2018 and has made a positive difference to shift fill outcomes and access to care particularly through home visits. The audit already undertaken was received positively and highly supportive of the model and is being built on through discussion with the Clinical Lead (OOHs) and the recently appointed Professional Development Lead for Advanced Practice at WAST. 26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019. 27/06/2023 - Meeting to be held with locality managers for APP on 12/07/2023 to discuss shift fill and current model. Working with SDEC and Intermediate Care to understand the feasibility of a joint rotational model, further from previous discussions with TUEC and Primary Care. Discussion ongoing with WAST in terms of supporting the mentorship of trainee APPs and the growth of new cohorts. Shift fill is less than 50% per week as at June 2023 due to current qualified APPs leaving, and unable to backfill positions. Contract re-negotiation with WAST is highly likely, and likely to cause additional delays to the implementation of this recommendation. 16/08/2023 - due to management structure changes at WAST, and several APPs leaving, this has delayed the full implementation of the recommendation, however improvements beginning to be noticed and a new cohort of APPs are currently embedding. Ongoing financial constraints are also impacting on the ability to fully implement this recommendation as at August 2023 04/12/2023 - There has been a prolonged period of reduced APP shift fill that is being addressed by WAST with the assurance that shift fill is set to improve imminently. 08/05/2024 - Shift fill did improve however not sustained. This may be linked to the same APPs being used in other areas of the HB despite OOHs funding two WTE. Assessment of the sustainability and resilience of the APP relationship with WAST is being considered and a decision will be reached in Q1 24/25. This again may be influenced by the move to Primary Care and any opportunities this may present for 24/7 offering of Primary Care. The revised date has been amended to reflect realistic progress within this financial year. 26/07/2024 - There is performance variation with this role, and there needs to be a further collaborative review with WAST and input post OCP (see links to consolidation and rural model actions). 24/09/2024 - Action to be reviewed post-OCP to determine long-term opportunities 16/12/2024 - a new leadership structure in WAST looking after APPs, we have now held an introductory meeting and intend to formalise these on an ongoing basis to look at how we formalise utilisation of APPs on an ongoing basis, given that demand for them in other areas is prevalent. 18/03/2025 - review of the APP programme to be considered in line with the development of the Primary Care & Community Services strategic plan 01/10/2025 - APP Arrangements are currently in review. Changes in WAST need to be understood and clarity is required to determine an whether SLA or MoU will be renewed. A review of our MDT model is going to be carried out once the salaried GPs recruitment is completed. Revised date = June 2026 (to allow time for recruitment and review of plan).
Peer Review Out of Hours Peer Review, issued April 2023	R12. There was some success in developing the health care support worker roles and the National 111 programme supported the Health Board to train drivers and reception staff. However these staff are not being utilised on shift in OOHs.	Review how utilisation of HCSW in bases in the West could support a rural model of care.	Primary Care	Chief Operating Officer	30/06/2023	30/06/2023	26/04/2023- Explore with CTUHB. Ties in with TUEC programme work. Skill set to be scoped and compared with opportunities and needs. 26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019. 27/06/2023 - Work is ongoing with the OOH Service to understand the current Airedale model. Working with SDEC and Intermediate Care to understand the feasibility of a joint rotational model, further from previous discussions with TUEC and Primary Care. Due to changes in senior leadership arrangements, this work is ongoing as at June 2023. Interaction with Salus may cause further delay, therefore proposed revised timescale of December 2023. 16/08/2023 - current financial constraints are limiting the ability to progress this recommendation at pace, as OOH structure may change, therefore recommendation to be re-visited once more clarity in place. 04/12/2023 - There is no further progress to date. 08/05/2024 - Those trained as HCSW are being encouraged to utilise their skills. Clinicians are being encouraged to support such colleagues and feedback has been positive. As the number of face to face consultations continues to increase these opportunities should also be more frequent. Evaluation of the role will be ongoing. All new recruits to the OOH operational team will be trained as HCSW through the Skills to Care programme. 26/07/2024 - This is faltering due to lack of engagement with the predominant locum GP workforce. 30/09/2024 - Re-evaluation of action following OCP 16/12/2024 - Dashboard reports will be developed to enable a better understand of service needs, which will support collaboration with the Six Goals programme. 18/03/2025 links to other peer review recommendations around HCSWs and the link with the Primary and Community Services Academy and the development of the Primary Care and Community Services Strategic Plan development 01/10/2025 - The rural model of care will be considered following service changes such as recruitment of salaried GPs (see R1 and R6) which will inform MDT possibilities. A significant amount of work in the UEC space where other services are involved has largely superseded this recommendation (e.g. Six Goals programme). To be escalated via CCG for steer on closure of recommendation on the basis that newer initiatives and workstreams have superseded this work (evidence to be collated for approval to close action). A revised date of June 2026 has been given to allow time to collate information/evidence etc and enact any further actions required following report to CCG.

Peer Review Out of Hours Peer Review, issued April 2023	R16. Clinicians raised concerns about the appropriateness of calls sent across from 111, which could have been closed by 111.	Consider a table top review of calls sent across by 111 deemed inappropriate	Primary Care	Chief Operating Officer	30/09/2023	30/09/2023	26/04/2023- Data gathering has continued with the recent restoration of Adastra and its concentrator. Analysis of call profiles to be undertaken and interpretations to be compared. 26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019. 04/12/2023 - Continues to be challenged nationally by all HBs. Professor Mark Lawrence has undertaken a survey to be published in the new year. Upwards of 60% of calls are passed as priority 1 (Emergency in general practice) however les than 1% of these maintain that level of priority following medical triage. 05/03/2024 - Regular feedback to 111 about the appropriateness of calls and disproportionately large numbers of Priority 1 calls. This is also a factor in the above action. The report by Professor Mark Lawrence has recently been shared and is being reviewed nationally. WAST are due to have a replacement for their front end Clinical Assessment programme and this will allow some changes including a change to some triage categories which may see the sensitivity reduced and less calls being categorised at Priority 1. 08/05/2024 - New system has been in place for 1 week and has seen a change in process. The data from this new system will be monitored and assessed over the next 6 months in order to determine whether it has improved the processes in place. 26/07/2024 - The new front end system is undergoing a national review and this action will be captured within the scope of this. This includes a Delphi study and we will likely close this action post publication of the study. 20/09/2024 - awaiting publication of the results of the Delphi study. However, we are still hearing anecdotally that inappropriate calls are being passed through i.e. patient is too unwell to attend or self care could be applied. We will continue to review calls and monitor progress. 16/12/2024 - we are still awaiting the Delphi publication. We also know that we have under reporting in OOH, we are encouraging more Datix reporting, so we can better understand the extent of the problem and ensure appropriate review. Revised Due Date: 31/12/2025 01/10/2025 - Feedback from clinicians around any local issues in our Health Board to be undertaken and to be fed back to CCG to approve closure of this recommendation. A form is being developed to sent out.
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	Incorporated into process and e mail request to Assistant Directors of Nursing to ensure all action plans associated with complaints are entered into AMAT rather than separate documents for monitoring. Evidence to be linked to datix.
Welsh Risk Pool Concerns Assessment (December 2024)	R10 HDUHB to consider issuing an Inquest Policy and SOP which can provide clarity on the process to the wider organisation	To provide a supplementary SOP on inquest management to the Inquest guidance document. To be approved by Listening and Learning Sub-Committee in March 2025 and updated on policy database.	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	31/03/2025	31/03/2025	
Welsh Risk Pool Concerns Assessment (December 2024)	R11 HDUHB to utilise Datix Cymru for the management of inquests ensuring all documents are uploaded.	Review permissions, with the Hywel Dda Datix Cymru system lead, to ensure there is security in how records are accessed within the health board to maintain confidentiality and protection of witness statements and other documentation.	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	31/03/2025	31/03/2025	Quality Assurance Information System Senior Officer to provide Head of Legal Services with confirmation of staff who access the claims modules and the types of records in this module e.g. Inquests. At present the Claims team only plus the Datix Administration team have full access to the module with the exception of Court of Protection which is restricted further.