Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Date	**2026-10-08**
Time	**09:00 - 12:30**
Location	**Microsoft Teams Meeting**

Virtual Quality, Safety & Experience Committee

HDD_Quality, Safety & Experience Committee

NHS Wales

Agenda - 8 October 2026

1 Governance

1.1 Declarations of Interest

Eleanor Marks (Hywel Dda UHB - HDUHB Vice Chair)

1.2 Minutes from the Previous Meeting and Table of Actions

Eleanor Marks (Hywel Dda UHB - HDUHB Vice Chair)

2 Escalation Report- Executive Leads

3 Planning Goal 2: Customer Service Excellence

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

4 Risk

4.1 Assurance and Risk Report

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

4.2 Deep Dive: Orthopaedics

Lianne Gregory (Hywel Dda UHB - Service Delivery Manager), Paula Goode (Hywel Dda UHB - Service Director for Planned and Specialist Care)

4.3 Deep Dive: Dermatology

Ceri Wisdom (Hywel Dda UHB - Service Delivery Manager), Paula Goode (Hywel Dda UHB - Service Director for Planned and Specialist Care)

5 Never Events Assurance Report

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

6 Patient Safety Plan 2026-2031

Cathie Steele (Hywel Dda UHB - Interim Assistant Director of Nursing Assurance and Safeguarding), Sharon Daniel (Hywel Dda UHB - Executive Director of Nursing, Quality & Patient Experience)

7 Assurance

7.1 Quality Assurance Report

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

7.2 Listening and Learning Sub Committee Update Report

Louise O'Connor (Hywel Dda Health Board - Assistant Director), Mark Henwood (Hywel Dda UHB - Executive Medical Director)

7.3 Infection Prevention and Control Assurance Report

Sharon Daniel (Hywel Dda UHB - Executive Director of Nursing, Quality & Patient Experience), Cathie Steele (Hywel Dda UHB - Interim Assistant Director of Nursing Assurance and Safeguarding), Rebecca Richards (Hywel Dda UHB - Head of infection prevention)

7.4 Insourcing 52 week First Consultant Appointment Quality Assurance Report

Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Keith Jones (Hywel Dda UHB - Director of Operational Planning & Performance)

8 Clinical Care Group Assurance Reports

8.1 Mental Health and Learning Disabilities Clinical Care Group Assurance Report

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

8.2 Learning Disabilities Services Patient Story and Deep Dive

Rebecca Temple-Purcell (Hywel Dda UHB - Assistant Director of Nursing, Patient Safety, Quality and Experience), Kate Scott (Hywel Dda UHB - Remote email account), Eleanor OConnor (Hywel Dda UHB - Service Manager Learning Disabilities)

8.3 Planned and Specialist Care Clinical Care Group Assurance Report

Paula Goode (Hywel Dda UHB - Service Director for Planned and Specialist Care), Tamara Bromley (Hywel Dda UHB - Assistant Director of Nursing)

9	**Policies/ Procedures for Approval**	
9.1	**004 Claims Management Policy Extension** *Louise O'Connor (Hywel Dda Health Board - Assistant Director)*	
9.2	**1561 - 'Listening to People' Integrated Patient Safety, Concerns Management and Resolution Policy** *Louise O'Connor (Hywel Dda Health Board - Assistant Director)*	
10	**For Information**	
10.1	**QSEC Work Plan 2026-27**	
10.2	**Joint Commissioning Committee Highlight Report**	
11	**Date of Next Meeting : 3 December 2026**	

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09:00,

1 - Governance

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1.1 - Declarations of Interest

Eleanor Marks (Hywel Dda UHB - HDUHB Vice Chair)

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1.2 - Minutes from the Previous Meeting and Table of Actions

Eleanor Marks (Hywel Dda UHB - HDUHB Vice Chair)

For approval

Attachments

2026-08-11 - Quality, Safety Experience Committee - Minutes.pdf

QSEC TOA 11 AUG26.pdf

MINUTES OF THE Quality, Safety & Experience Committee

Date of Meeting:	**9:30 AM, Tuesday 11 August 2026**
Venue:	**Microsoft Teams Meeting; Picton - Dolau Cothi Meeting Room**

Present:	Eleanor Marks (Chair of the Committee and Vice Chair of the Health Board) Michael Imperato (Independent Member) Chantal Patel (Independent Member) Neil Prior (Independent Member) Rhodri Evans (Independent Member)
In Attendance:	Sharon Daniel (Executive Director of Nursing, Quality and Patient Experience) (Lead Executive Director) Neil Wooding (Chair of Hywel Dda University Health Board) Joanne Wilson (Director of Corporate Governance/Board Secretary) Mark Henwood (Executive Medical Director) Andrew Carruthers (Chief Operating Officer) Nadine Gould (Deputy Director of Nursing, Quality and Patient Experience) Cathie Steele (Interim Assistant Director of Nursing Assurance and Safeguarding) Bethan Lewis (Assistant Director of Public Health Strategic Business and Operations), deputising for Ardiana Gjini (Executive Director of Public Health) Louise O'Connor (Assistant Director (Legal and Patient Support)) Cathie Steele (Interim Assistant Director of Nursing Assurance and Safeguarding) Dana Scott (Director of Midwifery & Professional Governance for Women & Children) Jo Bradburn (Deputy Director of Allied Health Professions), deputising for James Severs (Executive Director of Allied Health Professions and Health Sciences) Elin Brock (Head of Research, Innovation & Improvement) Charlotte Westacott (Head of Safeguarding) Olwen Morgan (Assistant Director of Nursing)(part) Louisa Morris (Clinical Director for Clinical Effectiveness), deputising for Subhamay Ghosh (Associate Medical Director for Quality & Safety) Angela Bell (Assistant Director of Quality, Safety and Patient Experience for Allied Health and Health Science Clinical Care Group) (part) Simon Chiffi (Head of Operations) (part) Anna Chiffi (Assistant Director of Nursing, Patient Safety, Quality) (part) Neil Griffiths (Service Delivery Manager of Urology and Rheumatology) (part) Lisa Humphrey (General Manager – Planned Care) (part) Ruth Poynting (Committee Services Officer) (Minutes)
Apologies:	Subhamay Ghosh (Associate Medical Director for Quality & Safety) Ardiana Gjini (Executive Director of Public Health) James Severs (Executive Director of Allied Health Professions and Health Sciences)

Minutes Ref.	Item	Action

QSEC 26 (55) Welcome and Apologies

Ms Eleanor Marks welcomed everyone to the meeting and acknowledged that previous meeting packs contained an unmanageable number of reports. Members expressed concern regarding the significant duplication of information across reports and requested that future reports be more concise, targeted and focused on key issues requiring Committee consideration and assurance. Executive colleagues were asked to take this into consideration when preparing future reports.

Apologies for absence were noted as above.

QSEC 26 (56) Declarations of Interest

HDdUHB Register of Board Members Interests 2026-27

QSEC 26 (57) Minutes from the Previous Meeting and Table of Actions

Members confirmed that the minutes were an accurate record of the proceedings, and no comments or amendments were raised. The minutes were therefore APPROVED.

QSEC(26)43: This action is closed as communication was sent 22 June 2026.

Decision: The Committee APPROVED the minutes of the Quality, Safety and Experience Committee meeting held on the 11 June 2026 as a correct record of proceedings; and REVIEWED and NOTED the Table of Actions from the Quality, Safety and Experience Committee meeting on the 11 June 2026.

QSEC 26 (58) Committee Self Assessment

Mrs Joanne Wilson presented the Committee Self-Assessment update, noting that two actions remained ongoing. Members were advised that progress had been aligned with work on operational governance, with governance arrangements reviewed and strengthened through the implementation of the *New Ways of Working.*

Dr Neil Wooding acknowledged improvements in the quality of Committee papers, however believed that further progress was required. Ms Wilson reported that training and support had been made available to all who requested it and emphasised that Executive teams now needed to take ownership of applying the guidance provided.
Ms Marks questioned whether papers were receiving sufficient Executive scrutiny prior to submission. In response, Ms Sharon Daniel advised that the Organisation was continuing to develop its

quality management systems, with quality assurance forming an important part of the next phase of improvement.

Dr Wooding reiterated the need for robust Executive quality assurance and stronger leadership oversight of papers. Mr Neil Prior highlighted the significant volume of reading required and stressed the importance of clearly demonstrating the impact of reports on patient care, enabling the Committee to focus its scrutiny on matters of greatest importance.

Decision: The Committee TOOK ASSURANCE from the progress made against the actions being undertaken to improve its effectiveness.

QSEC 26 (59) Urology Deep Dive and Carers Story

Mr Neil Griffiths presented an update on progress against the Urology Improvement Plan. Members noted improvements since October 2025, including enhancements to the cancer diagnostic pathway through additional MRI capacity, reduced reporting turnaround times, and pathology waits now reduced to approximately one week.

Progress had also been made in prostate services, including earlier communication of diagnoses, the appointment of a dedicated Prostate Pathway Coordinator, and recruitment to a Prostate Clinical Nurse Specialist post due to commence in October 2026. Further developments included stabilising the on-call rota, improving follow-up management, reducing delays for patients awaiting stone surgery, and securing additional weekend diagnostic lists from October 2026.

Mr Griffiths reported that cancer performance had improved significantly, with the number of patients waiting for treatment reducing from approximately 850 to 600 over the previous two months. He advised that continued progress would improve the likelihood of patients being treated within the 62-day pathway target.

Mrs Chantal Patel sought assurance that the additional resources invested were translating into improved patient outcomes. Mr Griffiths explained that earlier diagnosis was enabling patients to access treatment quicker, while Mr Andrew Carruthers highlighted the link between earlier diagnosis and improved outcomes, noting that some urological conditions did not require immediate treatment.

Ms Marks emphasised the need for clearer evidence of actual and potential patient harm. Mrs Patel also highlighted concerns raised through the Waiting List Management Ethics meetings regarding inconsistent processes and queried whether a more consistent organisational approach could be adopted.

Mr Michael Imperato sought clarification on the causes of the theatre capacity gap. Mr Griffiths advised that capacity challenges

affected planned care across the organisation and that theatre schedules had been redesigned to maximise existing weekday capacity and improve efficiency.

Mr Mark Henwood highlighted opportunities to improve productivity through changes to working practices in outpatient and theatre services, whilst acknowledging that staff would require support to deliver these improvements. Mr Carruthers outlined three key operational risks affecting performance: theatre staffing, insufficient anaesthetic cover, and infrastructure issues which had resulted in some theatres being unavailable for use.

Dr Neil Wooding highlighted examples of inefficiency within patient pathways, particularly where matters that could be managed by other staff were being escalated unnecessarily to consultants. Mr Henwood agreed that small inefficiencies could have a significant cumulative impact on waiting lists. Ms Sharon Daniel noted that such improvements could be measured and monitored.

The importance of understanding the impact of service improvements on patient outcomes and patient experience was emphasised, noting that future reports would benefit from greater evidence of actual and avoided harm. Discussions also highlighted opportunities to improve productivity and pathway efficiency through service redesign, including ensuring that patients are supported by the most appropriate member of the multidisciplinary team, reducing unnecessary follow-up activity and maximising use of existing capacity. Members welcomed the focus on incremental service improvements and pathway redesign as a means of improving both patient experience and access to care

In response to queries regarding the sustainability of the improvement trajectory, Mr Griffiths advised that significant progress had already been achieved through service redesign rather than additional investment, including work with Prostate Cymru to support a more nurse-led model of care. He expressed confidence that performance would continue to improve over the next three to six months. Mr Carruthers noted, however, that some improvements were reliant on non-recurrent Welsh Government funding and that workforce and infrastructure challenges would need to be addressed to achieve long-term sustainability.

Ms Eleanor Marks welcomed the innovative approaches being adopted, however noted concerns regarding the service's performance relative to other organisations in Wales. Members sought assurance that the recent improvements would be sustainable and translate into measurable improvements in performance, patient outcomes and experience over the coming months. Mr Griffiths acknowledged this position and remained confident that the current trajectory would result in further improvement.

The Committee took assurance from the update, noting the progress already achieved and the plans in place to deliver further improvements. A further update was requested in six months' time. AC/NG

Decision: The Committee TOOK ASSURANCE that work is underway to improve the Urology pathway, whilst noting the expectation that demonstrable and sustainable progress should be evidenced within the proposed six-month timeframe.

QSEC 26 (60) Assurance and Risk Report- Executive Leads

Mrs Wilson presented the Assurance and Risk Report, advising that 11 corporate risks are aligned to the Committee's remit had been reviewed and updated. Members noted that a number of risks were currently under review and would be considered by the Executive Team.

The Committee discussed Risk 797 in detail. Cllr Evans highlighted the significance of the risk and sought assurance regarding the timescales for improvement. Mr Carruthers advised that work was underway to separate the current risk into distinct elements to provide greater clarity, supported by two improvement plans. Progress was being made in recruiting and training stenographers, although the lengthy training period and existing backlog meant improvements would take time to deliver. Members expressed concern regarding the projected timescale for resolution and requested greater detail on the anticipated trajectory of the risk over that period.

Mr Prior queried the rationale for the high risk score and sought clarification on the potential consequences should the risk materialise. Members discussed the varying levels of harm associated with different diagnostic delays, noting that some areas carried a greater risk of significant patient harm than others. Members questioned whether the current risk score accurately reflected the likelihood and impact described and expressed concern regarding the acceptability of maintaining a risk rated at 25 over a prolonged period. A clearer explanation of the anticipated consequences, likelihood of occurrence and trajectory for improvement was requested. Mrs Sharon Daniel advised that separating the risk would provide a clearer understanding of the individual risk profiles and residual risks.

Dr Wooding emphasised the need to better understand the likelihood of harm occurring and challenged whether a reliance on staff training alone was sufficient, given the urgency of the issue. Members also discussed the impact of the risk on staff morale and the importance of exploring a wider range of mitigating actions.

The discussed concerns regarding communication, accountability and governance across the organisation and service boundaries, highlighting the need for effective cross-service working, stronger oversight and clearer mitigation plans.

Ms Eleanor Marks requested a clearer assessment of the clinical risk, anticipated trajectory of improvement at the actions required to reduce the risk.

Risk 1032 was also discussed. Members noted concerns regarding the absence of recurrent funding and the likelihood that performance targets would not be achieved. Mr Carruthers advised that the service viewed the risk primarily as reputational rather than clinical in nature and noted that the area was no longer included within the Welsh Government accountability framework. Members requested further consideration of whether the current risk rating remained proportionate.

In considering the Aseptic Unit risk, Mr Henwood reported that infrastructure improvements were underway and expected to be completed by December 2026. Recruitment had strengthened staffing arrangements and reduced reliance on a single point of failure. While support from other Health Boards had been explored, limited assistance was available. Members were advised that the risk score was expected to reduce as improvements were implemented.

The Committee also reviewed overdue audits detailed within Appendix 2. Cllr Evans highlighted the significant number of audits outstanding despite previous correspondence from the Committee requesting updates. Mrs Wilson confirmed that formal escalation processes had been followed and that letters had been issued on behalf of the Committee. Members agreed that the level of outstanding audits limited the Committee's ability to gain assurance.

Discussion also focused on mortuary capacity and associated risks. Members expressed concern regarding the impact of limited capacity on patient and family experience, particularly within older estate facilities. Mr Carruthers advised that current arrangements relied on a memorandum of understanding with Swansea Bay University Health Board and that a broader review of arrangements was required. Members recognised that capacity pressures extended beyond the Health Board and affected external partners, including funeral directors and local authorities.

Due to a lack of assurance, the Committee agreed to ADVISE the Board that further assurance is required and to ALERT the Board to the outstanding audits.

Decision: The Committee was NOT ASSURED by the Assurance and Risk report due to insufficient evidence of the additional actions in place to address the identified concerns and provide assurance on the majority of issues highlighted.

QSEC 26 (61) Allied Health Professions and Health Sciences

Ms Angela Bell presented an update on the Allied Health Professions and Health Sciences Clinical Care Group (CCG), highlighting progress in three key areas: strengthening

governance arrangements, enhancing risk management, and improving the use of the risk register. Members noted that the CCG had achieved 100% compliance with business continuity requirements and had embedded a more structured approach to risk management through regular risk reviews.

Ms Bell outlined work to improve timely and equitable access to services through a Health Board-wide approach to managing demand, reviewing service criteria, and strengthening cross-CCG working. Progress was also reported in relation to organisational change, with consultation completed and leadership posts progressing to recruitment.

Members noted increased incident reporting, which was supporting organisational learning and service improvement. Ms Bell advised that there had been no corresponding increase in reported patient harm. Ms Daniel welcomed this progress and requested that future reports provide greater detail on levels of harm and their impact on access to services.

Discussion also focused on complaints management. Ms Marks noted a reduction in complaints, however queried delays in responding to some cases. Ms Bell explained that complaint responses often required operational input and specialist knowledge from a range of services, highlighting the importance of effective communication across teams.

Ms Bell identified demand management, service efficiency and cross-CCG collaboration as key priorities moving forward. Cllr Evans welcomed the introduction of bi-monthly risk review workshops, which Ms Bell advised had improved both the number and quality of risks recorded on the register. Mr Carruthers noted the importance of maintaining effective communication between CCGs and avoiding silo working. Members understood that concerns regarding communication and collaboration across service and CCG boundaries had arisen in several reports considered by the Committee and suggested that this may represent a wider organisational issue requiring further consideration.

Dr Wooding commented that a lack of engagement and system-wide communication remained a broader organisational risk, while Mrs Patel suggested that future reports should include greater emphasis on patient lived experience.

The Committee received assurance from the update and noted the positive progress in governance, risk management and cross-CCG working.

Decision: The Committee was ASSURED by the quality governance arrangements in place within the Allied Health and Health Sciences Clinical Care Group in relation to quality, safety and patient experience, and noted the evidence of strengthened

governance, improved business continuity compliance, sustained risk oversight and active patient safety governance.

QSEC 26 (62) Facilities

Ms Jo Bradburn introduced the Facilities and Estates reports, noting that the approach aligned with the organisational change programme being led within the directorate. Members agreed that future reporting should present Estates and Facilities as separate items on the Committee workplan.

Ms Elin Brock introduced the Facilities update and advised that the service continued to make progress against its improvement programme. Whilst there was no evidence of widespread deterioration in performance, a number of actions remained in progress to strengthen service delivery. Members noted that robust governance arrangements had been established, including enhanced oversight of cleaning services, and were assured that compliance with food hygiene and allergen standards remained high.

Ms Brock reported that significant recruitment activity was underway to stabilise the workforce, particularly within domestic services. The implementation of the new NHS Wales Standards of Cleanliness had increased expected standards without additional funding, requiring a careful balance of resources between higher and lower risk areas. Cleaning audit performance remained below target, particularly at Withybush Hospital (WGH), primarily due to workforce shortages and sickness absence. Improvement plans were in place, and it was anticipated that performance would improve as newly recruited staff commenced in post during the autumn.

Members noted the development of a quality assurance framework to strengthen performance management and support a more multidisciplinary approach to service delivery and reporting. Work was also underway to better understand patient experience and incorporate this into service improvement.

Cllr Evans queried the declining audit performance and sought assurance regarding the expected trajectory. Ms Brock advised that recruitment and workforce stabilisation should result in improved performance by the end of the year. Mr Prior questioned how the effectiveness of the governance arrangements could be demonstrated. Members emphasised the importance of demonstrating the effectiveness of governance arrangements through measurable outcomes, including consideration of cleanliness standards, infection prevention and control indicators, patient experience and service performance. In response, Ms Bradburn advised that governance structures had previously operated in silos and that preparations for an internal audit would provide further assurance regarding their effectiveness.

Dr Wooding commented that the report was largely descriptive and highlighted the ongoing importance of organisational culture and standards within the service.

Ms Marks emphasised the value of incorporating patient lived experience into future reporting and requested a future deep dive on food and hydration, including information relating to food waste. Members noted that food waste was monitored locally, however not routinely reported at Health Board level. SC

Decision: The Committee was ASSURED by the quality governance arrangements in place within the Facilities Service Group in relation to quality, safety and patient experience, and took assurance that appropriate governance, oversight and monitoring processes were in place to support the delivery of safe and effective services.

QSEC 26 (63) Estates

Mr Simon Chiffi presented the Estates update and reported positive progress in strengthening governance arrangements. Members noted that the Estates Governance Group was now fully established, improving oversight and reporting arrangements across the service. Risk management processes had also strengthened, with a high proportion of actions progressing as planned.

Despite this progress, members recognised the ongoing challenges associated with maintaining an ageing estate and the importance of long-term capital investment. Mr Chiffi highlighted the role of the Targeted Estates Funding (TEF) programme and ongoing work to address infrastructure risks across the estate.

In response to concerns raised by Ms Marks regarding the impact of recent heatwaves, Mr Chiffi acknowledged the vulnerabilities associated with the ageing estate and highlighted ongoing work to replace air-handling systems at Prince Philip Hospital (PPH) through the TEF programme. Members were advised that the heatwave period coincided with these replacement works, resulting in reduced capacity and periods when the system was unavailable.

Mrs Nadine Gould reported findings from a rapid review, noting in the main positive patient feedback regarding staff despite the limitations of the estate. Immediate actions had been implemented, including revisions to uniform standards, and a task and finish group had been established to oversee further improvements.

Cllr Evans highlighted concerns regarding several extreme risks, including longstanding issues relating to data quality and fire safety matters. Mr Chiffi advised that risks were subject to weekly review meetings and that implementation of a new facilities management system would support improved data quality and risk

management processes. Members were advised that further detail would be provided through ARAC reporting.

The Committee received assurance from both updates and noted the ongoing work to strengthen governance, workforce capacity, quality assurance and risk management across the Facilities and Estates services.

Decision: The Committee was ASSURED by the quality governance arrangements in place within the Estates Service Group in relation to quality, safety and patient experience, and took assurance that appropriate governance, oversight and monitoring mechanisms were in place to support the safe, effective and sustainable delivery of services.

QSEC 26 (64) Quality Assurance Report

Ms Cathie Steele presented the Quality Assurance Report and advised that, whilst an appendix had been omitted from the papers, the report reflected the ongoing development of the Health Board's Quality Management System (QMS), which had originally been approved in 2023. Members were informed that a strategic refresh of the QMS had been undertaken to strengthen its application across the organisation and improve the way quality information was reported and used.

Mrs Patel queried whether recurring themes identified within the report were being captured through a standardised approach and enquired whether future reporting could include positive outcomes as well as areas of concern. Ms Steele advised that lessons learned were now being broken down by CCG, which would support greater visibility of quality improvements and organisational learning.

Members discussed changes relating to deprivation of liberty safeguards and the implications of recent legislative developments. Ms Steele explained that relevant data would be reported through the Mental Capacity and Consent Group before escalation through the governance structure to the Committee. She also noted that reporting had moved away from focusing solely on incident types and was increasingly centred on identifying and monitoring improvements arising from incidents.

Dr Wooding sought clarification on how the QMS would drive measurable change. Ms Steele explained that the aim was to demonstrate continuous compliance with the Duty of Quality rather than relying solely on annual reporting, with data from CCGs providing supporting evidence. Members emphasised the importance of demonstrating tangible improvements and measurable impact rather than relying on assurance that improvements would emerge over time. The importance of demonstrating that learning and assurance activity was translating into measurable observable improvements in practice, and patient

outcomes, was highlighted. Mrs Daniel reinforced the need for future reports to clearly evidence outcomes and impact.

Mr Prior expressed concern regarding the number of overdue inspections and suggested that future reports should be more explicit about the areas requiring support and intervention. Ms Steele acknowledged this feedback and advised that future iterations of the report would provide greater detail, including links to wider themes around communication and collaboration between services.

Ms Marks highlighted concerns regarding communication across services. In response, Ms Steele advised that improvements in management oversight were being observed. She also drew attention to a recent increase in mortality indicators, which had been subject to a detailed review and reported through the appropriate governance arrangements.

Mrs Patel sought assurance regarding the trajectory of complaints management and queried whether improvements related solely to response times or to the resolution of concerns. Members were advised that the position was more nuanced than the headline figures suggested. Mrs Louise O'Connor reported that Locality and Operational Complaints Teams were actively managing this work and that the early resolution process was proving effective. It was noted that complaint numbers had reduced significantly, with a reported 70% reduction, and that survey feedback from service users had been largely positive.

Ms Marks emphasised the importance of ensuring that learning was fully embedded and translated into demonstrable improvements. Mrs O'Connor advised that work was underway to capture and share learning arising from complaints, recognising that some of the issues identified were systemic in nature and required organisation-wide solutions.

Decision: The Committee was ASSURED regarding the effectiveness of the Quality Management System controls described within the report, noted the principal themes emerging from incidents, complaints, patient feedback, inquests, regulatory activity and IPC surveillance, and took assurance that learning was being translated into measurable improvement through agreed improvement plans.

QSEC 26 (65) Listening and Learning Sub Committee Update Report and Annual Report 2025/26

Mrs O’Connor introduced the report and shared a patient experience account from a bereaved mother relating to the care during the final weeks of her life.

The account detailed concerns regarding delays in care, inadequate pain management, lack of dignity and respect, inappropriate ward accommodation, inappropriate meal provision with limited engagement and communication from staff during

care. The family described that the patient felt isolated, frightened and uncared for at a time when she most needed compassion and support. Particular concern was expressed regarding the lack of assistance provided when the patient chose to self-discharge and return home, where she was cared for by family members until her death two weeks later.

Members acknowledged the profound impact of the experience on the family and noted that care, compassion and humanity should remain central to patient care regardless of operational pressures. Members reflected that the concerns raised related to systems and processes, as well as issues of dignity, compassion, humanity and patient-centred care. It was recognised that these aspects of care should remain central regardless of operational pressures. Concerns of this nature, particularly following a death, were being reported with increasing frequency and that assurance was required that learning was being embedded across the organisation.

Mrs O'Connor provided assurance that the Head of Nursing was undertaking follow-up work in relation to the concerns raised, including engagement with the staff involved. Members noted that apologies had been offered to the family and that contact had been maintained, including telephone discussions.

The Chair requested that an apology be issued to the patient's mother on behalf of the Committee. LOC

Mr Prior emphasised the importance of ensuring that lessons identified are translated into meaningful and sustainable action. Mr Henwood supported this view, commenting that staff should not require a policy to demonstrate compassion and support towards patients who choose to self-discharge.

Ms O'Connor advised Members that the issues raised would be taken forward through the Sub-Committee's learning processes, with the aim of embedding improvements and implementing actions to help prevent similar experiences occurring in the future.

Decision: The Committee:

- TOOK ASSURANCE from the areas identified by the Sub-Committee as providing assurance. The Committee was assured that appropriate oversight and governance arrangements were in place across the matters reported and that issues requiring further attention had been appropriately highlighted.
- APPROVED the Annual Report 2025/26

QSEC 26 (66) Safeguarding Assurance Report

Ms Charlotte Westacott presented the Safeguarding Assurance Report and noted that safeguarding matters continued to be monitored through established governance arrangements, with significant concerns escalated through the appropriate channels.

Members were advised that demand on safeguarding services continued to increase, with a sustained rise in referrals relating to abuse and neglect alongside growing complexity of cases. There is an increasing number of looked after children across the Hywel Dda area, including children placed outside the Health Board's geographical boundary and, in some cases, in England.

Ms Marks sought assurance regarding the impact of capacity pressures on safeguarding services. Ms Westacott advised that workforce gaps existed within parts of the service and highlighted concerns regarding staff wellbeing and the risk of burnout. Members were informed that discussions were underway with commissioners regarding funding to support additional specialist safeguarding posts, which would significantly enhance capacity and resilience within the service. In addition, engagement was taking place with CCGs to explore opportunities to support and strengthen these specialist roles.

The Committee agreed to ADVISE the Board of the risks associated with workforce and capacity challenges, whilst noting that safeguarding governance arrangements remain in place.

Decision: The Committee WAS NOT ASSURED that safeguarding arrangements could be fully sustained given ongoing workforce instability and service capacity pressures.

QSEC 26 (67) Inpatient Falls Assurance Report

The Committee received an update from Mrs Anna Chiffi on the work of the Inpatient Falls Group and the progress made over the previous 12 months. Mrs Chiffi noted the national move away from the use of the term "falls" towards a broader preventative approach focused on patient safety and mobility.

It was reported that a System Wide Safety Mobilisation Group had been established to provide broader oversight and promote a more preventative approach to reducing inpatient falls and associated harm. Members were advised that increasing levels of frailty, dementia and delirium amongst the patient population continued to present significant risks. Challenges remained regarding the consistent completion of risk assessments, workforce pressures and environmental factors that could contribute to incidents.

The overall number of inpatient falls has remained stable, with the majority of incidents resulting in low or no harm, with more serious incidents escalated for detailed review through the appropriate governance arrangements.

Significant progress had been made across a number of improvement initiatives such as the introduction of a decaffeinated drinks project at Bronglais Hospital (BGH) based on evidence linking caffeine consumption with an increased risk of falls. Under

the initiative, decaffeinated drinks had become the default option, whilst caffeinated alternatives remained available.
Mr Prior questioned whether the decaffeinated drinks initiative could be implemented across the Health Board. Ms Chiffi explained that, whilst there would be a financial impact associated with wider rollout, this may be balanced by reducing the length of hospital stays.

Cllr Evans queried whether increasing the number of water stations would be beneficial. In response, Ms Chiffi advised that water machines were now available across all acute departments and that additional hydration rounds had been introduced during periods of hot weather to support patient hydration. Ms Daniel noted, however, that water dispensers can present infection prevention and control risks, and therefore require appropriate oversight and management.

Ms Marks welcomed the increased focus on preventative measures and sought clarification regarding the Committee's role in supporting future developments. Ms Chiffi advised that work was underway to develop a system-wide strategy and a more consistent, structured approach to falls prevention across the organisation. The Committee's support in promoting consistency and maintaining oversight of progress would be valuable.

In concluding discussion, Ms Marks emphasised the importance of ensuring that issues raised through Board and Committee structures remained subject to ongoing oversight and follow-up, to ensure that identified improvements were implemented and sustained.

Decision: The Committee was ASSURED by the strengthening of governance, system-wide oversight and improvement activity, including the implementation of the Safer Mobilisation Group and the transition to a fully integrated, prevention-focused approach to reducing falls-related harm.

QSEC 26 (68) Management of Outpatients

The Committee received an update from Ms Lisa Humphrey on the management of outpatient follow-up waiting lists and the actions being taken to address delays in patient care.

Members were advised that approximately 72,500 patients were awaiting follow-up appointments, representing the lowest follow-up waiting list position in Wales. Whilst a significant proportion of patients were not experiencing clinically harmful delays, the Committee understood that some patients had exceeded their planned follow-up date by 100% or more. These patients formed part of a material quality list and were subject to clinical review processes to assess and manage risk. Ongoing work was focused on clinically led pathway improvements, patient pathway management and the implementation of a closed-loop response process to ensure appropriate oversight of patients awaiting

follow-up. The Committee was informed that ophthalmology continued to represent the largest specialty by volume and required a risk-based approach, recognising that patients have differing levels of clinical need. Whilst the ophthalmology waiting list had reduced, progress since April 2026 had been gradual.

Members were advised that 18 incidents of harm associated with delayed follow-up had been reported. However, the Health Board was not seeing significant levels of harm overall.

It was noted that work is underway to transfer suitable patients onto alternative pathways where clinically appropriate, supported by the waiting list team and ongoing communication with patients regarding their care options.

Dr Wooding commented that future reports would benefit from greater analysis and insight, rather than primarily describing activity being undertaken. Mr Evans queried whether the Welsh Government Strategic Group was being appropriately engaged in addressing the challenges associated with outpatient waiting lists.

Mr Henwood advised that a transformation process for outpatient services had recently been launched. Whilst acknowledging the significant challenges and deficits within the current outpatient model, he emphasised that there were considerable opportunities for improvement. Members that delivering sustainable change would require challenging decisions and changes in established clinical practice. It was also recognised that there remained opportunities to review the volume of follow-up appointments being undertaken and to ensure patients were only followed up where clinically necessary.

The Committee acknowledged that the key areas requiring further improvement had been identified and agreed that a further update should be presented in six months' time to provide assurance on progress against the outpatient transformation programme and associated workplan. AC/LH

Decision: The Committee TOOK ASSURANCE that progress is being achieved to mitigate harm to delayed follow up patients, and further work is in development as detailed in the report.

QSEC 26 (69) Epilepsy in Learning Disabilities Services

Ms Olwen Morgan presented an update on Epilepsy in Learning Disabilities Services, including progress against the recommendations arising from the Ombudsman’s report. She advised that the Task and Finish Group had completed the required actions and that the Ombudsman had confirmed satisfaction with the Health Board’s response.

A revised pathway for Epilepsy Services was approved in January 2026, although no audit has yet been undertaken to assess its effectiveness. Ms Morgan highlighted that some families continued to have concerns regarding the revised arrangements,

particularly in relation to crisis management for adults with learning disabilities and epilepsy, making it difficult to provide full assurance that the pathway is fit for purpose.

Ms Dana Scott explained that the initial audit had raised further queries and highlighted the need for a broader service review. An audit tool was being finalised, with audit activity expected to commence in September and October 2026. The findings would assist in testing the effectiveness of the pathway and inform future service development. Members were also advised that discussions were taking place with Swansea Bay University Health Board to strengthen access to specialist neurological services.

Dr Wooding reflected on his involvement at the outset of the work and observed that previous arrangements had not always demonstrated sufficient compassion towards families. He stressed that an important measure of success would be the extent to which families themselves felt confidence in the service and the care being provided.

Mr Imperato commented on the use of corporate language within reports and discussions. In response, Ms Marks emphasised the importance of ensuring that communications remained kind, compassionate and centred on the experiences of patients and families. Mrs O'Connor added that it was important for the Health Board to be able to demonstrate that it had delivered the improvements it had set out to achieve.

Ms Scott thanked Ms Morgan for the significant time and commitment she had dedicated to engaging with families and ensuring that their experiences informed the work of the Committee. Ms Marks also thanked Ms Morgan for her valued contribution to the Committee, noting that this would be her final meeting prior to retirement, and wished her well for the future.

Whilst recognising the progress made, the Committee agreed that further assurance would be required following completion of the planned audit and pathway review. The Committee received assurance on progress to date and requested a further update following completion of the audit work.

Decision: The Committee TOOK ASSURANCE on the compliance with the PSOW Public Interest Report (2025) recommendations and the progress in the review of the Learning Disabilities pathway and provision.

QSEC 26 (70) Escalation Report

Ms Dana Scott presented the Escalation Report, advising that the format had been developed following discussions with NHS Performance and Improvement. The report considered impacts across all four escalation levels and sought to ensure that quality and safety considerations were embedded throughout the escalation framework. Members were advised that work would

continue over the coming weeks to strengthen the alignment between escalation processes and quality and safety measures.

The Committee was also informed of ongoing All-Wales work relating to the transition from children's to adult services.

Ms Marks highlighted the importance of demonstrating to Welsh Government that the Health Board was capable of meeting de-escalation criteria. She noted variation in practices across wards and queried whether any immediate actions could be taken to support improvement. In response, Ms Scott explained that IPC measures were underpinned by behavioural science and that perceptions of risk could influence compliance and practice.

During discussion, Dr Wooding queried whether staff viewed IPC requirements as mandatory. Ms Scott responded that greater emphasis was required on demonstrating the link between how compliance and reduced patient harm, helping to reinforce the risks and consequences of non-compliance across the organisation.

Ms Marks also queried whether a deeper review of access issues was required. Members understood that Welsh Government was actively considering this matter and that sustained escalation continued to place a significant impact on the organisation's overall standing and performance.

Decision: The Committee RECEIVED ASSURANCE from the improvement programme and monthly case review, while recognising that compliance gaps in technique and training remain the principal barrier to sustained de-escalation.

QSEC 26 (71) 309 - Continuing NHS Healthcare Operational Policy to Support Framework for Implementation

No comments were raised in respect of Policy 309: Continuing NHS Healthcare Operational Policy to Support the Framework for Implementation, and the policy was approved.

Decision: Policy 309 - Continuing NHS Healthcare Operational Policy to Support Framework for Implementation was APPROVED.

QSEC 26 (72) 1097 Corporate Safeguarding Policy

No comments were raised in respect of Policy 1097: Corporate Safeguarding, and the policy was approved.

Decision: Policy 1097 - Corporate Safeguarding Policy was APPROVED.

QSEC 26 (73) 982 Incident, Near Miss and Hazard Reporting and Management Procedure

No comments were raised in respect of Procedure 982 Incident, Near Miss and Hazard Reporting and Management, and the procedure was approved.

Decision: Procedure 982 - Incident, Near Miss and Hazard Reporting and Management Procedure was APPROVED.

QSEC 26 (74) QSEC Work Plan 2026/27

No comments were made on the Work Plan.

QSEC 26 (75) Date of Next Meeting : 8 October 2026

QUALITY, SAFETY AND EXPERIENCE COMMITTEE (QSEC)/ PWYLLGOR ANSAWDD, DIOGELWCH A PHROFIAD
11/08/2026
TABLE OF ACTIONS/TABL GWEITHREDOEDD

Key: AC-Andrew Carruthers; LOC-Louise O'Connor; SC-Simon Chiffi

MEETING DATE	MINUTE REF	ACTION	LEAD	TIME SCALE	PROGRESS
11/08/2026	QSEC(26)59	Urology Deep Dive and Carers Story • To provide an update on the Urology Improvement Plan in 6 months time.	AC	09/03/2027	Complete Forward planned for February 2027
11/08/2026	QSEC(26)62	Facilities (Deep Dive) • To provide a deep dive on food and hydration, particularly in relation to food waste.	SC	03/12/2026	Complete Forward planned for December 2026
11/08/2026	QSEC(26)65	Listening and Learning Sub Committee Update Report and Annual Report 2025/36 • To send an apology letter to the individual identified in the patient experience story on behalf of the Committee.	LOC	08/10/2026	Complete Letter sent Monday 7th September
11/08/2026	QSEC(26)68	Management of Outpatients • To provide a further update in 6 months time to provide assurance on progress against the outpatient transformation programme and associated workplan.	AC	09/03/2027	Complete Forward planned for February 2027

2

2 - Escalation Report- Executive Leads

For assurance

Attachments

QSEC Escalation Update - October 2026 .pdf

Targeted Intervention Escalation Update: Hospital-Acquired Infections and Access

Lead Executive: Mrs Sharon Daniel, Executive Director of Nursing, Quality and Patient Experience
Report author: Mr Shaun Ayres, Director of Delivery

Where the position has moved

Purpose. This report brings the Committee up to date on the three hospital-acquired infection de-escalation criteria and on access, the second strand Welsh Government have asked the Health Board to examine. It adds the compliance position on nationally reportable serious incidents.

What has improved. E. coli fell to four hospital-onset cases in August, the first month at or below target since April. S. aureus reached its target of two in July. Access-linked incidents fell from 541 in the first eight months of 2025 to 451 in the same period this year, a fall of 17% against a 5% fall in all incident reporting. Serious incident investigations running beyond ninety working days fell from 68.4% in June to 29.2% on 7 September 2026.

What has not. C. difficile has moved the other way and is the clearest concern in this report. Cases have exceeded the monthly target in each of the last five months and July was the highest month recorded since this series began in 2023. Of the four access themes the Committee was asked to consider in August, three are still rising, and discharge planning has worsened since the spring.

What it means for de-escalation. One criterion has a realistic route to being met this autumn. On current performance the other two do not, and the rating for C. difficile moves to Alert.

Current Position

None of the three organisms has achieved the de-escalation standard, which requires monthly cases at or below the threshold for three consecutive months.

C. difficile moves from Advise to Alert. Five consecutive months above target, and a rise in the mean rather than one poor month, no longer supports the previous assessment of Advise.

S. aureus and E. coli remain Alert. Each reached its target in a single month during the year, so the thresholds are reachable. Neither has held a run.

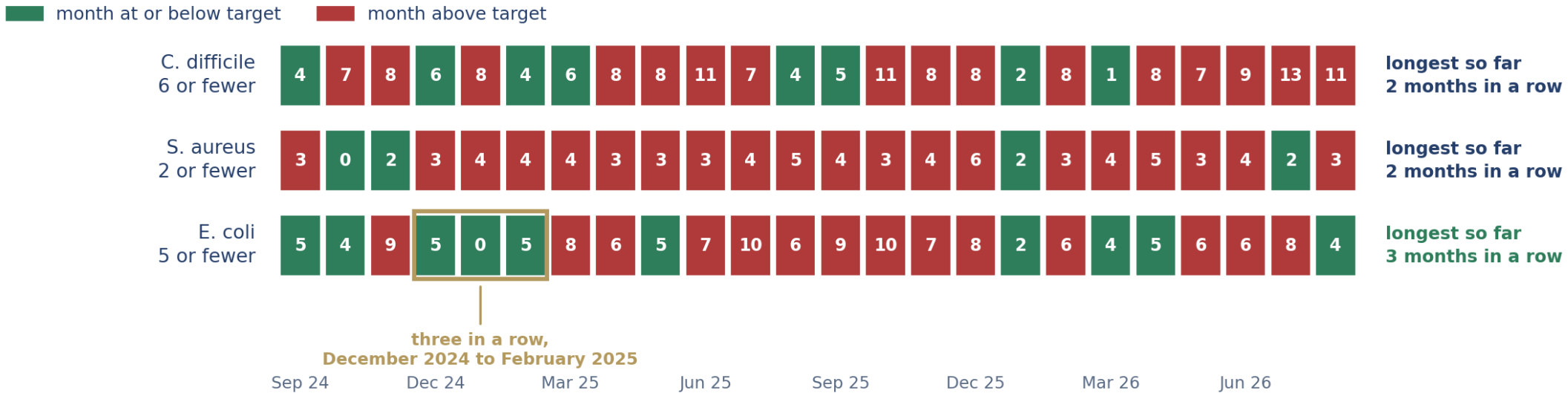
E. coli is the one to watch. August at four cases opens a window that closes at the end of October. Two more months at five or fewer would give the Committee its first completed criterion in this domain.

Organism	Rating	2026/27 to date	Months at target in the last 12 months	Earliest completion
C. difficile (≤6)	ALERT	9.6	3	End November
S. aureus (≤2)	ALERT	3.4	2	End November
E. coli (≤5)	ALERT	5.8	4	End October

Mean monthly cases April to August 2026. Months at target counts September 2025 to August 2026. Earliest completion assumes the target is met from September onwards.

How the three-month standard works

The test is not whether we can reach the target in a single month. It is whether we can reach it three months in a row. A good month on its own does not meet the de-escalation target, and one month above target means we start counting again from the beginning.



We do reach the target. Over the last two years we were at or below target in eight months for C. difficile, four for S. aureus and ten for E. coli. These are levels we touch regularly.

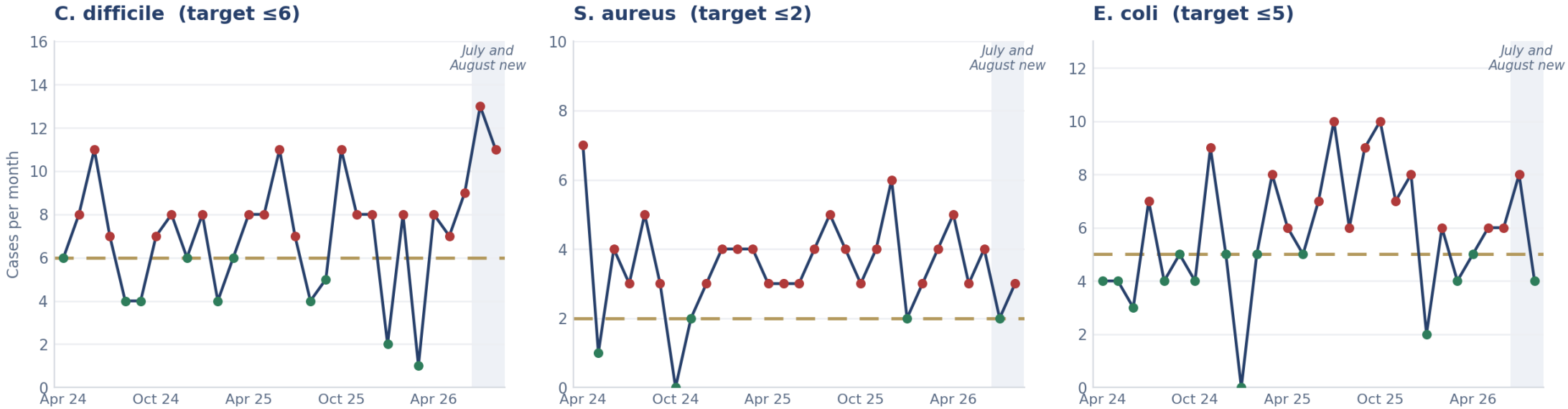
We do not stay there. The longest we have managed is two months together for C. difficile, ending March 2025, and two for S. aureus, ending November 2024. E. coli managed three together, from December 2024 to February 2025, then went back above target in March, so the improvement did not last.

The problem is staying at the target rather than getting to it. That is what the improvement programme has to change.

The infection trend at a glance

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Hospital-onset infections: monthly trend, April 2024 to August 2026



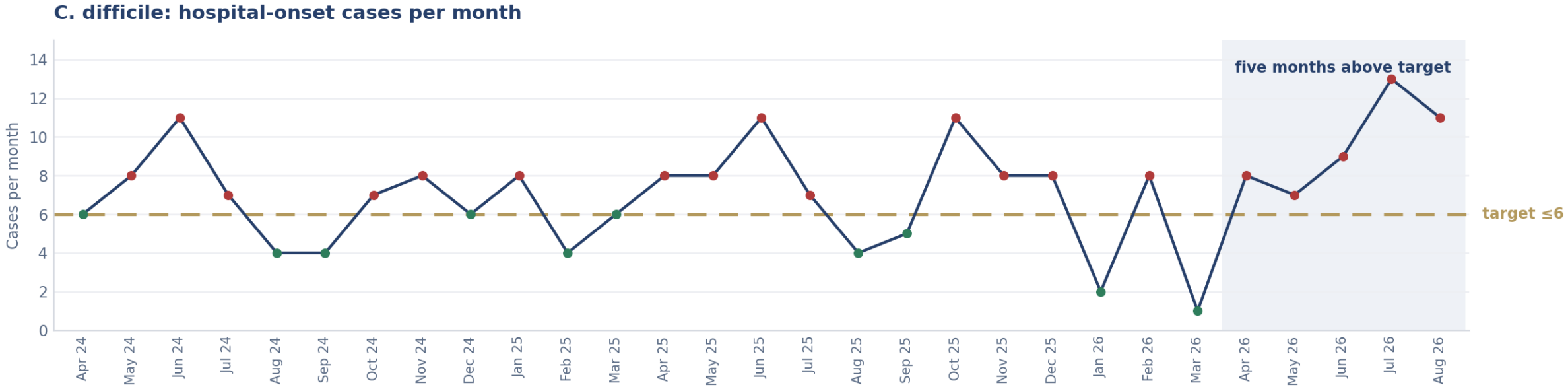
Green points show months at or below target; red points show months above it. The shaded band is new since the Committee last saw this data.

C. difficile: a mean of 6.8 in 2025/26 has risen to 9.6 across the five months of 2026/27 so far, against a target of 6. July reached 13, the highest month in the series.

S. aureus: 3.7 in 2025/26 and 3.4 so far in 2026/27, against a target of 2. July met the target for only the second time in twelve months, and the July and August average of 2.5 is the closest the organism has come.

E. coli: 6.7 in 2025/26 and 5.8 so far in 2026/27, against a target of 5. August fell to 4, the lowest month since March.

C. difficile: five months above target



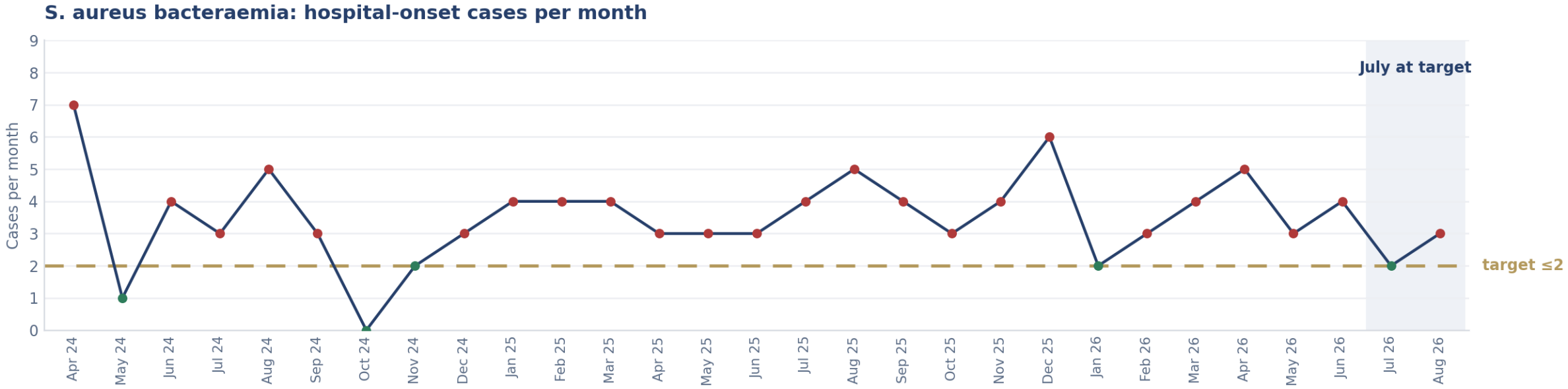
Target. Reduce hospital-onset cases by 25% to no more than 6 per month, sustained for three months. The 2025/26 mean was 6.8. The five months of 2026/27 so far average 9.6 (April 8, May 7, June 9, July 13, August 11).

What the data tells us. The last month at or below target was March. Since then, the count has not fallen below seven, and July at 13 is the highest month since this series began in March 2023. This is a sustained shift rather than a single spike.

What the actions are doing. Electronic prescribing and medicines administration is being introduced to strengthen antimicrobial stewardship, the NHS Wales Prevent C. difficile campaign launched here in June, and cases are reviewed monthly at the assurance group. Against that, four cases of cross-infection were reported on Ward 4 at Withybush Hospital in August, arising while wards were relocated into the Ward 3 footprint for fire improvement works.

Assessment. The rating moves to Alert. The earliest the criterion could now be met is the end of November, and that needs the count back to six or fewer from September.

S. aureus: the target achieved in July



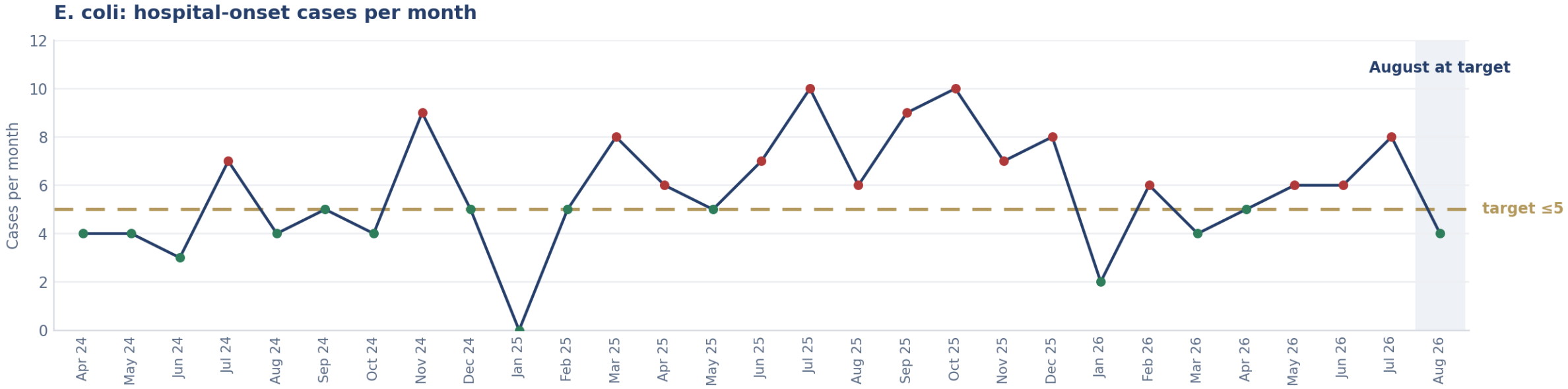
Target. Reduce hospital-onset cases by 33% to no more than 2 per month, sustained for three months. The 2025/26 mean was 3.7; 2026/27 so far averages 3.4 (April 5, May 3, June 4, July 2, August 3).

What the data tells us. July at two cases was the first month at target since January and the second in twelve months. August returned to three. The underlying level has edged down, from a first quarter mean of 4.0 to 2.5 across July and August, which is the closest the organism has come to the threshold.

What the actions are doing. Device-related, wound and musculoskeletal sources predominate, so the insertion and maintenance of invasive devices is where prevention has most effect. Aseptic non-touch technique, the standard method for handling devices and wounds without introducing infection, remains the focus. Care groups monitor compliance, assessor training is offered to clinical areas and high-rate areas are shared monthly.

Assessment. The rating remains Alert because no run has been held. A September at two or fewer would put the criterion within reach by the end of November.

E. coli: a window has opened



Target. Reduce hospital-onset cases by 25% to no more than 5 per month, sustained for three months. The 2025/26 mean was 6.7; 2026/27 so far averages 5.8 (April 5, May 6, June 6, July 8, August 4).

What the data tells us. August at four cases is the lowest month since March and the fourth month at or below target in the last twelve. The longest run so far in this reporting period is two months, March and April. Urinary tract and catheter-associated sources predominate, and community-onset infection far exceeds hospital-onset, so prevention reaches beyond the hospital.

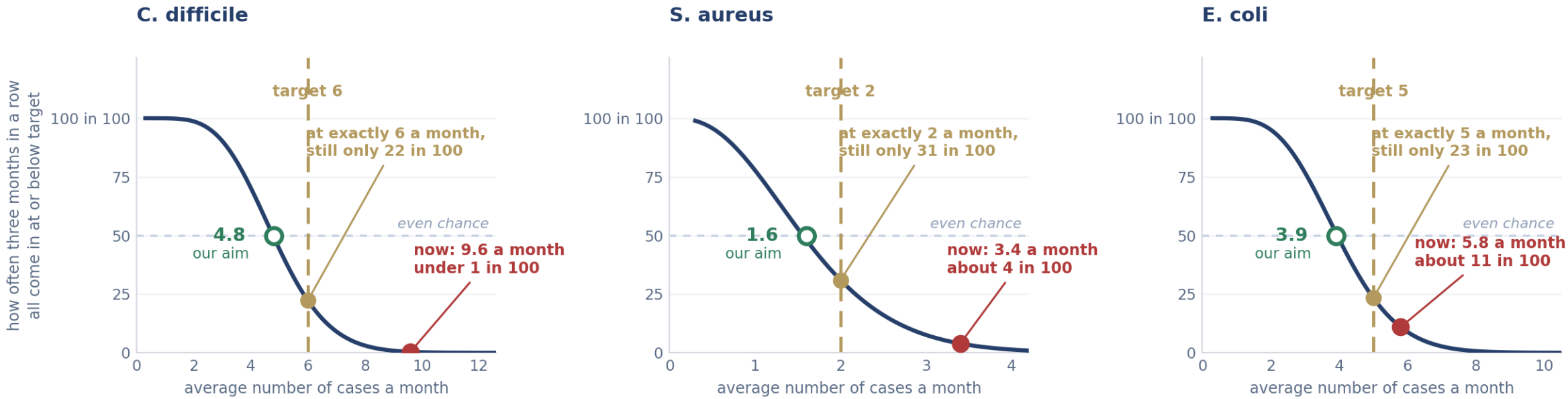
What the actions are doing. A urinary tract infection quality improvement programme is in development. Hand hygiene observational audits and infection prevention validation audits continue. Catheter avoidance, prompt removal and hydration are the levers that move this organism.

Assessment. The rating remains Alert until a run is held. September and October at five or fewer would meet the standard, and this is the single clearest opportunity in the report.

Why we have to aim below the target

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These are small numbers, so the count moves up and down from month to month even when nothing about our practice has changed. That movement decides whether any single month comes in at or below target and needing three months in a row makes it matter three times over.



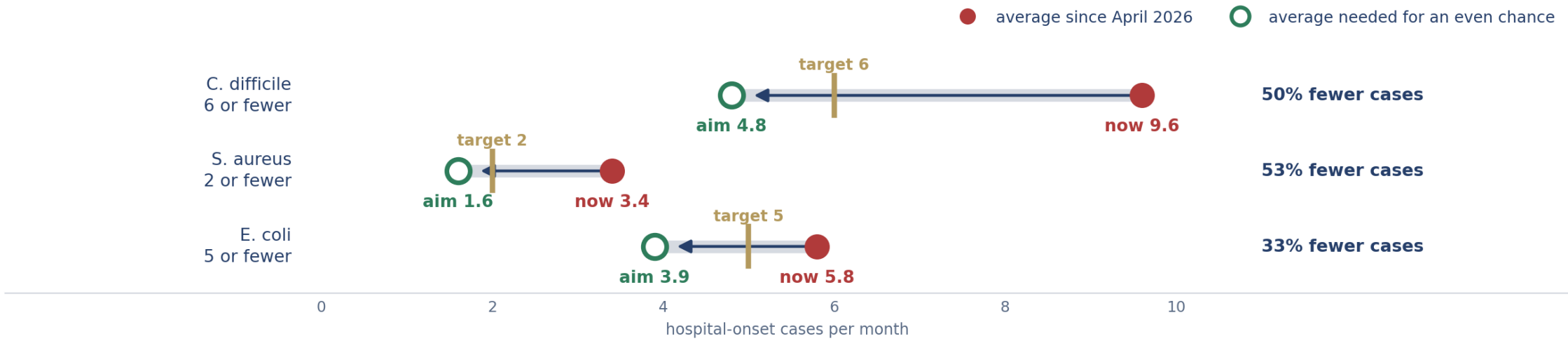
How to read the charts. Along the bottom is the average number of cases we record in a month. Up the side is how often three months in a row would all come in at or below target. The gold line marks the target.

What they show. Hitting the target on average is not enough. If C. difficile averaged exactly six cases a month, only about 22 three-month stretches in every 100 would have all three months at or below six. At our current average of 9.6 it is fewer than 1 in 100. E. coli, at 5.8, is about 11 in 100, so August followed by September and October is possible but unlikely at our current level.

What these numbers are. They say how often something would happen at a given level of infection. They are not a prediction for this autumn. The only way to move them is to bring the average number of cases down.

The level we need to get to

If we aim at the level where three months in a row becomes an even chance, each organism has a single number to work to. In all three cases that number is about a fifth below the target.



What this means. C. difficile has to halve, from an average of 9.6 cases a month to about five. S. aureus has to come down by about half, from 3.4 to between one and two. E. coli needs a third fewer, from 5.8 to about four, and is the closest to three months in a row this autumn.

What we are doing. We are managing the improvement programme against the average number of cases a month, rather than against whether we pass or fail in a single month, because the average is what aseptic technique, catheter care and antimicrobial stewardship actually change. Closing the technique and training gaps set out later in this pack is the first call on that work, and C. difficile is where the effect will show first.

What we ask of the Committee. To consider the average number of cases a month alongside the criterion from November, so the Committee can see cases falling even in months when we do not meet the target, and support for agreeing with Welsh Government how we will evidence the standard has been met when we reach it.

What the infections are telling us

Taken together, the three organisms point at a small number of modifiable drivers rather than isolated events.

Invasive devices. S. aureus remains concentrated in device, wound and musculoskeletal sources. This is the clearest line of preventable harm and the strongest argument for reliable aseptic technique.

Urinary tract and catheter care. E. coli is dominated by urinary sources, with most infection arising in the community. Catheter avoidance, prompt removal and hydration are the levers, and they reach beyond the hospital.

Antimicrobial use and the environment. C. difficile tracks antibiotic exposure and environmental contamination. Three periods of increased incidence were notified nationally over the summer: scabies on Cadog Ward at Glangwili in July, scabies on Dewi Ward in August, and C. difficile cross-infection on Ward 4 at Withybush, the last of these while wards were relocated for fire improvement works. Estate pressure and decontamination therefore sit alongside prescribing as one consideration.

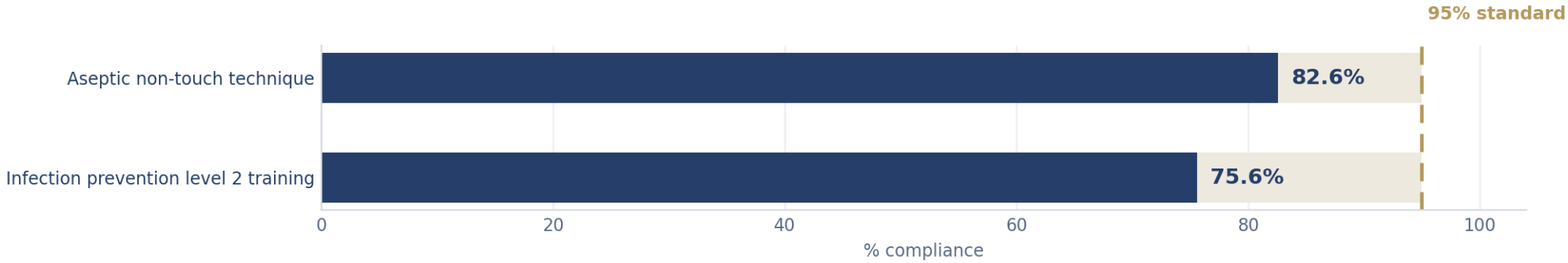
The common thread is unchanged from August. The interventions are known and in place. The gap is reliable, everyday delivery at ward level, and the C. difficile position is what that gap now looks like in the data.

Where assurance is not yet complete

In August we identified two compliance gaps as the principal barrier to sustained de-escalation. These remain the latest figures reported to the Committee.

Technique. Aseptic non-touch technique compliance sits below the 95% standard and varies widely across clinical areas, from below 50% to 100%. Competency assessment is not yet mandatory on the electronic staff record, which limits the assurance we can give.

Training and the environment. Infection prevention level 2 training is below the required standard and the assessment against the national cleaning standards for Wales was not complete at the last report.



Why this matters now. C. difficile has deteriorated across the same months in which these gaps have stayed open. That is not proof of cause, but closing them is the most direct route back to target.

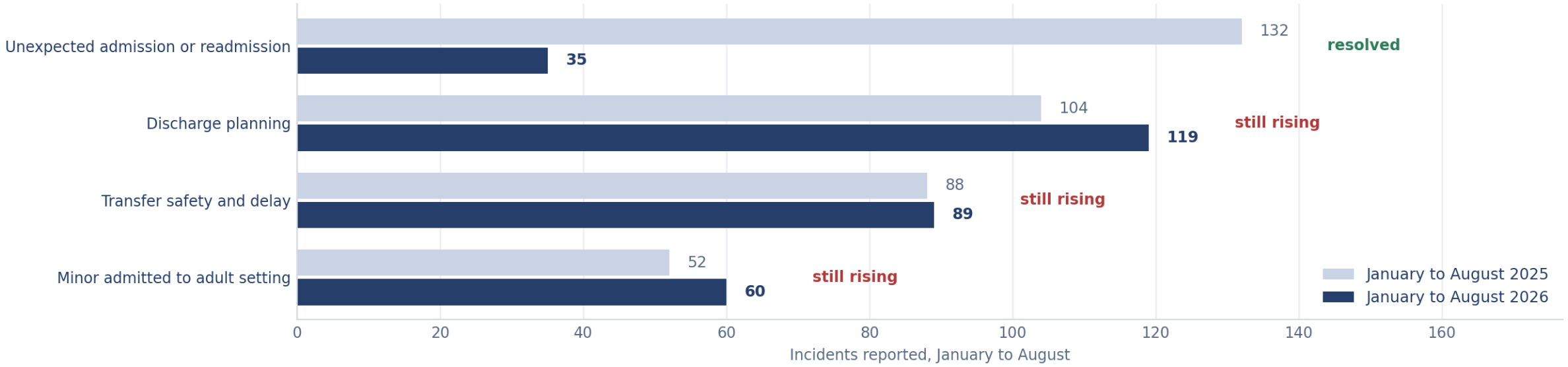
Key risks and next steps

Risks. C. difficile has been above target for five consecutive months and now carries the highest risk to de-escalation in this domain. S. aureus and E. coli remain above threshold, although each reached target within the year. Compliance gaps in technique and training limit what the improvement programme can deliver. Negative pressure isolation capacity remains a red-rated infrastructure risk for high consequence infections.

Next steps. Return C. difficile to six or fewer cases a month from September and hold it. Hold E. coli at five or fewer through September and October to complete the three-month standard. Bring aseptic technique compliance to the 95% standard and pursue mandatory competency on the electronic staff record. Complete the cleaning standards assessment. Progress the urinary tract infection quality improvement programme. Continue to develop options for compliant isolation facilities for future executive consideration.

Trajectory. The assessment assumes no further deterioration and depends on consistent ward-level delivery.

Access: what we said in August



In August we flagged four access themes as rising and asked the Committee to focus on them. Two months on, one has resolved/progressed and three have not.

Unexpected admission and readmission has fallen sharply, from 132 incidents in the first eight months of 2025 to 35 in the same period this year. The fall is steady from the autumn of 2025 rather than a single step, and is concentrated in escalation to high dependency care. The Committee may wish to seek assurance from the care group on what has driven it.

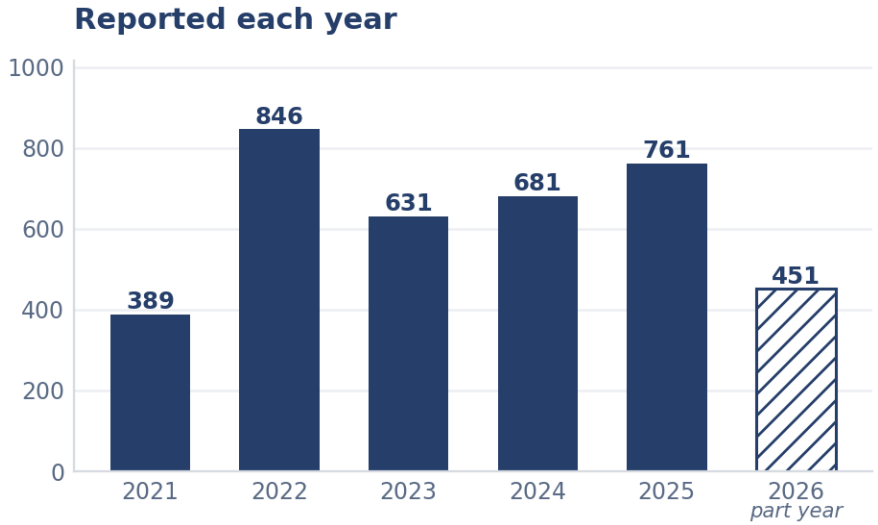
Discharge planning has worsened. Discharge incidents rose from 104 to 119, and within them the failure we named in August, a service referral not being made, rose from 13 to 49. Nineteen of this year's 49 arose at the emergency departments in Glangwili and Withybush.

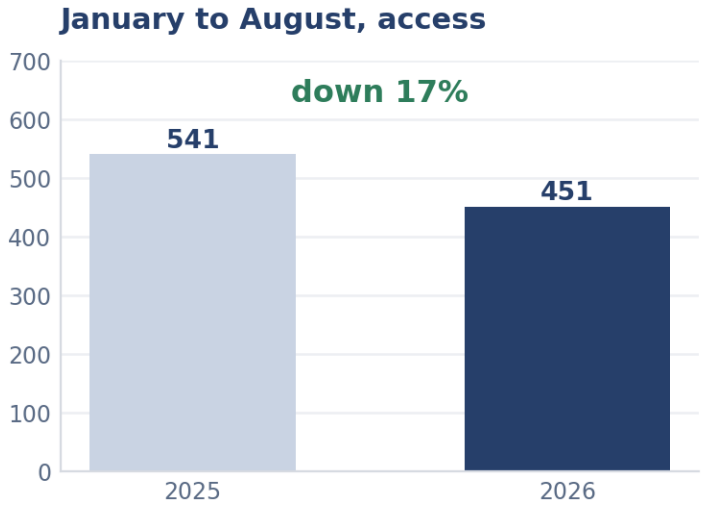
Transfer is flat in total but the safety component is rising: inappropriate or unsafe transfers rose from 38 to 46, and August was the busiest month in the period at 18 transfer incidents.

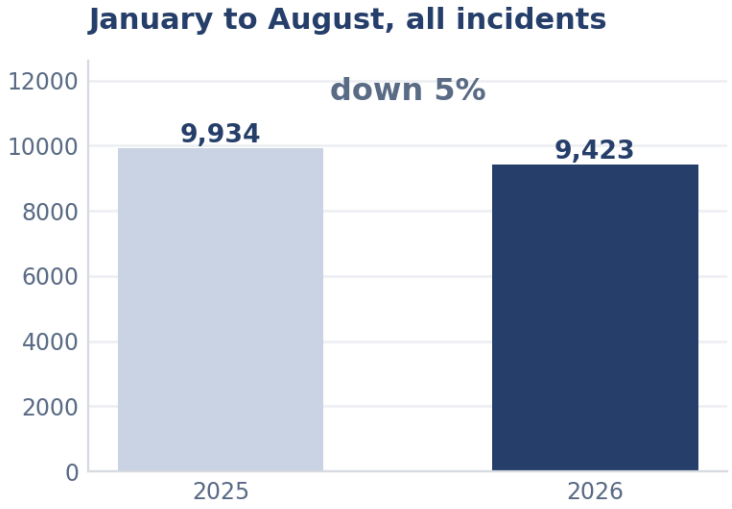
Admission of a minor to an adult setting continues to rise, from 52 to 60, and has already passed its 2024 full-year total of 59. The safeguarding concern we raised in August stands.

Access-linked incidents: where we stand

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Scale. We have recorded 3,759 access-linked incidents since 2021, covering delayed access and admission, transfers and discharge. The 2026 figure runs to the end of August and is provisional.

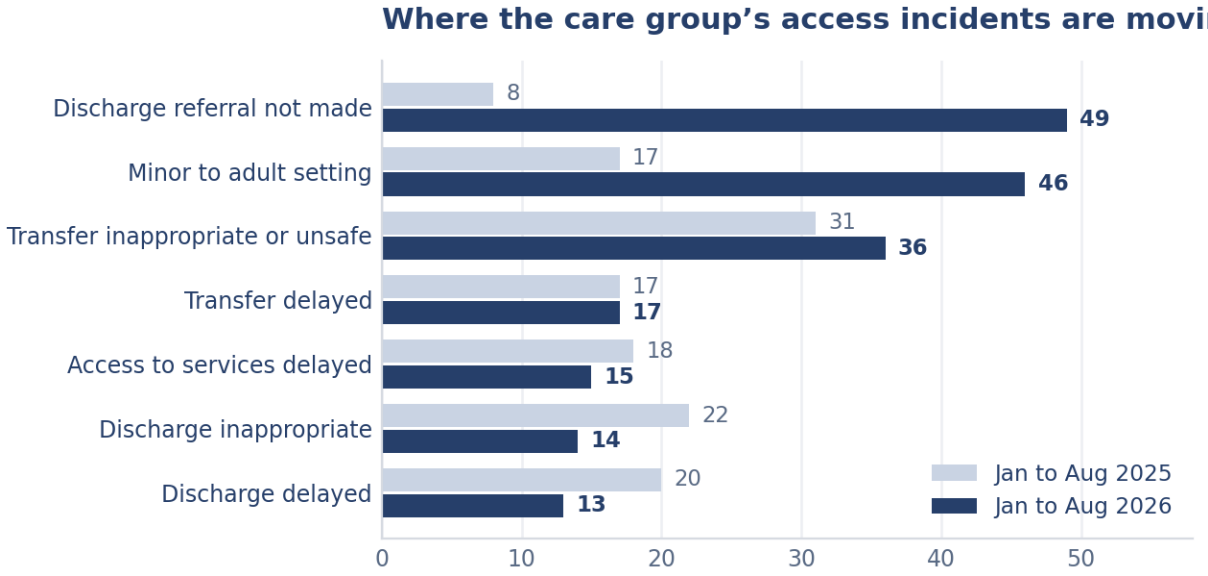
Direction. Access-linked incidents fell from 541 in the first eight months of 2025 to 451 in the same period this year, a fall of 17%. All incident reporting fell by 5% over the same period, so access pressure is easing faster than reporting overall. This is the clearest positive movement in the access data.

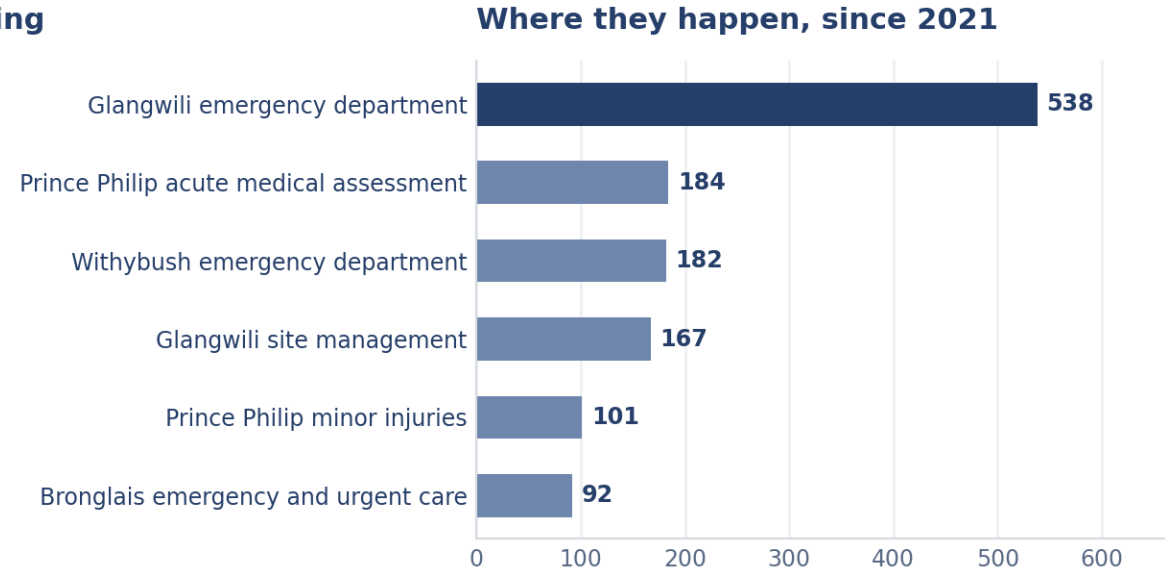
Harm. Most cause no or low individual harm. Ninety-five have reached moderate or greater harm since 2021, including seven severe or catastrophic. The value of this data is as a leading indicator of flow and access pressure rather than as a harm count.

Closure. A hundred and thirty-five of this year's access incidents have yet to complete a post-investigation harm assessment, against thirty at the same point last year. Across all incidents from 2025 onwards, 1,562 remain open beyond sixty days and 1,128 beyond a hundred and twenty, two-thirds of them within Community and Integrated Medicine. Closure timeliness is therefore a live assurance question alongside the volumes.

Review: incidents in unscheduled care

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board





Shape. The attached highlights access incidents within Community and Integrated Medicine, our Urgent and Unscheduled Care Group. 2,151 of the 3,759 access-linked incidents since 2021 sit there, and in the first eight months of this year the care group recorded 279 against 255 last year. While the Health Board total has fallen, this care groups has not.

Where it concentrates. Two themes account for almost all of the movement. A service referral not being made on discharge rose from 8 to 49, and admission of a minor to an adult setting from 17 to 46. Forty-three of this year's sixty minor admissions were reported on Merlin Ward at Glangwili and a further eleven on Morlais Ward, so the theme sits in one hospital.

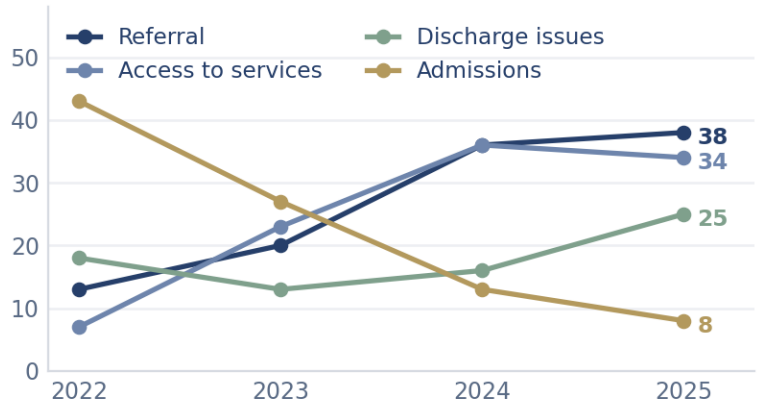
Where it happens. Glangwili emergency department accounts for 538 of the care group's access incidents since 2021, the largest single location by a wide margin, followed by the acute medical assessment unit at Prince Philip and the emergency department at Withybush.

What this suggests. Two responses would address most of the movement. Completing the discharge referral before a patient leaves the emergency department is a process fix within the care group's control. The pathway for young people presenting to adult settings reflects the availability of age-appropriate placements and needs a joint response with Mental Health and Learning Disabilities.

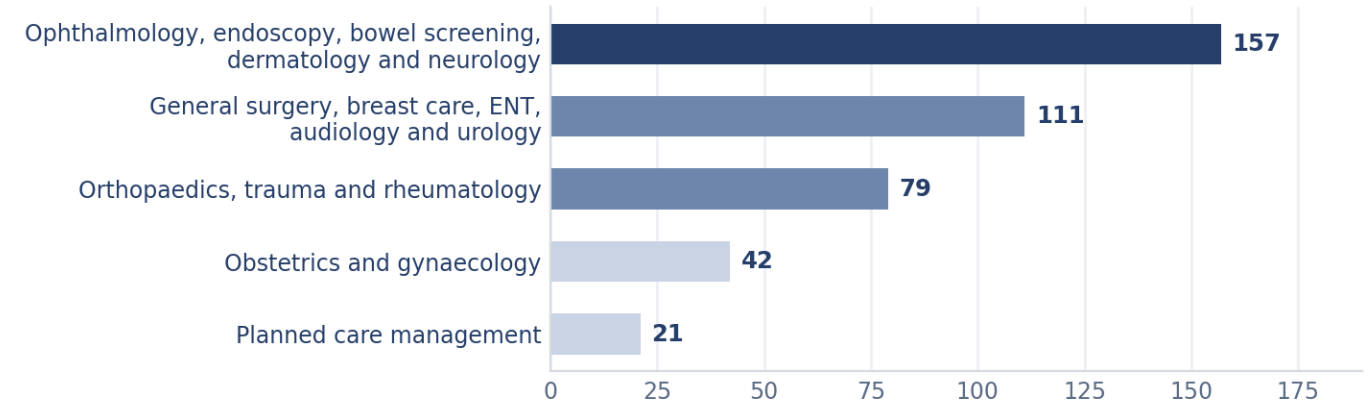
Review: complaints in Planned and Specialist Care

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

The themes behind appointments, Planned and Specialist Care



Where they concentrate, since 2025



Appointments, the largest theme by far, ran between 259 and 361 a year over the same period.

The review into access complaints within Planned and Specialist Care. 1,771 of the 2,621 access-related complaints since 2021 sit there, in our elective and outpatient services.

What people/patients complain about. Appointments dominate, at 1,347 of the 1,771. A delay in an appointment, waiting time or transport accounts for 604 of those and a cancelled appointment for a further 394. Behind appointments, referral rose every year to 2025 while admissions fell from 43 a year to 8, and within referral a delayed referral is the reason in 70 of 123 cases.

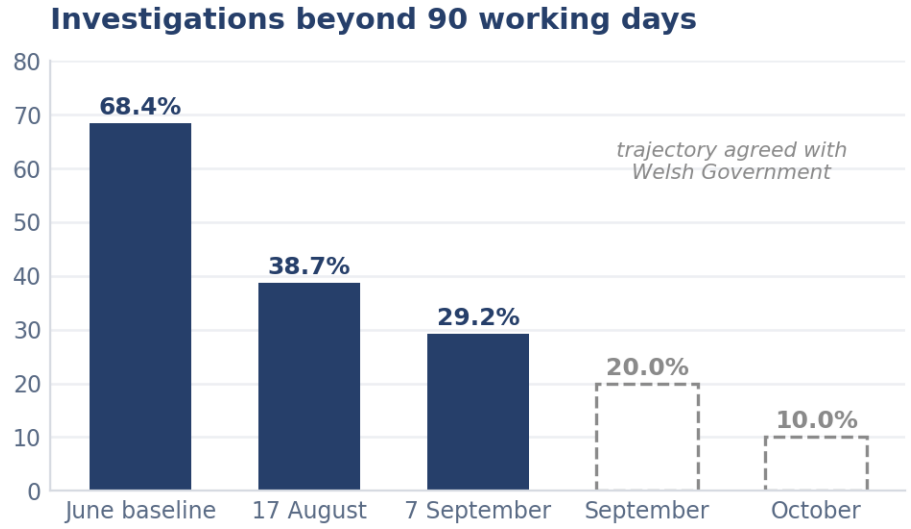
Where it concentrates. Since the start of 2025, three service groups account for most of the volume: ophthalmology, endoscopy, bowel screening, dermatology and neurology at 157; general surgery, breast care, ear nose and throat, audiology and urology at 111; and orthopaedics, trauma and rheumatology at 79.

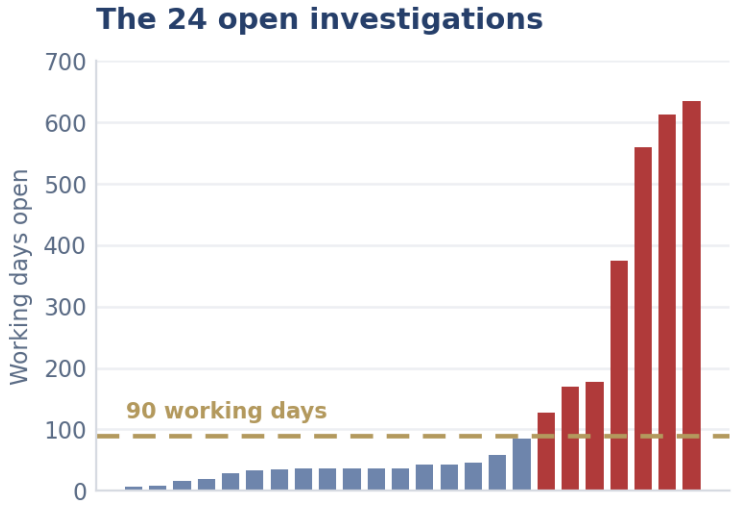
Outcome and harm. Of the 388 access complaints received here during 2025, 77 were upheld and 17 were graded at moderate harm or above on receipt. Volumes for 2026 are part-year and a material share of this year's complaints are still in progress, so this year's totals are not yet comparable.

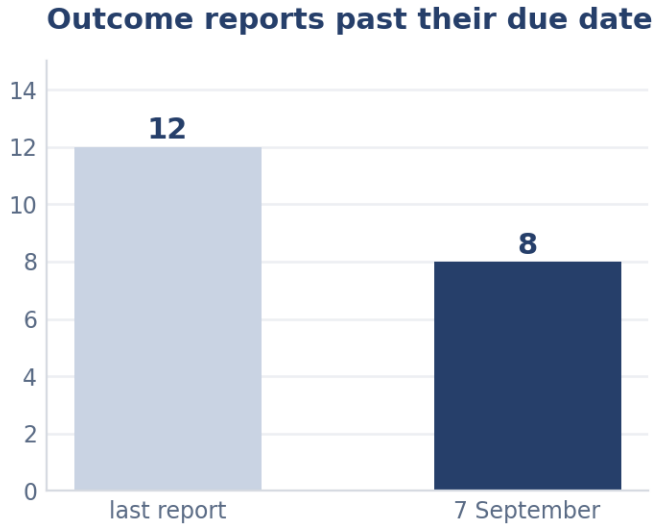
Reading the two lenses together. Complaints point at the planned and outpatient pathway; incidents point at unscheduled flow. Both converge on the same three levers: appointment and waiting time, referral completion, and discharge.

Nationally reportable incidents

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Nationally reportable incidents are the serious incidents every health board must notify Welsh Government of. Closure timeliness are managed rather than the number open, so stronger reporting is never discouraged.

The position. Twenty-four investigations are open. Seven have been open beyond ninety working days, 29.2% of the total, down from 38.7% at 17 August and 68.4% at the June baseline. NHS Wales Performance and Improvement recorded a significant reduction in overdue investigations on 4 September. The eight investigations whose outcome report has passed its due date are down from twelve at the last report.

Against trajectory. The profile agreed with Welsh Government is 20% in September and 10% or fewer in October. At 29.2% the Health Board are three cases short of the September point.

Where the difficulty sits. Five of the seven longest-running investigations are in Mental Health and Learning Disabilities and three of those have been open beyond 560 working days. The remaining two are in Community and Integrated Medicine. Weekly review, mandated closure dates and director-level escalation of stalled cases are working on the newer cohort, which is why the rate has more than halved since June.

What closes the gap. Three closures from the mental health cohort would reach the September point. They are the oldest and hardest cases in the system and each needs a named completion date.

What is improving and what remains a challenge

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Measure	Position in August	Position now	Direction
C. difficile	Advise, first quarter mean 8.0	Alert, 9.6 and five months above target	Worse
S. aureus	Alert, first quarter mean 4.0	Alert, 3.4 and target met in July	Improving
E. coli	Alert, first quarter mean 5.7	Alert, 5.8 and August at target	Window open
Aseptic technique and training compliance	82.6% and 75.6% against 95%	Refreshed position requested	Open
Access-linked incidents	757 in 2025, rising each year	451 in eight months, down 17%	Improving
Unexpected admission and readmission	Rising, flagged for focus	132 to 35 year on year	Resolved
Discharge referral not made	Named as the main discharge failure	13 to 49 year on year	Worse
Transfer inappropriate or unsafe	Rising, flagged for focus	38 to 46 year on year	Worse
Minors admitted to an adult setting	Trebled since 2021, safeguarding concern	52 to 60 year on year	Worse
Serious incidents beyond 90 working days	38.7% on 17 August	29.2% on 7 September	Improving
Outcome reports past their due date	Twelve	Eight	Improving

Recommendation

The Committee is asked to:

- **Note** that C. difficile moves from Advise to Alert, having exceeded its monthly target in each of the last five months and reached the highest monthly count in the series in July, and that all three hospital-acquired infection criteria are now rated Alert.
- **Receive assurance** from the improvement recorded in S. aureus and E. coli and support the focus on holding E. coli at five or fewer cases through September and October to complete the three-month standard.
- **Scrutinise and Consider** that clearing three consecutive months requires the underlying rate to sit below the monthly target rather than at it, and support reporting that rate alongside the criterion from November, together with confirming with Welsh Government how sustained achievement will be evidenced when we reach it.
- **Note** the reduction in serious incident investigations beyond ninety working days from 68.4% in June to 29.2% on 7 September and request a named completion date for each of the three longest-running mental health investigations.

3

3 - Planning Goal 2: Customer Service Excellence

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

For assurance

Attachments

QSEC PG SBAR OCT 26.pdf

Appendix 1- Planning Goals Highlight Reports.pdf

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	08 OCTOBER 2026
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Delivery Against Planning Goal 2: Customer Service Excellence
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Sharon Daniel, Executive Director of Nursing, Quality and Patient Experience
SWYDDOG ADRODD: **REPORTING OFFICER:**	Angharad Lloyd-Probert, Senior Project Manager (Planning)

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Health Board approved the 2026/27 Annual Plan in March 2026, based on requirements specified in the NHS Wales Planning Framework 2026/29 and against the Escalation Framework, which was subsequently submitted to Welsh Government on 31 March 2026. Since submission, Welsh Government (WG) has issued further communication that noted the plan was unacceptable and unsupportable given the expected financial outturn for 2026/27.

For 2026/27, **Planning Goal 2** has been aligned to the Quality, Safety and Experience Committee (QSEC), namely:

Planning Goal 2: Customer Service Excellence

As in previous years it is the expectation that QSEC will receive an update on the progress made in the development (delivery) of the Planning Goal for onward assurance to the Board through the Board Assurance Framework

Cefndir / Background

Planning Goals
One key aspect of the Annual Plan remains our Planning Goals (previously referred to as Planning Objectives). Of the eight Planning Goals one is aligned to this Committee –:

- Planning Goal 2: Customer Service Excellence

Asesiad / Assessment

The overarching status of the Planning Goal 2 is **On Track**. Highlight report for the individual component of the PG can be found in annex 1 demonstrating evidence of the work which has been completed, as well as actions which are planned over the forthcoming months.

Argymhelliad / Recommendation

The Committee is asked to receive **ASSURANCE** on the current position regarding the progress of the Planning Goal aligned to the QSEC, in order to assure the Board that the Planning Objective is progressing and is on target, and to raise any concerns where a Planning Objectives is identified as behind in its status and/or not achieving against its key deliverables

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	2.4 To receive an assurance on delivery against all relevant Planning Goal
Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply Choose an item. Choose an item. Choose an item. Choose an item. Choose an item.
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply Choose an item. Choose an item. Choose an item. Choose an item.
Amcanion Strategol y BIP: UHB Strategic Objectives:	3. Great care Choose an item. Choose an item. Choose an item. Choose an item.
Nodau Cynllunio 2026/27 Planning Goals 2026/27	2. Customer Service Excellence Choose an item. Choose an item. Choose an item. Choose an item. Choose an item. Choose an item. Choose an item.
Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	9. All HDdUHB Well-being Objectives apply Choose an item. Choose an item. Choose an item. Choose an item. Choose an item. Choose an item. Choose an item.
Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau)	5. A more preventative approach, including earlier identification and intervention, will be taken to support people to maintain and improve their health and wellbeing.

A Social Model for Health and Wellbeing: (*complete for strategic change and/or significant service changes)*	Choose an item. Choose an item. Choose an item. Choose an item. Choose an item. Choose an item. Choose an item.
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	3 Year Plan and Annual Plan 26-27
Rhestr Termau: Glossary of Terms:	Explanation of terms is included within the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Any financial impacts and considerations are identified in the report
Ansawdd / Gofal Claf: Quality / Patient Care:	Any issues are identified in the report
Gweithlu: Workforce:	Any issues are identified in the report
Tegwch Iechyd: Health Equity:	
Risg: Risk:	Consideration and focus on risk is inherent within the report. A sound system of internal control helps to ensure any risks are identified, assessed and managed
Cyfreithiol: Legal:	Any issues are identified in the report
Enw Da: Reputational:	Any issues are identified in the report
Gyfrinachedd: Privacy:	Not applicable
Cydraddoldeb: Equality:	Not applicable

DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG
SAFE | SUSTAINABLE | ACCESSIBLE | KIND

Submitted By: Marilize du Preez

Date Submitted: 24/09/2026

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

Planning Goal: G2 Drive Customer Services Excellence

Executive Lead: Sharon Daniel

Reporting Period:

Overall status: On-track

Rationale for overall status (please provide a brief summary of current progress indicating any key highlights or potential barriers to delivery)

Progress against planned outcomes / trajectories / milestones (please provide SPC/data charts and an explanation of any variances):

- **Agreed Customer Service Framework & Standards**: Strategic vision setting workshop held bringing together patient experience, policy expectations and existing system enablers to inform next steps.
- **Work towards operational Single Point of Contact (SPOC) and enhanced Patient Advice Liason Service (PALS)-style function:** Communication hub (CH) and Waiting List Support Service (WLSS) providing a SPOC for a cohort of operational services across secondary, primary and community care. PALS is currently stood down due to capacity and resource is diverted into the early resolution / stage 1 process of the Listening to People process. The enhanced PALS function is subject to resubmission of a business case.
- **Improved timeliness and resolution of concerns, feedback and queries/ Reduction in escalation from concerns to formal complaints:** Patient Support telephone queries are managed via the CH/WLSS increasing early, timely resolution to concerns and queries, especially around waiting times, appointment cancellations and waiting list management. Early resolution processes and management of this approach has seen a 70% reduction in the volume of formal complaints, ensuring there is a more proportionate and person-centred response to concerns management.

Activities completed in previous reporting period:

- Communication hub "SPOC" activity (July 2026): 13, 253 Incoming Calls Answered; 2,460 Outgoing Calls Answered; 5,483 Incoming email queries & referrals managed, WLSS (July 2026): 1606 patient activities (calls/ emails/ referrals)- expansion of both services limited by capacity and digital infrastructure, multiple service waiting to "on-board". 1925 of these are cases that would normally have been managed through patient support services.
- Integrated patient safety and triage process implemented improving governance, and oversight across all domains ensuring a streamlined and investigate once approach, triangulation leading to earlier identify of themes and patient safety risks.

Activities planned for next milestone and reporting period:

- Establish Single Point of Contact (SPOC)/ Customer Services Centre Steering group (31/12/2026)
- Link with exemplars in customer services to inform the development of a Customer Service Framework and Standards.
- Develop and implement service level agreements with each Clinical Care Group to ensure compliance for timely responses, and appropriate reporting (31/10/2026)
- Capacity within Communication Hub and Waiting List Support Service to support early resolution and reduction in concerns escalation to formal complaints. (31/10/2026)
- Pilot Video Relay Service for Deaf community within the CH.

Any other Comments

Matters for information: No designated project management resource to support delivery of the SPOC.

Risks to delivery: See risk 2357, Operational Risk 2422

Any other comments: Delivery of the planning goal is subject to the procurement and implementation of a digital patient service centre infrastructure. Current digital infrastructure of the Communication Hub limiting scope for expansion. The scoping exercise for the digital infrastructure is aimed to b Q4 26/27.

4

4 - Risk

4.1

4.1 - Assurance and Risk Report

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

For assurance

Attachments

QSEC - Assurance Risk Report October 26.pdf

Appendix 1- QSEC Principal Risk Register - Sep 26v2.pdf



Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Assurance and Risk Report

Quality, Safety and Experience Committee – 8 October 2026

Situation

This report provides the Quality, Safety & Experience Committee (QSEC) with the status of the principal risks, operational risks, and Welsh Health Circulars.

The Committee is asked to seek assurance from the Lead Executive Directors that the principal risks have been updated as part of the Strategy Refresh, and that there are processes in place to oversee operational risks to ensure these are being managed effectively, and that WHCs are being implemented by the Health Board.

Corporate risks, audit and inspections recommendations and Ministerial Directions are reported at alternate meetings, and due to be presented to QSEC at its next meeting in December 2026.

Principal Risks:	Operational Risks	Welsh Health Circulars
2	489	28

Further developments since the previous report to QSEC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Both QSEC and the Audit and Risk Assurance Committee (ARAC) have raised concerns regarding the organisation's delivery of assurance and improvement activity, resulting in correspondence being sent by the Chairs of each Committee to Executives and a meeting with the CEO to discuss their continuing concerns.

QSEC has expressed concern regarding the significant number of overdue audit, inspection and regulatory recommendations, alongside issues relating to ownership, accountability and quality of implementation plans. QSEC noted that progress is not being achieved at the expected pace, with repeated slippage against agreed timescales risking confidence in the Health Board's ability to translate learning into sustainable improvement.

Both Committees have called for strengthened executive oversight, clearer accountability and improved delivery to ensure audits process as planned, and recommendations are implemented in a timely and effective manner. Performance continues to be monitored via the Health Board's internal escalation framework

The Assurance and Risk team continue to support Clinical Care Groups and Executive Functions via a business partnering approach, which include:

- presentation of Assurance and Risk reports at local governance meetings, which details any areas of concern (including Audits and Inspections) via the 3A approach;
- 1-2-1 meetings with report and recommendation leads to support the development of management responses, and the provision of progress updates; and
- AMAT system training.



Risk Management - Overview

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

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

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

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

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

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



Principal Risks assigned to QSEC

Hywel Dda Risk Heat Map					
	LIKELIHOOD →				
IMPACT ↓	Rare 1	Unlikely 2	Possible 3	Likely 4	Almost Certain 5
Catastrophic 5					
Major 4			2357 →		
Moderate 3				2359 ↓	
Minor 2					
Negligible 1					

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

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

These risks have been identified by individual Directors and associated with the achievement of the Health Board's strategic objectives. The Health Board has updated the planning objectives, principal risks and outcome measures which support the four strategic objectives as part of the Strategy Refresh.

There are 2 principal risks currently aligned to QSEC (out of the 12 that are on the PRR as of 3 September 2026).

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

Principal risks aligned to QSEC

The principal risks aligned to the Committee highlight that the Health Board faces challenges in:

- Embedding a consistent quality, improvement and patient experience culture across the organisation.
- Delivering person-centred, high-quality services through effective systems, processes and digital capabilities.
- Balancing transformation and service improvement ambitions with workforce and capacity pressures.

The potential impacts of the risks include:

- Reduced quality, safety and consistency of care, affecting patient, family and staff experience.
- Increased governance, compliance and assurance challenges, including the ability to demonstrate the Duty of Quality.
- Delays in improvement, reduced organisational learning and failure to achieve strategic objectives.

Common actions noted across the risks demonstrate the need to:

- Strengthen governance, quality improvement and assurance arrangements.
- Improve the integration and use of digital systems, data and intelligence to support decision-making.
- Build workforce capability, standardise approaches and embed organisational learning to drive sustainable improvement.



Principal Risks assigned to QSEC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Previous Risk Score	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
2359 - Embedding a Quality Management System and demonstrating improvement	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	16	12 ↓ (Reviewed 23/09/2026)	6	30/04/2028

Rationale for Current Risk Score (CRS)

Although a Quality Management System (QMS) framework is established, further work is required to achieve consistent organisational implementation, mature measurement arrangements, effective triangulation of intelligence and demonstrable evidence of improvement. Financial pressures, workforce constraints, service stability concerns and competing operational priorities may limit organisational capacity to embed the QMS at the pace required. Failure to address these gaps could reduce the organisation's ability to demonstrate continuous improvement, provide robust assurance of quality and safety, evidence compliance with national expectations, and maintain confidence that risks to patients and services are being effectively identified, managed and improved.

Rationale for Target Risk Score (TRS)

A TRS of 6 is achievable only once:
- 7 day Urgent and Emergency Care (UEC) model is embedded across all counties.
- Planned Care recovery pathways are standardised and sustainable.
- A digital unified record supports early deterioration detection and flow.
- Enhanced community capacity reduces acute demand.
- Diagnostic resilience enables timely treatment and improved Referral to Treatment (RTT).
- Duty of Quality operationalisation is demonstrated across all care pathways through consistent use of the Quality Management System and articulation of the impact through the lens of the Healthcare Quality Standards (STEEEP).

Principal Risks assigned to QSEC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Previous Risk Score	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
2357 - Enhancing Patient and Staff Experience	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	**12**	**12** (Reviewed 24/09/2026)	**4**	31/03/2028

Rationale for Current Risk Score (CRS)

The score reflects developing but partial maturity of systems that gather, analyse and act on customer insight across patients and staff. Tools and forums exist (Civica, patient/staff surveys and pulses, Listening & Learning Sub Committee, Communication Hub, Waiting List Support Service (WLSS) engagement, Harms and Our Performance dashboards, Improving Together), yet integration and consistent follow through remain variable, limiting timely, reliable responses and systematic learning. There is fragility and capacity within the current waiting list support service, communication hub and Patient Advice and Liaison Service (PALS) service which requires digital and financial support to deliver enhanced customer service across the health board.

Rationale for Target Risk Score (TRS)

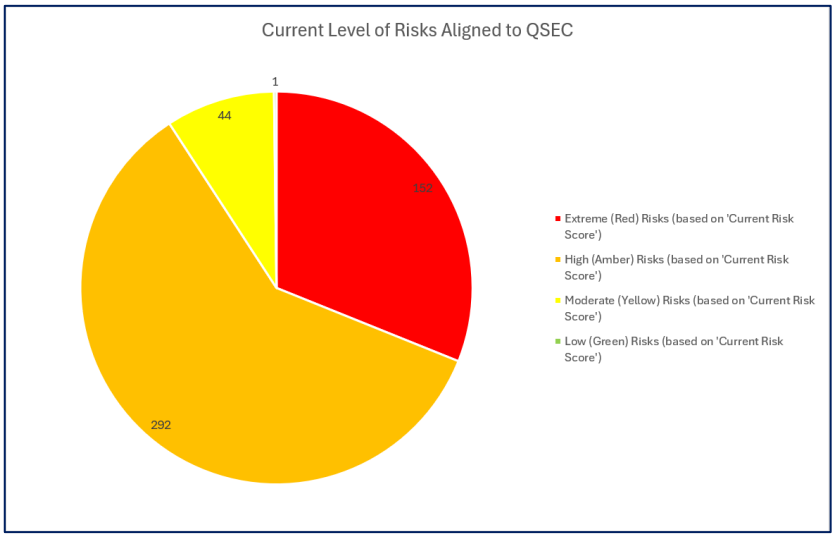
Achieving TRS requires: (1) establishing a Single Point of Contact (SPOC) and PALS style function; (2) adopting a customer service framework and standards; (3) implementing a unified query management approach with clear triage/escalation and defined response times; (4) strengthening triangulation across Civica, PREMs/PROMs, complaints, staff pulses, WLSS contact and quality/safety metrics; (5) routine post implementation reviews evidencing improvements for customers. To reduce this risk to the TRS of 4 will require realignment of resources to support the development of a customer service centre, and to support the enhancements required to the digital infrastructure.

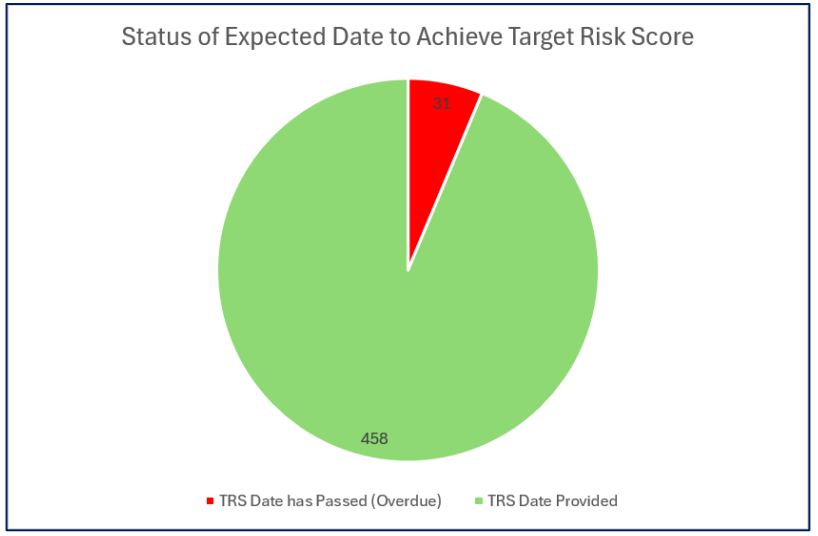
Operational Risks assigned to QSEC

489 operational risks are aligned to QSEC (484: June 2026). Due to the large number of risks aligned to the Committee, a summary of the risks are provided over the next slides.

All risks now have an assigned TRS date and 31 risks having an overdue TRS date. This is an improvement on 5 reported with having no TRS date, and 70 risks reported as having an overdue TRS date, reported to the Committee in June 2026.

Where expected dates to achieve the TRS have lapsed, 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?). In addition, the Assurance and Risk Team continue to highlighting these risks within governance reports and the expectations around their updates.







Operational risks aligned to QSEC

The operational risks aligned to the Committee highlight that the Health Board faces challenges in:

- Sustaining a safe and effective workforce across clinical, diagnostic, mental health and community services amid workforce shortages and recruitment challenges.
- Managing increasing demand and capacity pressures that are impacting access to assessment, diagnostics, treatment and rehabilitation services.
- Maintaining ageing estate, infrastructure and medical equipment required to support safe service delivery.
- Ensuring digital systems, clinical information processes and governance arrangements are robust and reliable.

The potential impact of the risks include:

- Increased risk of patient harm, delayed diagnosis, delayed treatment and poorer clinical outcomes.
- Reduced service capacity, longer waiting times and deterioration in patient experience.
- Disruption to clinical services caused by staffing gaps, equipment failures and infrastructure issues.
- Financial, regulatory and reputational consequences arising from failure to meet national standards, guidance and quality requirements.

Common actions noted across the risks demonstrate the need to:

- Strengthen recruitment, retention, workforce planning and staff development initiatives.
- Increase service resilience through demand and capacity reviews, pathway redesign and improved operational oversight.
- Secure investment in estate, infrastructure and equipment replacement programmes.
- Enhance digital capability, governance controls, compliance monitoring and assurance processes.



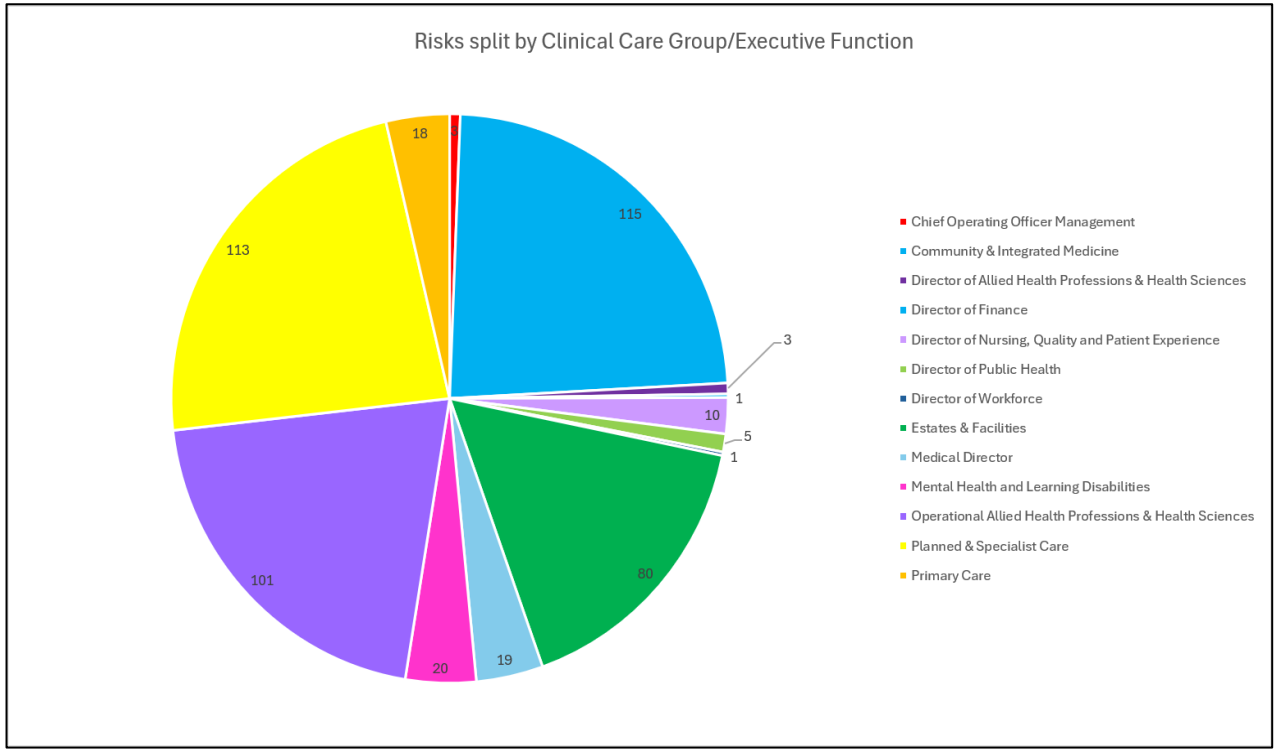
Operational Risks assigned to QSEC

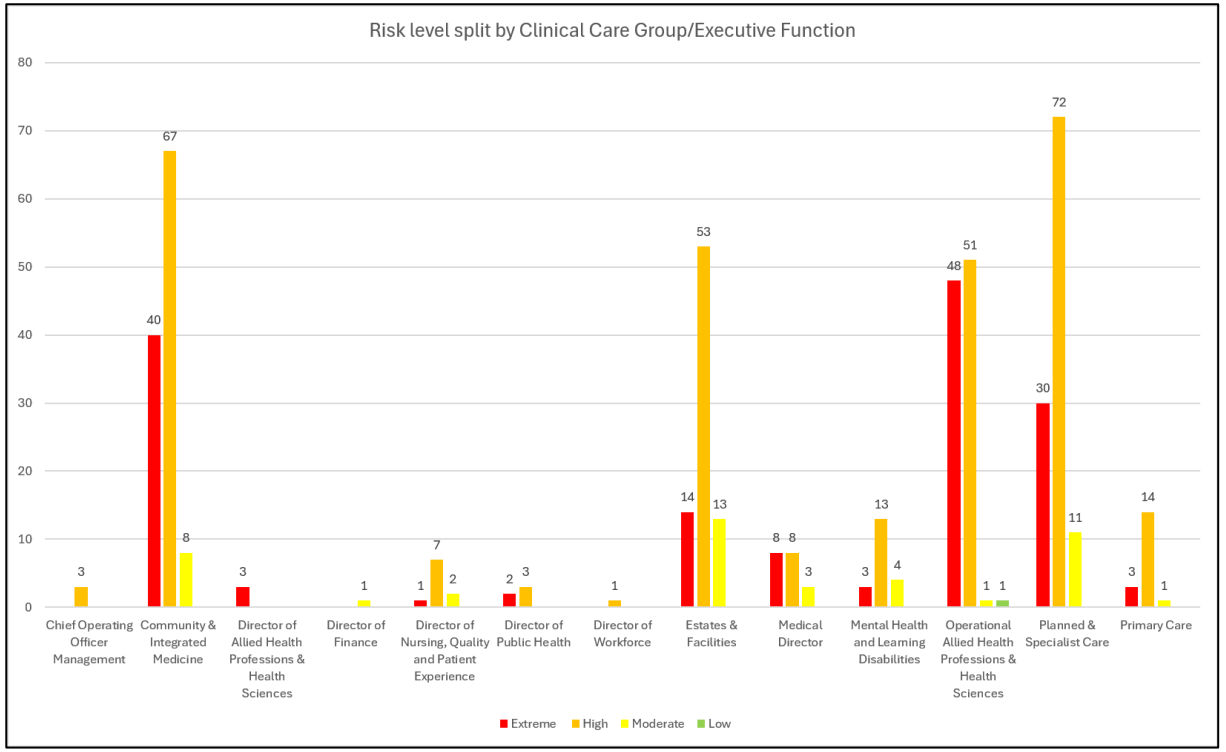
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risks Split Out By Clinical Care Group/Executive Function

As at 31st August 2026 Community & Integrated Medicine hold 115 risks assigned to QSEC, citing operational challenges within unscheduled care and the fragility across the urgent and emergency care system related to workforce compromise and increasing levels of demand and acuity.

Planned & Specialist Care follow with 113 risks, reflecting workforce shortages, service fragility, demand exceeding capacity, reliance on ageing or inadequate equipment, and continued lack of fully developed digital systems.



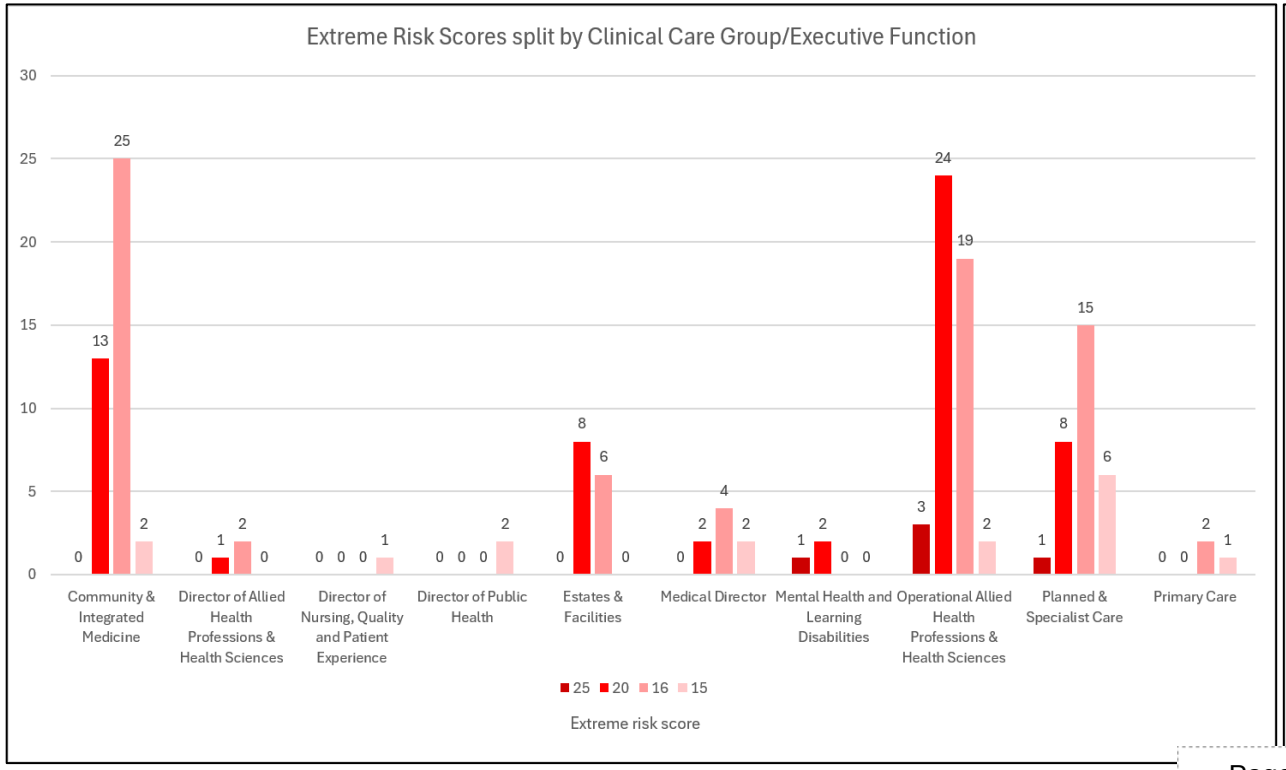


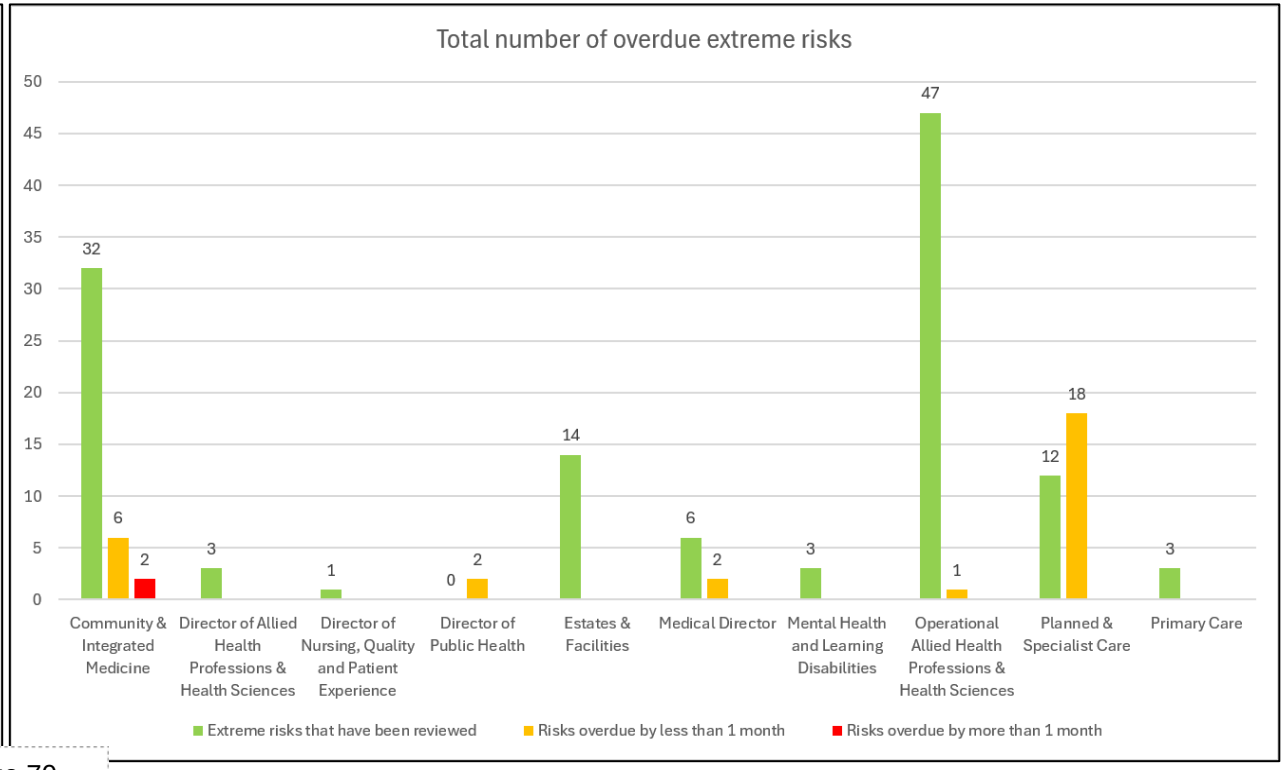
Operational Risks assigned to QSEC – Extreme scoring risks

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Risks with an extreme current risk score assigned to QSEC are concentrated within Operational Allied Health Professions & Health Sciences (48), Community & Integrated Medicine (40) and Planned & Specialist Care (30). Operational Allied Health Professions & Health Sciences hold 27 risks scored 20 or above, with financial constraints, service fragility, demand exceeding capacity, and infrastructure constraints cited as main drivers.

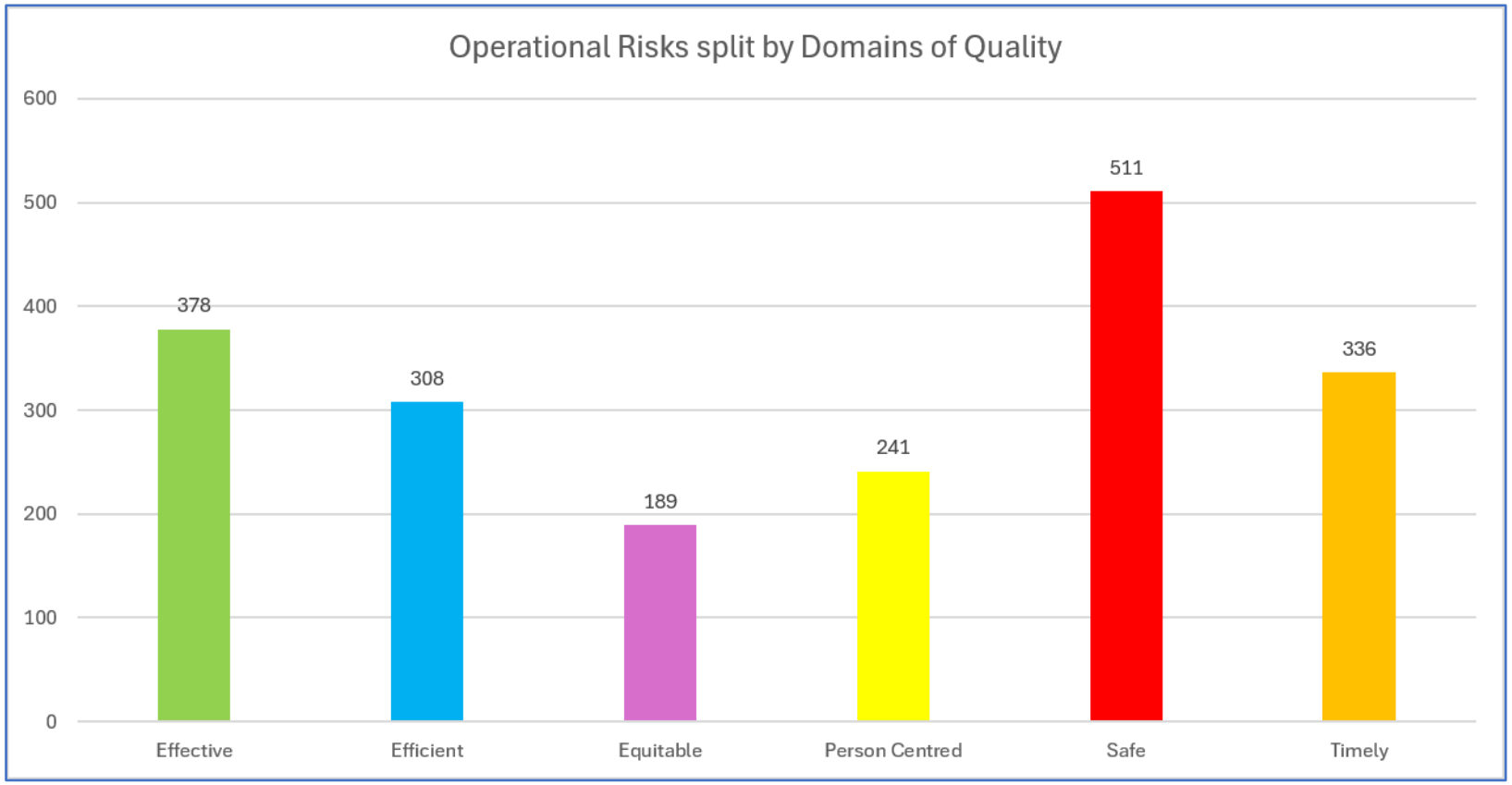
Planned & Specialist Care has 18 risks exceeding review date, followed by Community & Integrated Medicine with 8 risks exceeding review date (2 of which are overdue by more than 1 month), reflecting the operational pressures facing the Clinical Care Groups. Assurance and Risk Officers continue to offer support to risk leads to improve timely review.





Domains of Quality

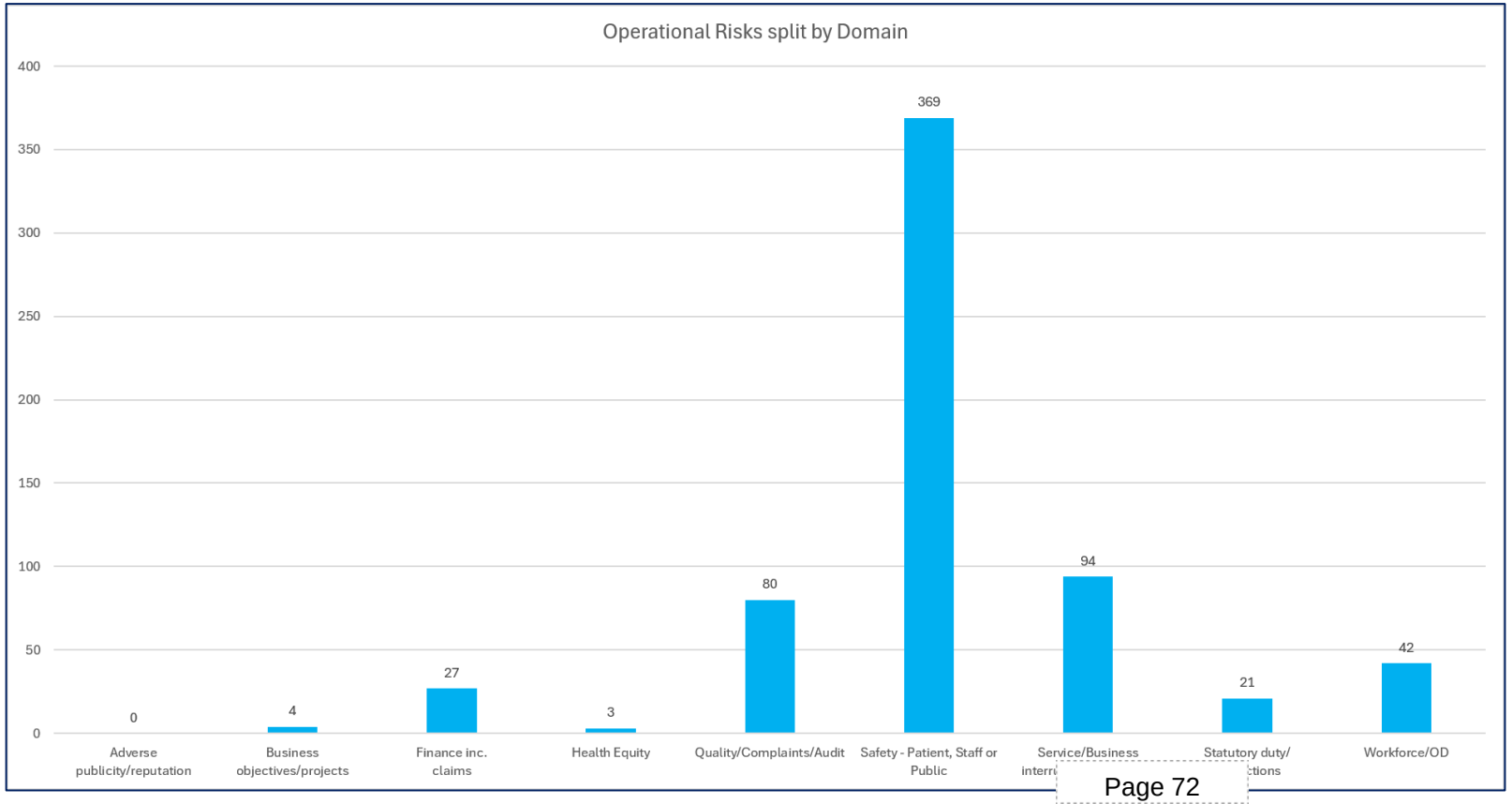
Risk owners can assign one or more of the six Domains of Quality to each risk. The chart shows the distribution of all operational risks across the six Domains of Quality (regardless of the Committee the risk is assigned to), highlighting that the highest number of risks is associated with the Safe domain (511), followed by Effective (378) and Timely (336).



Operational Risks by Domain

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

Out of 640 operational risks, 369 as assessed against the domain of 'Safety- Patient, Staff or Public' and 80 against 'Quality/Complaints/Audits'.



Risk Impact Domains:

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

Risk themes (1 of 3)

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

Theme owners and Sub-Committee Chairs 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 1 September 2026:

Theme	Definition	Sub-Committee/Group theme reported to	Number of risks	Date themed Risk Register last shared
Acute Deterioration / NEWS	A risk in relation to patient care and treatment relating to acute deterioration and NEWS scores / lack of escalation	RADAR Group	**12**	August 2026
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.	*N/A- not currently reported to a sub-committee/group*	**168**	August 2026
Consent and Mental Capacity	Risks relating to consent to examination or treatment e.g. missing, illegible, incorrect consent form; failure to obtain consent; mismatch between consent form and list etc. Risks relating to people who may lack mental capacity e.g. failure or concerns relating to: assessment of decision-making capacity; acting in the person's best interests; consulting with those close to the person etc.	Mental Capacity Act and Consent Group	**0**	*N/A - no risks aligned to theme*

Risk themes (2 of 3)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Theme	Definition	Sub-Committee/Group theme reported to	Number of risks	Date themed Risk Register last shared
Deprivation Of Liberty Standards (DOLS)	Risks relating to: • a failure to submit DoLS referral when needed • a person being deprived of their liberty when they have capacity to consent to be in hospital • a lack of awareness of what actions can and cannot be taken when a DoLS authorisation is in place (e.g. you can stop someone from absconding • DoLS doesn't give authority for care and treatment decisions • patient with a DoLS authorisation can be discharged).	Mental Capacity Act and Consent Group	**0**	*N/A- no risks aligned to theme*
Effective Clinical Practice	Risks related to the Health Board's ability to comply with evidence-based national guidance for health and care	Effective Clinical Practice	**0**	July 2026
Fragile Services	A fragile service is one where there is a risk or the actual delivery of a diminished service or a service being unable to be delivered due to staffing / or other challenges	Fragile Services Oversight Group	**209**	Sept 2026
HTA Compliance	A risk that involves complying with the regulations and legislation under the Human Tissue Act.	Human Tissue Authority Assurance Group	**6**	August 2026
Infection Control	A risk that may compromise the effectiveness of infection prevention and control measures, leading to staff and/ or patients being exposed to a confirmed or suspected pathogen increasing the likelihood of a transmission event and a healthcare acquired infection (HAI) or outbreak	Infection Prevention Strategic Steering Group	**38**	July 2026
Medical Devices	A risk relating to a medical device, which is any instrument (other than a medicine) that is used to diagnose, monitor, treat or manage a medical condition. The definition covers a wide range of products including syringes, dressings, surgical tools, scanners, software, apparatus, machines and some medical apps.	Medical Devices Group	**36**	August 2026

Risk Themes (3 of 3)

Risk theme	Theme description	Sub-Committee/Group theme reported to	Number of risks	Date themed Risk Register last shared
Medical Exposure / IRMER	A risk relating to the guidance and regulations for Health Board staff and patients in the use of Ionising Radiation for or medical equipment for treatment purposes and the deliberate exposure of patients to ionising radiation for diagnostic, therapeutic, or health monitoring purposes, with safety and optimisation	Medical Exposures Group	**0**	*N/A- no risks aligned to theme*
Medication	A risk that involves the prescribing, dispensing or supply, administration or monitoring of medicines.	Medicines Management Oversight Group	**27**	September 2026
NICE/National Guidance	Risks related to the Health Board's ability to comply with evidence-based guidance for health and care.	Effective Clinical Practice	**116**	July 2026
Nutrition and Hydration	A risk in relation to patient care and treatment relating to nutrition and hydration	Nutrition & Hydration Group	**30**	August 2026
Resuscitation	A risk in relation to patient care and treatment relating to resuscitation and DNACPR	RADAR Group	**3**	August 2026
Safeguarding	Safeguarding in its wider context is everyone's responsibility and we have duty of care to support children and adults. It is expected that services and professionals "own" their concerns and take responsibility for the work that needs to be done to keep individuals safe. This includes taking action before, during and after a safeguarding referral has been made. Should risks arise whereby children and adults may be put at risk due to gaps in service provision, or training compliance for example, then a safeguarding theme may be assigned to the risk.	Strategic Safeguarding Group	**30**	July 2026

Implementation of Welsh Health Circulars

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

Status Category	Definition	Number of WHCs
Overdue	The WHC is behind schedule to the timescale provided by the Lead officer or as stipulated in the WHC, or a plan (with date for implementation) is not yet in place.	5
Unable to Complete	The WHC cannot be implemented due to existing barriers and/or it is no longer relevant/appropriate for the Health Board. Formal sign-off by the CCG/Function Lead is required prior to escalation to the Executive Team for formal approval via operational governance structures.	3
Pending Decision	The WHC is pending a decision in order to implement e.g. outcomes of annual planning process, approval of funding requests, outcome of a QIA panel. Committee updates will detail whether the WHC is overdue or not whilst decision pending.	0
In Progress	The WHC is currently in progress, and within the agreed original timeframe for implementation.	9
Reliant on External Factors	The WHC is considered to be outside the gift of the Health Board to currently implement, e.g. reliant on an external organisation to implement.	3
Complete Pending Formal Approval	The Service / Function have completed the WHC and are currently awaiting formal approval to close.	1
Complete	The WHC has been confirmed as completed by the CCG / Function Lead and formal approval to close has been received.	5

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

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

WHCs - Overdue



Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Name of WHC	Clinical Care Group / Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	Reason for Overdue Status	Impact of non-compliance according to risk assessment	Next Steps
019-22: Non-Specialised Paediatric Orthopaedic Services **Issued June 2022**	Planned & Specialist Care	Chief Operating Officer / CCG Service Director for Planned & Specialist Care	**Original implementation date not met** **Original Completion Date:** 30/04/2025 **Revised Completion Date:** Not Known	No risk identified on Datix.	The Trauma and Orthopaedics Service Leads developed a Maturity Matrix to support compliance with the requirements of this WHC. Due to the service specification requirements, completion of the Matrix will require input from multiple Clinical Care Groups (CCGs). All Service Leads identified within the Matrix have been contacted and asked to complete the sections relevant to their areas of responsibility.
002-24: Standards for Competency Assurance of Non-Medical Prescribers in Wales **Issued March 2024**	Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	**Original implementation date not met** **Original Completion Date: 31/03/2026 Revised Completion Date: 31/03/2029**	**Risk Ref:** 2450 **Current Risk Score:** 12 **Impacts:** Increased risk of prescribing errors and patient harm.	Parts 1 and 2 of the Welsh Health Circular have been completed, including submission of the nominated lead, position statement and action plan to HEIW. Work is ongoing to achieve Part 3 compliance, which requires arrangements for the employment, supervision and review of non-medical prescribers. Key developments include maintaining an up-to-date Health Board register, development of electronic data capture processes, review of the non-medical prescribing policy, and delivery of CPD sessions in partnership with Swansea University. The Health Board continues to participate in an All-Wales Task and Finish Group for the non-medical prescribing appraisal process, working alongside HEIW to oversee implementation of this WHC. Monthly meetings have been established with a key focus to review pilot programme feedback (following its commencement in September 2026), share learning, and support a consistent approach to implementation across Health Boards and Trusts.

WHCs - Overdue



Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Name of WHC	Clinical Care Group / Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	Reason for Overdue Status	Impact of non-compliance according to risk assessment	Next Steps
006-24: National Clinical Guideline for Stroke, for the UK and Ireland **Issued March 2024**	Community & Integrated Medicine	Chief Operating Officer / CCG Service Director for Community & Integrated Medicine	**Original implementation date not met** **Original Completion Date:** 30/04/2025 **Revised Completion Date:** Not Known	**Risk Ref:** 2409 **Current Risk Score:** 20 **Impacts:** Delayed assessment and treatment of patients; Increased length of stays	The Health Board has identified Stroke as being one of the fragile services that is being reviewed by the Clinical Services Plan (CSP). As such, the 5 key recommendations of this WHC cannot be fully implemented until the outcomes of the CSP have been determined. Risk associated with WHC is on Datix (2409) and confirmation has now been received that the QIA undertaken as part of the CSP process is sufficient and that a separate submission to the QIA Panel is not required for this WHC. Assurance & Risk Officer to continue to work with the Stroke Service Manager to ensure the remaining barriers to completion are clearly captured and understood.
041-24: Ambulance patient handover guidance **Issued October 2024**	Community & Integrated Medicine	Chief Operating Officer / CCG Service Director for Community & Integrated Medicine	**Original implementation date not met** **Original Completion Date:** 31/12/2025 **Revised Completion Date:** 30/11/2026	**Risk Ref:** 1027 **Current Risk Score:** 20 **Impacts:** Delayed assessment and treatment of patients; Increased serious incident	Ambulance Handover 45 group established between Welsh Ambulance Services University (WAST), Health Board and Local Authority, including a Programme Plan between Health Board and WAST, detailing timescales and owners of actions. Any delay in progress to be escalated through UEC Programme Group and National escalation meetings.

WHCs - Overdue



Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Name of WHC	Clinical Care Group / Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	Reason for Overdue Status	Impact of non-compliance according to risk assessment	Next Steps
013-26: Publication of Quality Statements for Mental Health, and Self-Harm (Not Available Online) **Issued April 2026**	Mental Health and Learning Disabilities	Chief Operating Officer / CCG Service Director for Mental Health and Learning Disabilities	**Original implementation date not met** **Original Completion Date:** 30/04/2026 **Revised Completion Date:** Not Known	No risk identified on Datix.	Local requirements already embedded across MH&LD. Awaiting evidence to be uploaded to AMAT to enable closure by Executive Director.

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

WHCs – Unable to Complete

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

WHCs – Unable to Complete

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

WHCs - In Progress

Welsh Health Circular	Clinical Care Group/Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	UHB Implementation Date
030-23: New 2023 National Safety Standards for Invasive Procedures (NatSSIPS2) by the Centre for Perioperative Care (CPOC) and Patient Safety Notice PSN 034 **Issued August 2023**	Medical Directorate	Medical Director	Sep-26
039-25: AMR and HCAI Improvement Goals for 2025 – 2027 **Issued October 2025**	Nursing, Quality & Patient Experience Directorate	Director of Nursing, Quality & Patient Experience	Mar-27
024-25: NHS Wales hearing care: future approach to audiology services **Issued December 2025 (NEW)**	Planned & Specialist Care	Chief Operating Officer / CCG Service Director for Planned & Specialist Care	Jan-31
051-25: Safety netting discharge leaflets for adults and children **Issued December 2025**	Nursing, Quality & Patient Experience Directorate	Director of Nursing, Quality & Patient Experience	Dec-26
001-26: Timelines and responsibilities for implementing the patient and family-initiated escalation approach, Call4Concern **Issued January 2026**	Nursing, Quality & Patient Experience Directorate	Director of Nursing, Quality & Patient Experience	Dec-26
015-26: All Wales General Practice and Health Board Clinical Interface Standards **Issued April 2026**	Medical Directorate	Medical Director	Apr-27
014-26: NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme for 2026/27 **Issued April 2026**	Medical Directorate	Medical Director	Apr-27
024-26: Regulation 28 Prevention of Future Deaths Report –Assurance on alarm “latching” functionality in acute monitored environments **Issued May 2026**	Nursing, Quality & Patient Experience Directorate	Director of Nursing, Quality & Patient Experience	Jul-27
027-26 Update to ‘Safety netting discharge leaflets for adults and children **Issued August 2026**	Nursing, Quality & Patient Experience Directorate	Director of Nursing, Quality & Patient Experience	Dec-26

WHCs – Reliant on External Factors

Welsh Health Circular	Clinical Care Group / Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	Reason for External Status	Impact of non-compliance according to risk assessment	UHB Implementation Date
040-23: The NHS Wales: Newborn and Infant Physical Examination Cymru (NIPEC) **Issued November 2023**	Planned & Specialist Care	Chief Operating Officer / CCG Director for Planned & Specialist Care	The service is currently compliant with all aspects of this WHC apart from the data capture requirements, for which no national system is currently available. An all-Wales data system is awaited. In the interim the Health Board has its own system for capturing the data.	No risk identified on Datix.	N/K
033-18: Airborne Isolation Room Requirements **Issued July 2018**	Nursing, Quality & Patient Experience Directorate	Director of Nursing, Quality & Patient Experience	Architectural Projects Team undertook Project Feasibility Report in July 2024 and provided estimate of costs £1,419,946 (including contingency fund of £109,416), with project time of 48 weeks from project brief development to completion of works to install negative pressure isolation suite in Clinical Decisions Unit (CDU) GGH. To date, funding not allocated for this project and whilst issue has been raised at 'All Wales High Consequence Infectious Disease Group' hosted by Public Health Wales, there has been no indication of central funding being considered by Welsh Government to support improvement and to move work forward. In the meantime, out turn costs continue to escalate and it is recognised that estimated costs of 2024 may have increased. As of September 2026, the Head of Infection Prevention confirmed that the situation is unchanged with the WHC remaining unable to be progressed due to funding ('unable to complete'), noting Swansea Bay University Health Board and Aneurin Bevan Uni[illegible]Board are in a similar position.	**Risk Ref:** 1640 **Current Risk Score:** 15 **Impacts:** Increased risk of transmitting infectious disease	N/K

WHCs – Reliant on External Factors

Welsh Health Circular	Clinical Care Group / Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	Reason for External Status	Impact of non-compliance according to risk assessment	UHB Implementation Date
016-24: Healthy Child Wales Programme: for school aged children **Issued April 2024**	Planned & Specialist Care	Chief Operating Officer / CCG Service Director for Planned & Specialist Care	A Healthy Child Wales Programme 2 (HCWP2) School-Aged Children Operating Model Workshop took place on 29 June 2026 to review implementation progress and agree next steps. The Welsh Government Policy Team has been tasked with developing a programme-lite HCWP2 Delivery Plan and refreshing reporting arrangements to provide greater clarity on deliverables, risks and dependencies. Consequently, local HCWP2 implementation remains dependent on national decisions and timescales, with further direction, revised delivery expectations and associated delivery plans awaited from Welsh Government.	No risk identified on Datix.	N/K

WHCs – Complete Pending Formal Approval For Closure

Welsh Health Circular	Clinical Care Group/Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	UHB Implementation Date
037-25: Infected Blood Inquiry: Implementation of Recommendation 7e: Implementing SHOT reports **Issued September 2025**	Operational Allied Health Professions & Health Sciences	Chief Operating Officer & Executive Director of Allied Health Professions & Health Sciences/ CCG Service Director for Operational Allied Health Professions & Health Sciences	Feb-26

WHCs – Complete and Approved



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Welsh Health Circular	Clinical Care Group/Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	UHB Implementation Date	Date WHC completed (i.e. Executive approval received).
006-18: Framework of Action for Wales, 2017-2020 (Not Available Online) **Issued Feb 2018**	Primary Care	Chief Operating Officer	Mar-26	Jul-26
004-25: NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme for 2026/27 **Issued April 2025**	Medical Directorate	Medical Director	Apr-26	Aug-26
006-26: Listening to People: The amended NHS Wales complaints, incidents and redress process **Issued March 2026**	Nursing, Quality & Patient Experience Directorate	Director of Nursing, Quality & Patient Experience	Jul-26	Jul-26
017-26 Enabling community pharmacies to supply medicines ordered by optometrists as part of providing NHS care in Wales (Not Available Online) **Issued March 2026**	Primary Care	Chief Operating Officer	May-26	Jun-26
026-18: Phase 2 – primary care quality and delivery measures **Issued July 2018**	Primary Care	Chief Operating Officer	Mar-26	Jul-26

Recommendations

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

Risk Management

- **RECEIVE ASSURANCE** that principal risks have identified controls in place which are working effectively, and 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.
- **RECEIVE ASSURANCE** that there are processes in place to oversee operational risks to ensure these are being managed effectively.

Welsh Health Circulars

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





DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG

SAFE | SUSTAINABLE | ACCESSIBLE | KIND

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University Health Board

Risk Ref	Risk (for more detail see individual risk entries)	Executive Director	Domain	Previous Risk Score	Risk Score Sep-26	Trend	Target Risk Score (tolerable score)	Expected Date of achieving Target Risk Score	Risk on page no…
2359	Embedding a Quality Management System and demonstrating improvement	Daniel, Sharon	Quality/Complaints/Audit	NA	4×4=16	New risk	3×2=6	30/04/2028	6
2357	Enhancing Patient and Staff Experience	Daniel, Sharon	Quality/Complaints/Audit	NA	3×4=12	New risk	2×2=4	31/03/2028	11

RISK SCORING MATRIX

Likelihood x Impact = Risk Score					
		Corporate Risk Description:			
Likelihood	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Frequency - How often might it/does it happen? (how many times will the adverse consequence being assessed actually be realised?)	This will probably never happen/recur (except in very exceptional circumstances).	Do not expect it to happen/recur but it is possible that it may do so.	It might happen or recur occasionally.	It might happen or recur occasionally.	It will undoubtedly happen/recur, possibly frequently.
	Not expected to occur for years.*	Expected to occur at least annually.*	Expected to occur at least monthly.*	Expected to occur at least weekly.*	Expected to occur at least daily.*
	* time-framed descriptors of frequency				
Probability - Will it happen or not? (what is the chance the adverse consequence will occur in a given reference period?)	**(0-5%*)**	**(5-25%*)**	**(25-75%*)**	**(75-95%*)**	**(>95%*)**
	*used to assign a probability score for risks related to time-limited or one off projects or business objectives.				
Risk Impact Domains	**Negligible - 1**	**Minor - 2**	**Moderate - 3**	**Major - 4**	**Catastrophic - 5**
Safety of Patients, Staff or Public	Minimal injury requiring no/minimal intervention or treatment.	Minor injury or illness, requiring minor intervention.	Moderate injury requiring professional intervention.	Major injury leading to long-term incapacity/disability.	Incident leading to death.
	No time off work.	Requiring time off work for >3 days	Requiring time off work for 4-14 days.	Requiring time off work for >14 days.	Multiple permanent injuries or irreversible health effects.
		Increase in length of hospital stay by 1-3 days.	Increase in length of hospital stay by 4-15 days.	Increase in length of hospital stay by >15 days.	An event which impacts on a large number of patients.
			Agency reportable incident.	Mismanagement of patient care with long-term effects.	
			An event which impacts on a small number of patients.		
Quality, Complaints or Audit	Peripheral element of treatment or service suboptimal.	Overall treatment or service suboptimal.	Treatment or service has significantly reduced effectiveness.	Non-compliance with national standards with significant risk to patients if unresolved.	Totally unacceptable level or quality of treatment/service.
	Informal complaint/inquiry.	Formal complaint.	Formal complaint -	Multiple complaints/ independent review.	Gross failure of patient safety if findings not acted on.
		Local resolution.	Escalation.	Low achievement of performance/delivery requirements.	Inquest/ombudsman inquiry.
		Single failure to meet internal standards.	Repeated failure to meet internal standards.	Critical report.	Gross failure to meet national standards/performance requirements.
		Minor implications for patient safety if unresolved.	Major patient safety implications if findings are not acted on.		
		Reduced performance if unresolved.			

Workforce & OD	Short-term low staffing level that temporarily reduces service quality (< 1 day).	Low staffing level that reduces the service quality.	Late delivery of key objective/ service due to lack of staff.	Uncertain delivery of key objective/service due to lack of staff.	Non-delivery of key objective/service due to lack of staff.
			Unsafe staffing level or competence (>1 day).	Unsafe staffing level or competence (>5 days).	Ongoing unsafe staffing levels or competence.
			Low staff morale.	Loss of key staff.	Loss of several key staff.
			Poor staff attendance for mandatory/key training.	Very low staff morale. No staff attending mandatory/ key training.	No staff attending mandatory training /key training on an ongoing basis.
Statutory Duty or Inspections	No or minimal impact or breach of guidance/ statutory duty.	Breach of statutory legislation.	Single breach in statutory duty.	Enforcement action	Multiple breaches in statutory duty.
		Reduced performance levels if unresolved.	Challenging external recommendations/ improvement notice.	Multiple breaches in statutory duty.	Prosecution.
				Improvement notices.	Complete systems change required.
				Low achievement of performance/delivery requirements.	Low achievement of performance/delivery requirements.
				Critical report.	Severely critical report.
Adverse Publicity or Reputation	Rumours.	Local media coverage – short-term reduction in public confidence. Elements of public expectation not being met.	Local media coverage – long-term reduction in public confidence.	National media coverage with <3 days service well below reasonable public expectation.	National media coverage with >3 days service well below reasonable public expectation. AMs concerned (questions in the Assembly).
	Potential for public concern.				Total loss of public confidence.
Business Objectives or Projects	Insignificant cost increase/ schedule slippage.	<5 per cent over project budget. Schedule slippage.	5–10 per cent over project budget. Schedule slippage.	Non-compliance with national 10–25 per cent over project budget. Schedule slippage. Key objectives not met.	Incident leading >25 per cent over project budget. Schedule slippage. Key objectives not met.
Finance including Claims	Small loss.	Loss of 0.1–0.25 per cent of budget.	Loss of 0.25–0.5 per cent of budget.	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget.	Non-delivery of key objective/ Loss of >1 per cent of budget.
	Risk of claim remote.	Claim less than £10,000.	Claim(s) between £10,000 and £100,000.	Claim(s) between £100,000 and £1 million.	Failure to meet specification/ slippage
					Claim(s) >£1 million.
Service or Business interruption or disruption	Loss/interruption of >1 hour. Minor disruption.	Loss/interruption of >8 hours.	Loss/interruption of >1 day.	Loss/interruption of >1 week.	Permanent loss of service or facility.
		Some disruption manageable by altered operational routine.	Disruption to a number of operational areas within a location and possible flow onto other locations.	All operational areas of a location compromised. Other locations may be affected.	Total shutdown of operations.
Environmental	Minimal or no impact on the environment.	Minor impact on environment.	Moderate impact on environment.	Major impact on environment.	Catastrophic/critical impact on environment.
Health Equity	Minimal or no impact on our attempts to improve health equity	Minor impact on our attempts to improve health equity or low level of certainty on the impact we are having on health equity	Moderate impact on our attempts to improve health equity or a lack of sufficient information that would demonstrate this. Indications that we are not having a positive impact on health improvement or health equity	Major impact on our attempts to improve health equity. Validated data suggesting that we are not improving the health of the most disadvantaged in our population whilst clearly supporting the least disadvantaged. Validated data suggesting we are having no impact on health improvement or health equity.	Validated data clearly demonstrating a disproportionate widening of health inequalities or a negative impact on health improvement and/or health equity.

RISK MATRIX

IMPACT ↓	LIKELIHOOD →				
	RARE	UNLIKELY	POSSIBLE	LIKELY	ALMOST CERTAIN
	1	2	3	4	5
CATASTROPHIC 5	5	10	15	20	25
MAJOR 4	4	8	12	16	20
MODERATE 3	3	6	9	12	15
MINOR 2	2	4	6	8	10
NEGLIGIBLE 1	1	2	3	4	5

RISK ASSESSMENT - FREQUENCY OF REVIEW

RISK SCORED	DEFINITION	ACTION REQUIRED (GUIDE ONLY)	MINIMUM REVIEW FREQUENCY
15-25	Extreme	Unacceptable. Immediate action must be taken to manage the risk. Control measures should be put into place which will have an effect of reducing the impact of an event or the likelihood of an event occurring. A number of control measures may be required.	This type of risk is considered extreme and should be reviewed and progress on actions updated, at least monthly.
8-12	High	Very unlikely to be acceptable. Significant resources may have to be allocated to reduce the risk. Urgent action should be taken. A number of control measures may be required.	This type of risk is considered high and should be reviewed and progress on actions updated at least bi-monthly.
4-6	Moderate	Not normally acceptable. Efforts should be made to reduce risk, providing this is not disproportionate. Establish more precisely the likelihood & harm as a basis for determining the need for improved measures.	This type of risk is considered moderate and should be reviewed and progress on actions updated at least every six months.
1-3	Low	Risks at this level may be acceptable. If not acceptable, existing controls should be monitored & reviewed. No further action or additional controls are required.	This type of risk is considered low risk and should be reviewed and progress on actions updated at least annually.

Assurance Key:

3 Lines of Defence (Assurance)		
1st Line	Business Management	Tends to be detailed assurance but lack independence
2nd Line	Corporate Oversight	Less detailed but slightly more independent
3rd Line	Independent Assurance	Often less detail but truly independent

Key - Assurance Required	
	Detailed review of relevant information
	Medium level review
	Cursory or narrow scope of review

NB Assurance Map will tell you if you have sufficient sources of assurance not what those sources are telling you

Key - Control RAG rating	
LOW	Significant concerns over the adequacy/effectiveness of the controls in place in proportion to the risks
MEDIUM	Some areas of concern over the adequacy/effectiveness of the controls in place in proportion to the risks
HIGH	Controls in place assessed as adequate/effective and in proportion to the risk
INSUFFICIENT	Insufficient information at present to judge the adequacy/effectiveness of the controls

Date Risk Identified:	Mar-26		
Strategic Objective:	3. Great Care		

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

Risk ID:	**2359**	**Principal Risk Description:**	There is a risk that the Health Board may be unable to demonstrate full compliance with the Duty of Quality or deliver sustained quality improvement in the delivery of our strategy. This is caused by inconsistent implementation of key organisational frameworks such as the Quality Management System and Fragile Services Framework, continued service fragility and system pressures. This could lead to an impact/affect on the Health Board being unable to evidence decision making though a quality lens, systemâ€'wide continuous quality improvement, reduced ability to provide assurance that patient care is safe, timely, effective, efficient, equitable and person-centred (STEEEP), loss of public confidence and heightened regulatory scrutiny.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)		**No trend information available.**
Domain:	Quality/Complaints/Audit	
Inherent Risk Score (L x I):	5×5=25	
Current Risk Score (L x I):	4×4=16	
Target Risk Score (L x I):	3×2=6	
Expected Date To Achieve TRS:	30/04/2028	
Trend:	*New risk*	

Rationale for CURRENT Risk Score:

Financial pressures, known and unassessed service fragility, implementation of the agreed quality management system and assurance that all strategic decisions are made through the quality lens.

Rationale for TARGET Risk Score:

A TRS of 6 is achievable only once:
- 7 day UEC model is embedded across all counties.
- Planned Care recovery pathways are standardised and sustainable.
- A digital unified record supports early deterioration detection and flow.
- Enhanced community capacity reduces acute demand.
- Diagnostic resilience enables timely treatment and improved RTT.
- Duty of Quality operationalisation is demonstrated across all care pathways through consistent use of the Quality Management System and articulation of the impact through the lens of the Healthcare Quality Standards (STEEEP).

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Quality Planning • 6 Goals for Urgent & Emergency Care (UEC) delivery framework defining the future model for urgent and emergency care. • Planned Care Recovery Programme focused on RTT reduction, theatre utilisation, diagnostics and cancer performance. • Women's Health improvement actions, including access reviews and pathway redesign. • Mental Health strategy focused on strengthening crisis response, community alternatives and early intervention. • Digital Strategic Plan, including e Observations, electronic patient flow and unified data architecture. • Development of a regional data fabric and digital front door to support future access and integration. • International recruitment strategy, preceptorship programmes, ACP/ANP pipeline and medical workforce stabilisation plans. • Organisational Change Process supporting the move to 7 day services. Quality Control • Daily and weekly operational huddles focused on patient safety, flow and harm surveillance. • Waiting List Support and prioritisation processes to manage and protect highest risk patients. • Our Safety and Our Performance dashboards available to all CCGs for real time oversight of patient safety indicators. • Performance dashboards monitoring access, flow, productivity and quality metrics. • Operational oversight of partial UEC improvements (clinical streaming, virtual wards, 5 day SDEC). Quality Assurance • Quality Management System (Improving Together) incorporating STEEEP indicators. • Quality Impact Assessments (QIAs) and Equality Impact Assessments (EQIAs) to assure safe and equitable service change. • Formal governance and escalation through Directorate IGGs, QSEC, Performance Committee and IQFPD oversight cycles. • Use of consistent assurance data from harms and performance dashboards to support Executive and Board assurance. Quality Improvement	Quality Planning • Full 7 day SDEC, Clinical Streaming and Hospital@Home models not yet implemented consistently across all sites. • Incomplete community capacity to prevent demand, redirect patients, and support Home First models. • Women's Health and Mental Health pathway optimisation still in early stages of implementation. • Estates constraints limiting patient flow, theatre productivity and diagnostic expansion. • Insufficient diagnostic and therapeutic capacity to support delivery of UEC transformation and Planned Care recovery at scale. Quality Control • Digital interoperability gaps, limiting access to fully integrated, real time clinical risk and flow signals. • Operational impact of capacity shortfalls in diagnostics, theatres and community services affecting ability to manage flow in real time. • Workforce capacity pressures in key professions impacting operational consistency and responsiveness. Quality Assurance • Variation in pathway standards and clinical practice across localities, reducing assurance of equitable and consistent care. • Incomplete digital integration, limiting assurance that early warning signs, clinical risk and deterioration are	Implement phased 7 day CSS, SDEC, H@H (per business case).	Carruthers, Andrew	31/03/2028	Support required from Medical Director and Executive Director of Nursing, Quality and Patient Experience to fully implement this action.
		Develop extended hours model and workforce plan.	Henwood, Mr Mark	30/04/2028	Support required from Medical Director and Executive Director of Allied Health Professions and Health Sciences to fully implement this action.
		Implement theatre, outpatient & diagnostics optimisation; GIRFT.	Carruthers, Andrew	31/03/2027	Support required from Medical Director to fully implement this action.
		Deliver Digital Strategic Plan foundations and real-time analytics.	Thomas, Huw -	31/03/2027	Year 1 foundations are currently underway.
		Expand urgent community response, frailty, virtual wards.	Carruthers, Andrew	31/03/2028	Support required from Medical Director to fully implement this action.
		Implement Health Equity Framework & pathway standardisation.	Gjini, Ardiana	31/03/2027	Support required from Medical Director, Executive Director of Nursing, Quality and Patient Experience and Executive Director of Allied Health Professions and Health Sciences to fully implement this action.

• Incremental delivery and optimisation of UEC improvements, including clinical streaming, virtual wards and Same Day Emergency Care. • Improvement activity within the Planned Care Recovery Programme to improve flow, productivity and patient outcomes. • Women's Health pathway redesign improving access, quality and experience. • Mental Health service transformation to improve crisis response and reduce reliance on acute care. • Continuous improvement enabled through digital transformation (flow management, data integration, e Obs). • Workforce capability development via preceptorship, advanced practice expansion and stabilisation initiatives.	consistently visible across settings. • Workforce constraints reducing assurance that staffing models can reliably sustain safe and effective services. Quality Improvement • Scaling and standardisation of SDEC, Clinical Streaming and Hospital@Home models across all sites. • Improvement required in diagnostic and therapeutic capacity, including productivity and access. • Strengthening community based alternatives to reduce avoidable hospital attendance and admission. • Digital improvement to integrate real time risk, flow and safety intelligence. • Pathway optimisation for Women's Health and Mental Health to achieve consistent, system wide impact. • Workforce improvement actions to address supply, skill mix and sustainability pressures.	Embed pathways, workforce and service redesign.	Carruthers, Andrew	31/03/2027	Support required from Mental Health CCG Director to fully implement this action.
		Develop QMS agenda template for sub-groups of QSIG and QMS report for groups reporting to QSIG.	Daniel, Sharon	~~31/05/2026~~ 31/10/2026	Support required from Risk and Governance Team for reporting into QSIG e.g. amending AAA report Template ToR has been trialled with SSSG and IPSSG.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
ED 4-hr / 12-hr measures; ambulance handover <15/45 mins. RTT (26/36/52/104-week) performance; Diagnostics <8 weeks; Cancer targets. Weekend activity/flow metrics including zero-day LOS for SDEC. H@H utilisation, avoidable admissions, early supported discharge. Harm events: deterioration, inpatient falls, waits to treatment. Equity indicators: deprivation gap, rurality access, protected characteristics outcomes. Workforce: fill rates, vacancies, sickness.	Clinical Care Group Integrated Governance Groups .	1st			UEC Business Case - Board (Jan 2026). Digital Strategic Plan - Board (Jan 2026) A Healthier Mid & West Wales Strategy Refresh - Board (Jan 2026) Planned Care Recovery updates to FPC Safety & Experience Reports to QSEC (bi-monthly)	Limited assurance of weekend risk reduction until 7 day model is operational Need stronger triangulation across UEC + Planned Care + community outcomes Limited real-time predictive analytics	Compile and present an evidence pack demonstrating QMS (Improving Together) embedded in decision-making, including STEEEP measures, QIA/EQIA usage and governance minutes to evidence Duty of Quality compliance.	Daniel, Sharon	31/05/2026	QMS reporting template and evidence pack in development; initial submission due May-26.
	Use of Our Safety, PROMS. Listening to People (complaints and incidents) and other quality related data .	1st					Implement real-time deterioration and patient-flow alerts (eObs/EPR + dashboards) and produce a routine assurance report for IGGs/QSEC.	Thomas, Huw -	31/03/2027	Digital foundations underway; alerting approach to be incorporated into Year 1 delivery.
	Patient flow meetings .	1st					Commission an evaluation of Phase 1 of the 7-day UEC model (including weekend outcomes, safety and flow metrics) and report findings to QSEC.	Carruthers, Andrew	30/09/2026	Scope to be agreed with Medical Director; evaluation approach and timescales to be confirmed.
	Audits .	1st					Deliver and evidence full operationalisation of the 7-day UEC model (SDEC, clinical streaming, Hospital@Home) across all sites, including weekend performance assurance.	Carruthers, Andrew	31/03/2028	UEC business case approved Jan-26; phased implementation in progress.
	Performance dashboards .	1st					Agree and deliver a sustainable Planned Care recovery plan (diagnostics + theatres optimisation/GIRFT) with clear assurance metrics and committee reporting.	Carruthers, Andrew	31/03/2027	Programme established; optimisation plan to be tracked through Performance Committee.

Patient experience: PREMs, complaints, Friends & Family, Civica feedback.	Reports to DDIC, FPC, PODCC & QSEC .	2nd				Deliver Digital Strategic Plan priorities to enable a unified record and predictive analytics, with a Board-level assurance dashboard.	Thomas, Huw -	31/03/2027	Year 1 foundations underway; analytics roadmap in development.
	HIW inspections .	3rd				Expand community & preventative capacity (20Four7/Community by Design), including urgent community response, frailty and virtual wards, with outcome and utilisation assurance metrics.	Henwood, Mr Mark	30/04/2028	Model design underway; workforce and capacity plan to be agreed and implemented.
	External audits undertaken by Audit Wales .	3rd				Implement the Health Equity Framework and pathway standardisation to reduce unwarranted variation; incorporate equity indicators into routine assurance reporting.	Gjini, Ardiana	31/03/2027	Framework implementation planned; baseline equity metrics being defined.
	Internal Audits on quality, governance and digital .	3rd				Embed the use of the Healthcare Quality Standards (STEEEP) and enablers across all services and improve reporting through the QMS lens to committees and groups (Support required from all Directors).	Daniel, Sharon	31/03/2027	Reporting cycles established; standardisation of outcome measures and assurance mapping in progress.

Date Risk Identified:	Mar-26		
Strategic Objective:	1. Thriving Teams		

Executive Director Owner:	Daniel, Sharon	**Date of Review:**	Sep-26
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Nov-26

Risk ID:	**2357**	**Principal Risk Description:**	There is a risk the Health Board will be unable to consistently deliver a high quality, person centred experience for patients, families and staff, in line with its ambition to provide safe, compassionate and equitable care. This is caused by the absence of a fully embedded, organisation-wide customer service and experience framework, including the lack of a Single Point of Contact, limited advice and support capacity, and fragmented systems for triaging, tracking, and managing care pathways, and learning from and acting on customer feedback and concerns. This could lead to an impact/affect on patient and staff experience, early identification and reduction of harm, equitable access to support, reduced public trust and confidence, staff morale, and missed opportunities to learn, improve and deliver its strategic objectives for quality, safety, efficiency, prevention and population outcomes.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	**No trend information available.**
Domain:	Quality/Complaints/Audit
Inherent Risk Score (L x I):	4×4=16
Current Risk Score (L x I):	3×4=12
Target Risk Score (L x I):	2×2=4
Expected Date To Achieve TRS:	31/03/2028
Trend:	*New risk*

Rationale for CURRENT Risk Score:
The score reflects developing but partial maturity of systems that gather, analyse and act on customer insight across patients and staff. Tools and forums exist (Civica, patient/staff surveys and pulses, Listening & Learning Sub Committee, Communication Hub, WLSS engagement, Harms and Our Performance dashboards, Improving Together), yet integration and consistent follow through remain variable, limiting timely, reliable responses and systematic learning. There is fragility and capacity within the current waiting list support service, and communication hub. PALS service has been stood down due to capacity and requirement to focus on early resolution as part of the Listening to People Process. This requires digital and financial support to deliver enhanced customer service across the health board.

Rationale for TARGET Risk Score:
Achieving TRS requires: (1) establishing a SPOC and PALS style function; (2) adopting a customer service framework and standards; (3) implementing a unified query management approach with clear triage/escalation and defined response times; (4) strengthening triangulation across Civica, PREMs/PROMs, complaints, staff pulses, WLSS contact and quality/safety metrics; (5) routine post implementation reviews evidencing improvements for customers. To reduce this risk to the TRS of 4 will require realignment of resources to support the development of a customer service centre, and to support the enhancements required to the digital infrastructure.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Central Communication Hub with workstreams supporting operational teams to communicate with patients. Contact details available to the public via website. Waiting List Support Service (WLSS) engagement using the 3Ps approach. PALS in place. Civica real time feedback deployed across multiple services. Improving Together sessions and dashboards; Harms and Our Performance dashboards for triangulation. Quality Impact Assessment process embedding experience considerations in service change. Ongoing engagement with Llais and communities, including novel approaches deployed during major consultations. To add detail on Patient Experience Charter / policies / procedures / strategies for patient communication. WLSS - full report on activity in line with national requirements to identify pathway concerns (i.e activity outcomes aligned to national guidance). Listening and Learning Committee.	Fragmented, unconnected customer query routes (multiple phone numbers, emails, inboxes), risk of dropped or delayed responses. No integrated system/dataset providing whole system oversight of customer contact points and outcomes. Insufficient PALS capacity "front of house", WLSS and Communication Hub to provide early resolution, advocacy and real time support. No standard protocol for triage, escalation, tracking and closure of enquiries across all services. Lack of an organisation wide customer service framework and standards with defined behaviours and response time expectations. Inconsistent triangulation of qualitative and quantitative data (Civica, PREMs/PROMs/FROMs, complaints, WLSP, dashboards).	Design and implement a Health Board wide Single Point of Contact (SPOC) with clinical oversight. This will require the project management capacity, scoping, designing and resourcing of a SPOC model (telephony + digital + case management) for patients, families and staff, with defined service standards (e.g., call answer time, first contact resolution, escalation criteria, response time SLAs). (Support will be required of the Director of Finance, Director of Communications, Director of Strategy and Planning and Chief Operating Officer to fully implement this action).	Daniel, Sharon	31/12/2027	New action.
		Establish a modernised PALS style service to provide on the ground support to facilitate early resolution, signposting, advocacy and proactive follow up. This will require alignment with Speak Up arrangements and complaints to avoid duplication. (Support will be required of the Director of Workforce, Chief Operating Officer and a Patient Experience Lead to fully implement this action).	Daniel, Sharon	31/03/2027	New action.
		Implement a unified customer query management & tracking system to provide one system of record required to log, triage, track and close all customer enquiries; integrate with Civica and complaints, and to provide near real time operational and Board level reporting. (Support will be required of the Director of Finance and Patient Experience Lead).	Daniel, Sharon	~~31/12/2026~~ 31/03/2027	New action.

Adopt a Customer Service Framework & Standards + training which will set out the definitions required of behaviours, response times, escalation rules, and compassionate communication standards, and the delivery of targeted training (listening skills, conflict resolution, difficult conversations, inclusive communications). (Support will be required of the Director of Worforce, Director of Communications and Patient Experience Lead to fully implement this action).	Daniel, Sharon	31/03/2027	New action.
Strengthen triangulation & insight which will require the integration of Civica, PREMs/PROMs/WLSS contacts, complaints, staff pulses, operational KPIs and safety indicators into a unified Customer Experience Dashboard; embed in Improving Together and Board reporting.	Daniel, Sharon	31/12/2026	New action.
Embed routine post implementation reviews (PIRs) to assess customer experience impact of service changes; publish learning and improvement actions.	Daniel, Sharon	30/09/2026	New action.
Enhance the digital infrastructure to accommodate all services and functions hosted within the SPOC	Thomas, Huw -	31/12/2027	New action.
Develop a workforce plan to support the development and implementation of digital systems.	Daniel, Sharon	~~30/09/2026~~ 31/12/2026	Development of a SPOC is dependent on a digital infrastructure, with a Patient Services Centre paper due to be presented to Board in November 2026.
To update all forms of communication and correspondence, website and links ensuring patients are signposted to the relevant area (via search engine results)	Daniel, Sharon	~~30/09/2026~~ 31/12/2026	New action.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
SPOC metrics: time to answer, abandonment rate, first contact resolution, average handling time. PALS style metrics: % resolved within 48/120 hours; themes and early resolution rate. Civica metrics: coverage, response rate, positive sentiment, equity (experience by population group), top 5 themes by site/service. PREMs/PROMs/FROMs: experience indicators on priority pathways and trend over time. Complaints/Ombudsman: volume, severity, conversion from concerns to formal complaints, time to respond, early resolution. Staff pulse survey: customer service	Communication Hub Steering Group and operational leads .	1st			Patient Service Centre - Board (Jan26)	Inconsistent / lack of system integration to allow PROMs capture across whole patient pathways Timeliness: SLA not in place to monitor compliance for responses across all interfacing services Lack of SPOC project management governance	To further develop / strengthen access to PROMS/PREMS across whole patient pathway to drive decision making	Henwood, Mr Mark	31/01/2027	New action.
	Directorate Quality Governance Meetings .	1st					To develop and implement SLAs with each Clinical Care Group to ensure compliance for timely responses, and appropriate reporting (Support will be required from the Chief Operating Officer).	Daniel, Sharon	~~30/06/2026~~ 31/10/2026	Revised date provided due to the testing and development of a new patient concerns processes via the Communication Hub and Waiting List Support Service. Work is ongoing with operational teams to develop processes which will inform the formal SLAs.
	Improving Together performance sessions .	2nd					To develop a SPOC steering group, including involvement with Digital and incorporating previous WLSS Steering Group	Daniel, Sharon	~~30/06/2026~~ 31/12/2026	Revised action date provided as dependent on the digital infrastructure, with a paper due to Board in November 2026.
	Patient Experience Reports to Board .	2nd								
	Listening & Learning Sub Committee .	2nd								
	Quality, Safety & Experience Committee scrutiny assurance on improved outcomes .	2nd								
	Executive Team oversight of Planning Objectives .	2nd								
	Speak Up / engagement reports .	2nd								
	Our Performance and Harms dashboards .	2nd								

customer service culture items (respect, support, communication). Timeliness: SLA compliance for responses across all interfacing services.	HIW inspection findings and follow up .	3rd							
	PSOW decisions .	3rd							
	Internal Audit work on safety indicators / quality governance / triangulation as commissioned .	3rd							

4.2

4.2 - Deep Dive: Orthopaedics

Lianne Gregory (Hywel Dda UHB - Service Delivery Manager), Paula Goode (Hywel Dda UHB - Service Director for Planned and Specialist Care)

For assurance

Attachments

Deep Dive Elective Orthopaedics Update October 2026 V2.pdf



Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Deep Dive: Elective Orthopaedics UPDATE

Quality, Safety and Experience Committee

8 October 2026

Situation / Executive Summary

Purpose

To provide the Committee with assurance regarding the actions taken since the December 2025 Elective Orthopaedics Deep Dive, the current position of the service and impact on quality, safety and patient experience, and the ongoing management of residual risks.

Key Messages:

✅Progress has been made in addressing a number of the fragilities identified during the December 2025 Deep Dive including workforce sustainability, outpatient access and patient support arrangements.

✅ Improved access to outpatient assessment has been achieved through additional activity and waiting list initiatives

⚠Demand continues to exceed available treatment capacity, resulting in increasing pressure on inpatient and day case pathways and a deterioration in the longest treatment waits.

⚠Workforce, theatre and pre-assessment constraints continue to impact service resilience and the pace of elective recovery.

⚠Prolonged elective wait times remain a risk to patient outcomes and experience, although these risks continue to be monitored through established governance and assurance arrangements.

Assessment

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

The December 2025 Deep Dive identified a number of service fragilities across access, workforce, quality and patient experience. This update provides the current position against those areas and the actions taken to mitigate risk.



Theme	December 2025 position	October 2026 position	Status
Access and Capacity 	Significant backlog and prolonged waiting times for treatment remained, with sustained pressure on referral-to-treatment pathways. Longest waits had reduced from four years to two years, however waiting list pressures remained substantial	Treatment waits reduced to a maximum of two years by March 2026, demonstrating that recovery trajectories were achievable. However, demand has continued to exceed available treatment capacity and, in the absence of sustained additional activity, the longest waits have subsequently increased. Welsh Government recovery funding has now been secured to support elimination of waits over two years by March 2027. The Clinical Services Plan (CSP) option for Orthopaedics include provision of additional activity at Bronglais Hospital (BGH) and Prince Philip Hospital (PPH) to improve access and treatment capacity*. Stage 4 volumes have increased significantly since the stage 1 insourcing project.	**Improvement achieved but not sustained.**
Theatre Capacity 	Theatre constraints were affecting activity delivery, including limited access to General Anaesthetic day surgery capacity and reduced utilisation of available theatre space	Theatre capacity continues to be constrained due to competing organisational priorities, variable anaesthetic availability and loss of elective capacity across a number of sites**. As a result, the service remains unable to consistently deliver sufficient activity to meet demand, impacting the pace of elective recovery. A range of mitigating actions are being utilised to maximise available capacity, including internal waiting list initiatives, regional working, insourcing and outsourcing arrangements	**Significant challenge remains**
Pre-assessment Capacity 	Pre-operative assessment capacity did not match demand, impacting the ability to populate theatre lists and deliver activity in line with planned models	Pre-operative capacity remains a constraint and continues to impact productivity, theatre utilisation and the ability to populate theatre lists in line with demand. However, some pathway improvements have been introduced for selected lower-risk procedures through the use of screening questionnaires, enabling some patients to progress more rapidly to treatment whilst maintaining clinical safety. However, additional pre-assessment capacity is required to support sustainable elective recovery and maximise use of available theatre capacity	**Significant challenge remains**

Assessment (continued)

Theme	December 2025 position	October 2026 position	Status
Workforce Sustainability 	Reliance on variable pay arrangements to provide 24/7 medical cover for elective inpatients. Workforce resilience concerns existed across a number of staff groups	Approval was secured for additional junior doctor recruitment, and a revised resident doctor rota was implemented in September 2026. This has significantly reduced reliance on variable pay arrangements and provides a more sustainable model for 24/7 inpatient cover at PPH. Workforce resilience continues to be monitored to ensure compliance with national contract requirements and maintenance of safe staffing levels.	Improved
Medical Recruitment 	Recruitment challenges were identified within key sub-specialties, particularly Foot & Ankle services, alongside wider workforce fragilities and recruitment challenges at Bronglais General Hospital (due to ageing workforce and rural setting).	Temporary Foot and Ankle consultant cover has been secured and substantive recruitment is planned, with interest expressed in the post. Substantive recruitment is also planned to a complex arthroplasty consultant role. Recruitment requirements associated with future CSP implementation are currently being worked through as part of the development of a formal workforce plan.	Partially Improved
Outpatient Capacity 	Outpatient estate limitations restricted opportunities to develop more efficient multidisciplinary clinic models and optimise patient pathways	Stage 1 waiting times have reduced significantly from approximately 52 weeks to 26 weeks through Welsh Government-funded insourcing activity. However, this additional activity has increased demand within treatment pathways, whilst estate limitations continue to restrict development of multidisciplinary models of care and more efficient patient pathways*.	Significant challenge remains
Quality & Safety 	Concerns existed regarding access to critical care support pathways for elective orthopaedic patients, alongside challenges arising from deviation from agreed processes.	Prolonged waits continue to present a risk of deterioration in patient condition, quality of life and clinical outcomes. Work continues through the CSP programme to strengthen elective pathway resilience and support the long-term sustainability of elective orthopaedic services, including development of critical care pathways and identification of a ringfenced orthopaedic inpatient ward to reduce disruption from unscheduled care pressures and support compliance with British Orthopaedic Association (BOA) standards.	Significant challenge remains

Assessment (continued)

Theme	December 2025 position	October 2026 position	Status
Clinical Governance & Data 	Significant backlog in National Joint Registry (NJR) data entry reduced the ability to provide comprehensive outcome assurance.	Progress has been made in reducing the National Joint Registry (NJR) backlog through temporary additional resource arrangements improving data quality and reporting. However, a sustainable long-term solution for NJR management remains required*. The Welsh Orthopaedic Network's All Wales Clinical Conditions, Prioritisation and Pooling (ACCPAP) policy has been approved through the Orthopaedic Clinical Implementation Network (CIN), providing a more consistent approach to waiting list management and prioritisation.	Partially Improved
Patient Experience 	Prolonged waits increased the risk of deterioration in patient condition, quality of life and clinical outcomes, with treatment delays a prominent complaints theme.	Patient concerns, complaints and experience themes continue to be associated with prolonged waiting times and restricted access to elective treatment, reflecting the ongoing mismatch between demand and treatment capacity.	Significant challenge remains
Regional Working 	Challenges existed in collaborative working arrangements due to different clinical and administrative systems across organisations.	Regional collaboration has progressed within Foot & Ankle services. Work is also underway across both Health Boards, supported by NHS Wales Performance and Improvement, to develop a regional demand and capacity modelling tool to inform future service planning. Discussions continue regarding alignment of digital pathways across organisations. Hand & Wrist developments have been delayed due to anaesthetic & theatre capacity constraints**. Infrastructure and system variation continue to present barriers to further regional integration.	Partially Improved
Patient Support & Improvement Initiatives 	The Waiting List Support Service and Orthopaedic Prehabilitation Service had recently been established to support patients while awaiting treatment	Waiting List Support Services and Orthopaedic Prehabilitation continue to support patients whilst awaiting treatment and remain important components of the elective pathway. Welsh Government recovery funding will support productivity improvements through additional ODP, anaesthetic and pre-assessment capacity, with the aim of improving theatre utilisation, increasing activity and reducing treatment waits	Partially Improved

Current Service Fragilities

- **Service Fragilities**
- Demand continues to exceed available treatment capacity
- Theatre capacity remains constrained through anaesthetic workforce limitations and competing organisational priorities.
- Pre-assessment capacity continues to restrict theatre utilisation and productivity.
- Extended treatment waits remain a significant challenge, with 104-week waits increasing following elimination of the backlog in March 2026

Clinical Impact/Risk of Harm

- Prolonged waits increase the risk of deterioration in pain, mobility and functional status.
- Delayed treatment may adversely affect quality of life, independence and overall wellbeing whilst patients await intervention.
- Progression of symptoms during extended waits may result in more complex treatment requirements and recovery pathways.
- Treatment delays continue to present risks to patient experience and clinical outcomes, although these risks are mitigated through clinical prioritisation, waiting list validation and patient support services.

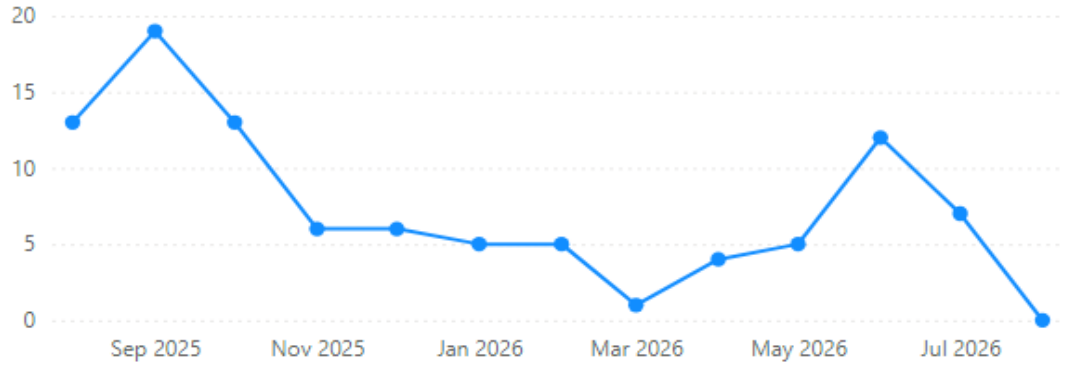
Complaints and Patient Experience

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Complaint volumes have reduced over the reporting period, with improvements seen in communication and appointment-related complaints.

Delays to treatment and access to care continue to be reflected within complaint themes and patient feedback.

Number of complaints received



- Total complaints in 2024/25 - 182
- Total complaints in 2025/2026 - 115
- Total complaints in 2026/27 (year-to-date) - 28

Top complaint themes.

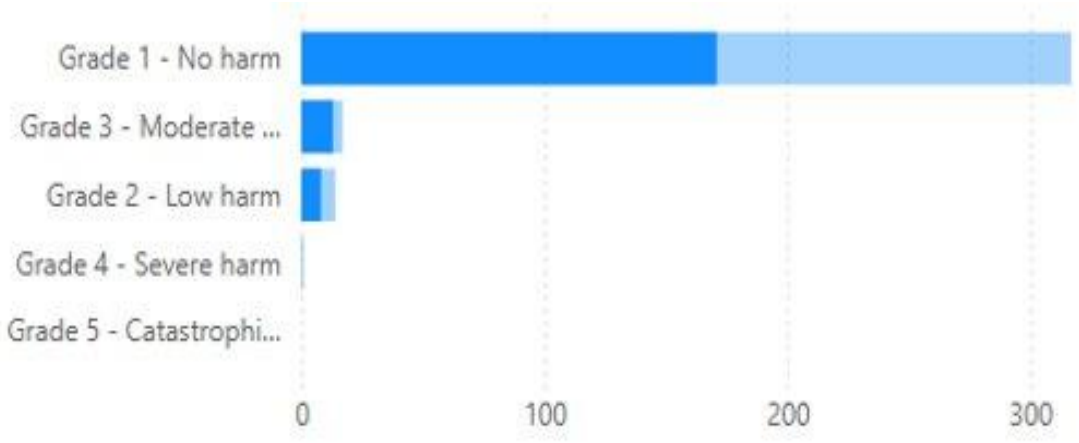
1) **Clinical Treatment/Assessment** - makes up 51% of 2024/2025, 58% of 2025/2026 and 61% of year to date totals.
2) **Appointments** - makes up 14% of 2024/2025 and 2025/2026 and 7% of year to date totals.
3) **Communication Issues** - makes up 9% of 2024/2025 and 2025/2026 and 4% of year to date totals.

Clinical Treatment/Assessment is the most frequently reported complaint theme. However, this dataset also includes trauma activity and cannot currently be separated into elective and trauma pathways.

Appointment and communication-related complaints have reduced proportionally over the reporting period, suggesting improvement in administrative and patient communication processes. Waiting List Support Services and Orthopaedic Prehabilitation continue to provide support for patients awaiting treatment.

Clinical Harm Associated with Closed Complaints

The majority of closed complaints were assessed as resulting in no harm, providing assurance that significant patient harm identified through complaint investigations remains uncommon.



•The majority of complaints investigated during the reporting period resulted in a **No Harm** grading.

•Whilst prolonged waits remain a recognised risk to patient outcomes and experience, complaint investigations have not identified widespread patient harm associated with elective orthopaedic pathways.

•Learning from complaints is reviewed through specialty governance arrangements and informs ongoing improvement activity.

Please note this dataset relates to the combined Trauma and Orthopaedic service and cannot currently be disaggregated to elective orthopaedics only

Mitigating Actions

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The following actions are in place to mitigate the risks associated with prolonged waiting times and support patient safety whilst awaiting treatment:

- Clinical prioritisation and regular waiting list validation processes are in place, supported by implementation of the ACCPAP policy.
- Patients have access to a single point of contact and are able to report deterioration and request clinical review where indicated.
- Waiting List Support Services and Orthopaedic Prehabilitation continue to support patients whilst awaiting treatment.
- Risks associated with prolonged waits are monitored through specialty governance, Clinical Care Group performance arrangements and planned care recovery governance.
- Welsh Government recovery funding and Clinical Service Plan (CSP) programme developments are intended to improve sustainable treatment capacity and support delivery of recovery trajectories.

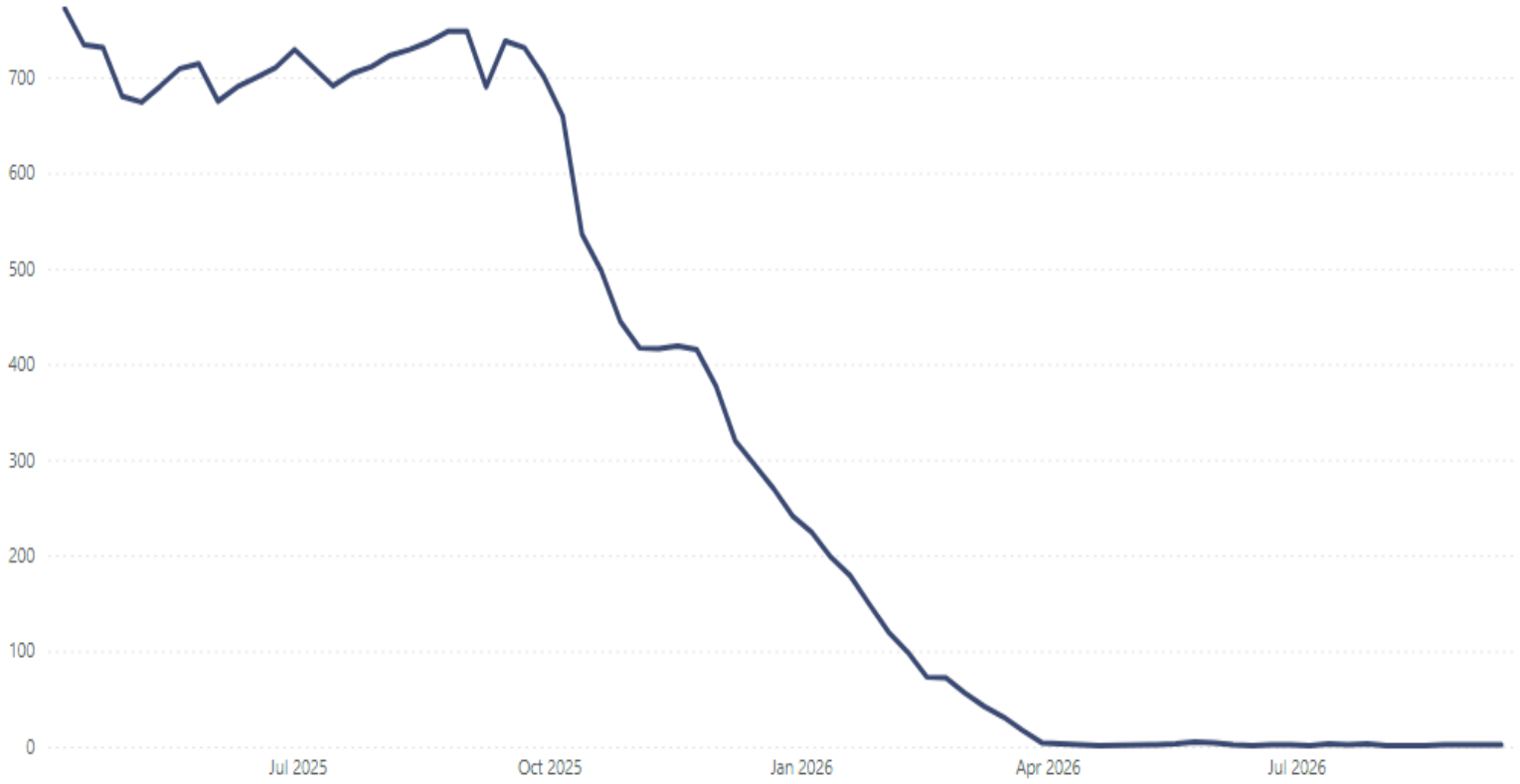
Key Assurance Message:

Whilst prolonged waiting times remain a significant challenge, mechanisms are in place to identify patient deterioration, provide support whilst waiting and ensure risks are actively monitored and managed.

Assessment Overview

- Stage 1 waits have reduced significantly following Welsh Government-funded insourcing activity.
- Increased outpatient activity has resulted in significant growth in inpatient and day case referrals.
- Available treatment capacity has not increased sufficiently to match demand.
- As a result, Stage 4 (104+ week) waits have increased following elimination of waits over two years in March 2026.
- The principal fragility remains the mismatch between demand and available treatment capacity
- Prolonged waits continue to present risks to patient experience, quality of life and clinical outcomes, although assurance processes remain in place to identify deterioration and manage risk.

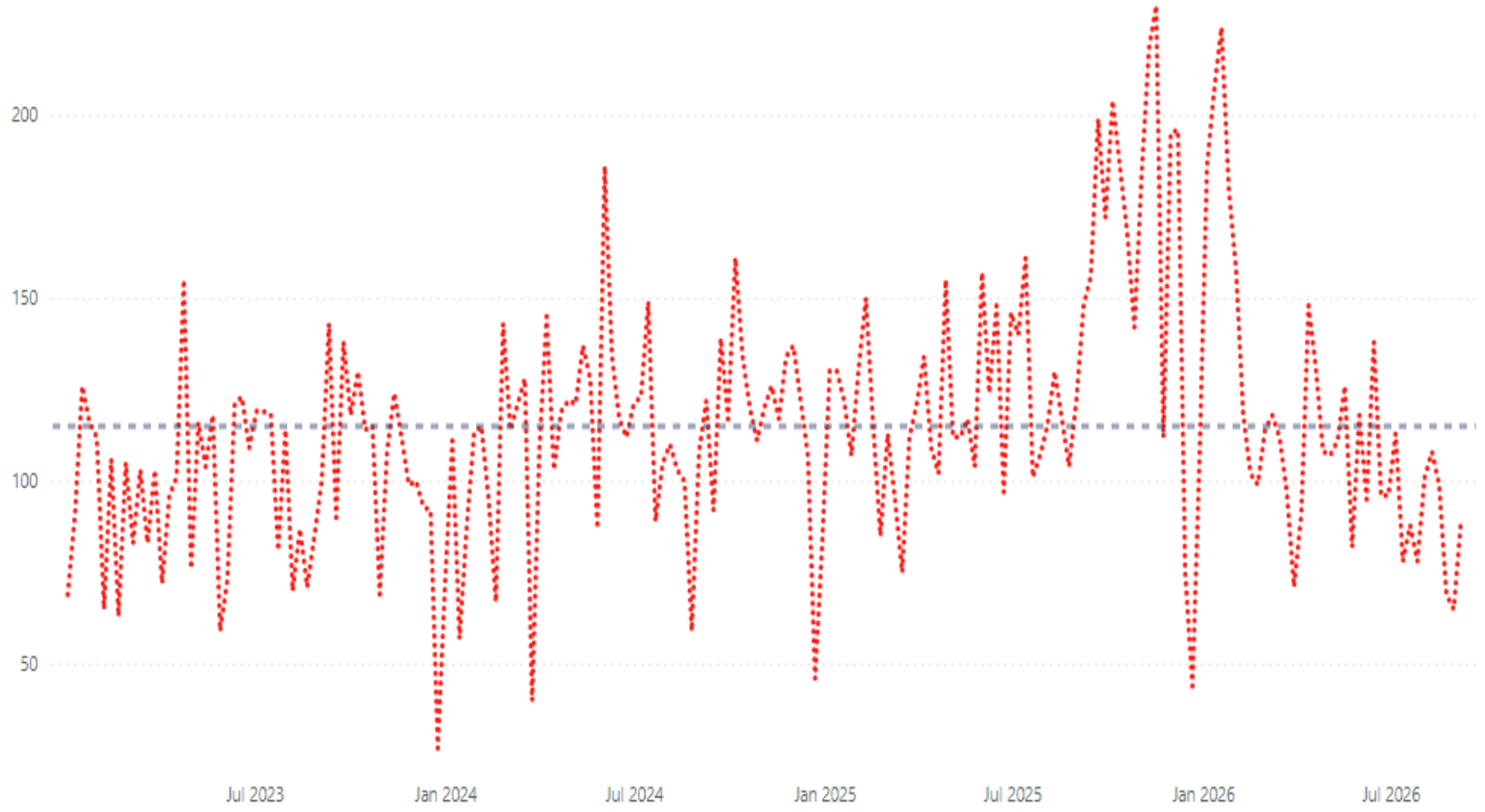
Referral to Treatment (RTT) Stage 1 Performance (26 Week Waits)



Amserol
Timely

Key Message: Stage 1 waiting times have reduced significantly from approximately 52 weeks to 26 weeks following Welsh Government-funded insourcing activity. This has improved access to initial outpatient assessment and reduced the longest waits for patients entering the orthopaedic pathway. However, the additional activity has resulted in increased conversion of patients into treatment pathways, placing greater demand on downstream capacity.

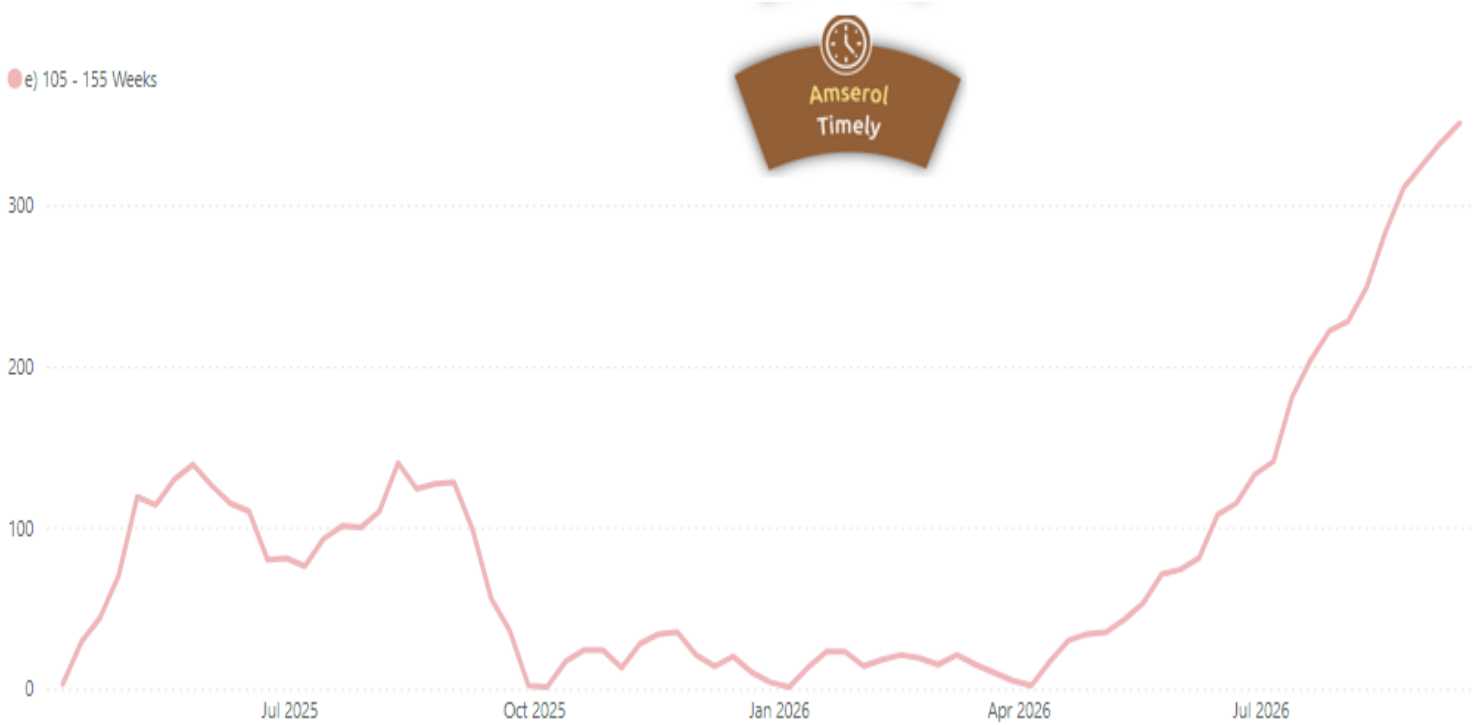
Increasing Demand for Treatment



Amserol
Timely

Key Message: Day case and inpatient referrals increased significantly as a result of the increased outpatient activity. Whilst this demonstrated improved access to initial assessment (wait times reduced to <26 weeks), it has also increased the number of patients progressing to treatment pathways, placing additional pressure on elective capacity. Referral growth has outpaced available treatment capacity, contributing to increasing pressure on Stage 4 waits and elective recovery trajectories

RTT Stage 4 Performance (104 week waits)



Month	104 week breaches
March 2026	1
April 2026	10
May 2026	32
June 2026	88
July 2026	187
August 2026	309
September 2026	450 (predicted landing)

Key Message: The service reduced waits over 104 weeks to a minimal level by March 2026, demonstrating that recovery trajectories were achievable. However, demand has continued to exceed available treatment capacity and, in the absence of sustained additional activity, the longest waits have subsequently increased.
Welsh Government recovery funding has now been secured to support delivery of the national ambition to eliminate waits over 104 weeks by March 2027.

Triangulated position

Access and Waiting times

- Stage 1 waits reduced through additional activity
- 104 week waits have subsequently increased

Demand and Capacity

- Increased outpatient activity has generated additional treatment demand
- Treatment capacity remains constrained

Workforce and Resources

- Workforce resilience improved through recruitment and rota changes
- Theatre, anaesthetic and pre-assessment constraints remain

Patient Experience

- Complaints and patient concerns continue to focus on waiting times and access to treatment

Quality & Safety

- Prolonged waits continue to present risks of deterioration in condition and quality of life



In Summary: The principal fragility remains a mismatch between demand and available treatment capacity. Whilst progress has been made in a number of areas, sustained additional capacity is required to achieve and maintain elective recovery.

Conclusion and Assurance

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Progress since December 2025:

- Workforce resilience has improved through implementation of a revised resident doctor rota and additional recruitment.
- Stage 1 outpatient waits have reduced significantly through additional activity.
- Progress has been made in reducing the National Joint Registry backlog and strengthening waiting list governance arrangements.
- Regional collaboration has continued to develop across a number of sub-specialties.



Residual Risks:

- Demand continues to exceed available treatment capacity.
- Theatre, anaesthetic and pre-assessment constraints continue to impact elective recovery.
- Prolonged waits remain a risk to patient experience, quality of life and clinical outcomes.
- Recruitment and workforce challenges remain within some specialist areas.



Assurance:

- Risks continue to be monitored through specialty governance arrangements, Clinical Care Group performance arrangements and planned care recovery governance.
- Progress is overseen through Clinical Care Group performance and planned care recovery processes.
- Delivery of further improvements is supported through Welsh Government recovery funding and the CSP programme.



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The Duty of **Candour**

Openness and honesty should be at the heart of every relationship between those providing treatment and care and those experiencing it.





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SAFE | SUSTAINABLE | ACCESSIBLE | KIND

The six domains of quality

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



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



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



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



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

4.3

4.3 - Deep Dive: Dermatology

Ceri Wisdom (Hywel Dda UHB - Service Delivery Manager), Paula Goode (Hywel Dda UHB - Service Director for Planned and Specialist Care)

For assurance

Attachments

2 Deep Dive Template Dermatology Sept 26 v0.2.pdf



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Deep Dive: Dermatology UPDATE

Quality, Safety and Experience Committee

8 October 2026

Situation

The purpose of this report is to provide the Quality, Safety and Experience Committee with an update on the progress made since the Dermatology deep dive that was presented on 4th November 2025 and to provide assurance regarding service performance, quality and risk management. The report focuses on key development in skin cancer and Referral to Treatment (RTT) performance, workforce sustainability and the associated impact of service delivery. This is supported by triangulation of performance and workforce data, incidents, complaints and to provide an assessment of service quality, safety and patient experience.

Background

The Dermatology Service currently operates under significant strain due to longstanding workforce shortages, limited clinical infrastructure, particularly regarding treatment space and rising demand.

The current service model is heavily reliant on external providers to support key operational functions, including triage, insourcing and teledermoscopy. To achieve long term sustainability, the model must adopt a more flexible, integrated approach that maximises digital innovation, multidisciplinary working and the effective use of internal resources. Current space constraints limit the ability to undertake core functions efficiently, creating operational inefficiencies and restricting opportunities for service transformation. Additional clinical and administrative accommodation would enable the existing workforce to be utilised more effectively, supporting a more resilient, efficient and quality focused service delivery model. This would strengthen service capacity and improve outcomes for patients while ensuring the service remain sustainable for the future.

The Dermatology Service has operated without a substantive Consultant Dermatologist since 2016. Despite improved workforce sustainability, including locum consultants, permanent General Practitioner with Extended Role (GPwER), x3 Specialty Doctors, specialist nursing teams and an Advanced Pharmacist, demand continues to outpace capacity.

The Health Board has the highest incident of melanoma in the UK and has experienced a 122% increase in referrals compared to an all Wales average of 5% (NHS Wales Performance and Improvement (P&I) 2025). Demand is forecast to rise further, with skin cancer cases expected to increase by 50% in the next 20 years.

Without investment in clinical capacity and infrastructure, the Health Board will be unable to sustainably achieve Unscheduled Care and RTT standards, resulting in ongoing risks to patient outcomes, performance and reputation. Proposals have been developed through the CSP process to address these challenges, with Option C approved by public consultation.



Assessment – Safe

Waiting list remains the same with and increase with the treatment delivery gap which increases the risk of patients deteriorating and avoidable harm

- **Urgent Suspected Cancer demand (USC)**

Required -110 slots and 70 slots minor procedures (MOP) per week (NHS P&I 2026 20% increase each year)

Gap – 30 slots per week for MOPs

- **Referral to Treatment (RTT)**

Patients are waiting 104 weeks for treatment and 52 weeks for outpatients appointments.

- Triaging backlog circa 600 referrals
- Backlog letters circa 500 backlog

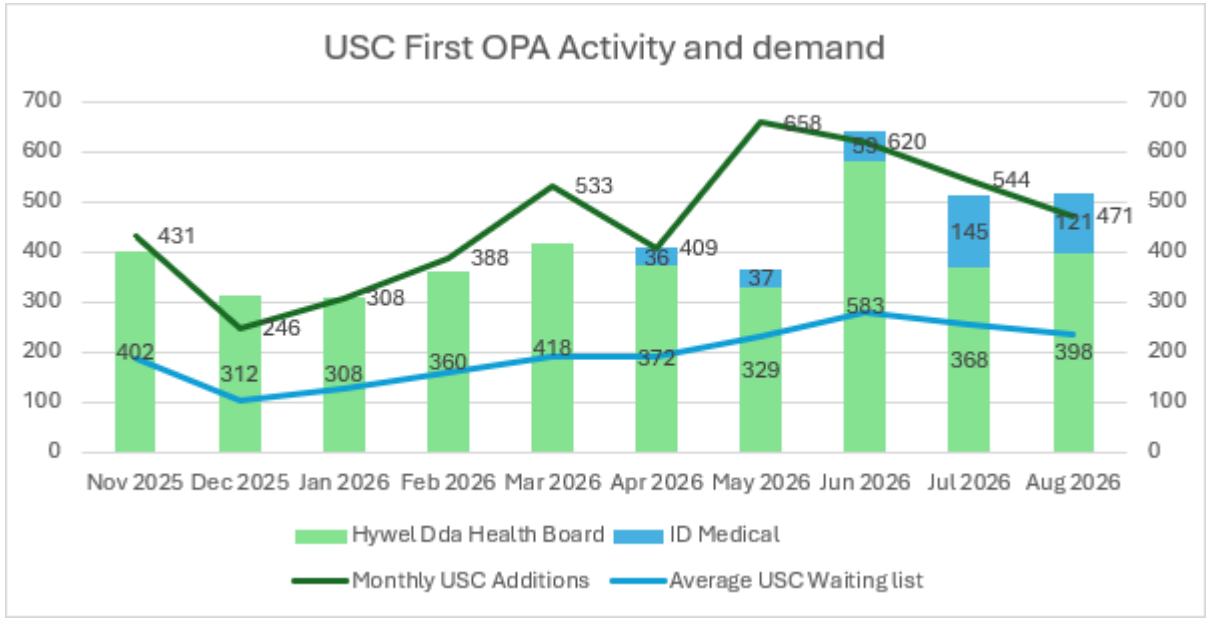
- Advanced Pharmacist providing medicines optimisation
- Dedicated biologic clinic and rapid access clinics supporting safe monitoring
- Job plans 100% compliant
- Regular governance meetings providing oversight and learning
- Clinical audits

Workforce Update

- Nurse Consultant job description to be refined for job matching
- Specialist Grade interviews 1st October 2026
- Permanent GPwER (GP with Extended Roles) recruited September 2026

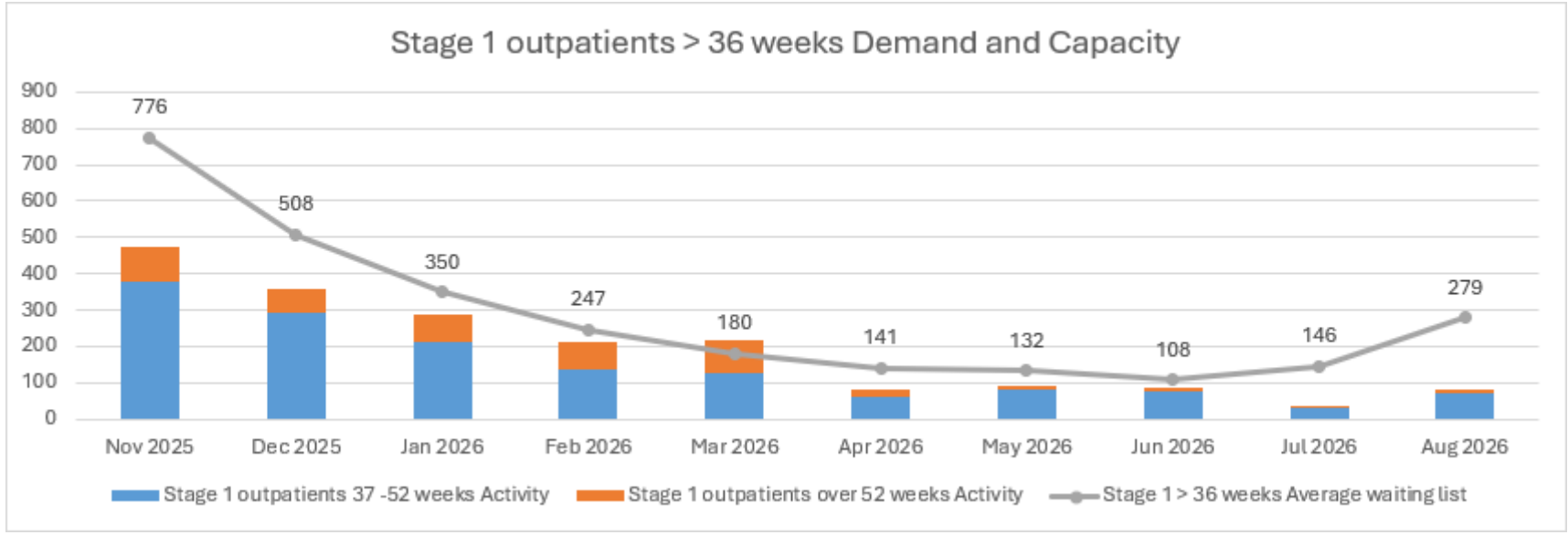


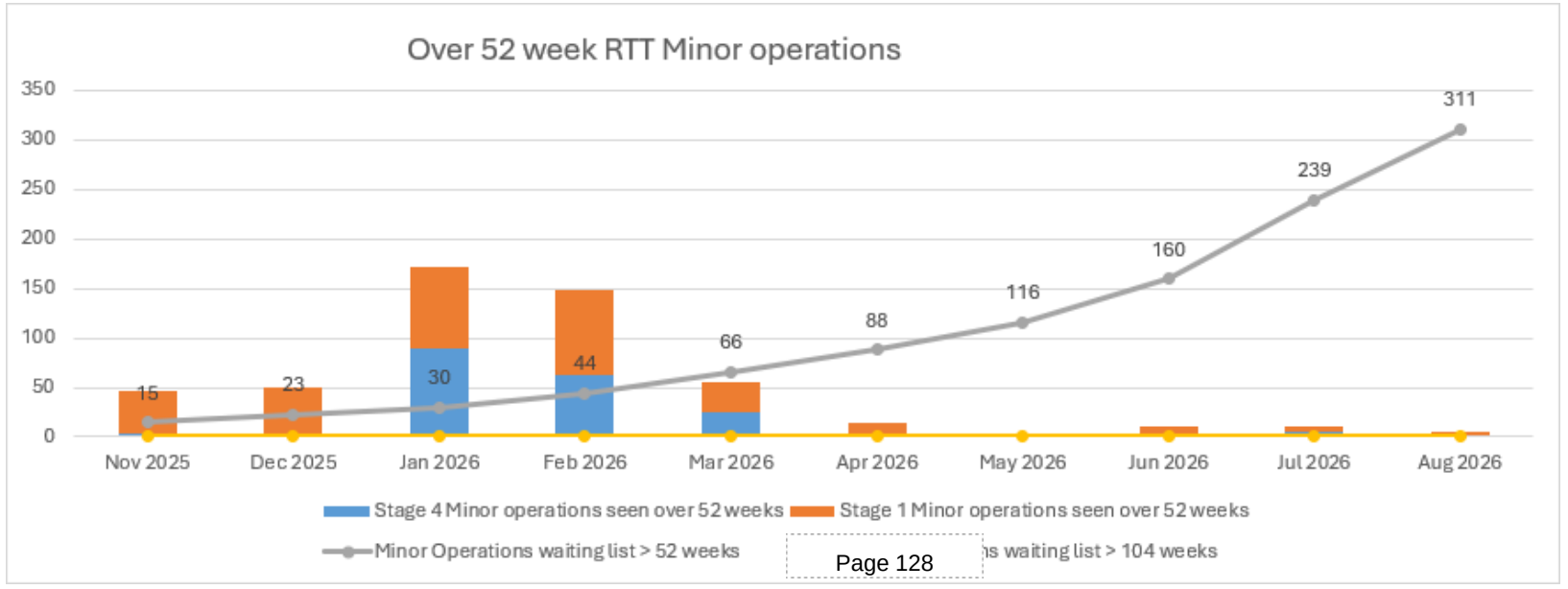
Assessment – Timely USC



- The data suggests that rising demand, particularly between March and June 2026, outpaced available capacity and drove a substantial increase in the USC waiting list.
- The expansion of activity, especially through ID Medical from July 2026 onwards alongside sustained Health Board output, appears to have reversed this trend with a reduction of **185 (32%) patients receiving their assessment within clinically appropriate timescales.**
- However, by August 2026 the waiting list remained broadly similar to the level seen at the start of the period, indicating that additional sustained capacity may be required to achieve longer-term reductions in backlog

Assessment – Timely RTT





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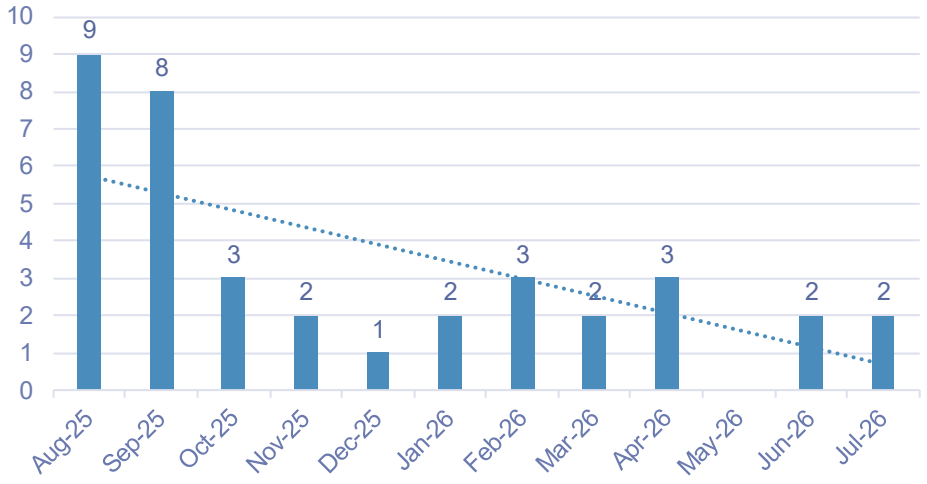
Teg Equitable

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Assessment – Effective

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Complaints

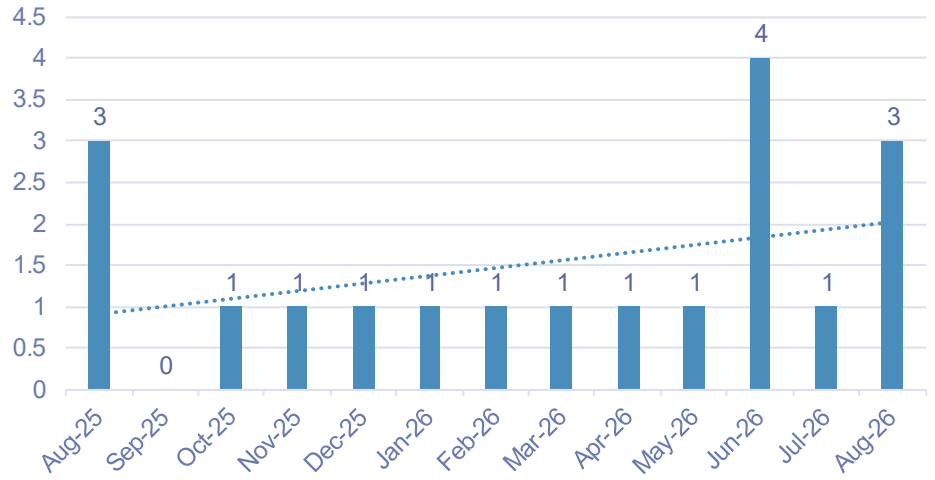


- Complaints peaked in August 2025 and September 2025
- Complaints reduced by 67% between September 2025 and October 2025
- During 2026, compliant levels remained 2-3 per month with 0 complaints recorded in May 2026

Compliments

- Five unsolicited compliment letters received, highlighting positive patient experiences. Patients reported feeling informed about procedures. Patients felt treated with dignity, kindness and respect. Communication was clear and understandable.
- Incident reporting demonstrates an open safety culture and proactive identification of risks.

Incidents



- Peak reporting of incidents occurred in June 2026
- August 2025 and August 2026 both recorded 3 incidents
- Slight upward trend overall driven by increased reporting during June and August 2026

Red (Severe): 3 incidents

Amber (Moderate): 3 incidents

Green (Low/None): 11 incidents

Total incidents: 17

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Assessment – Efficient

- The service is working inefficiently due to the infrastructure
- No see and treat clinics (British Association of Dermatologists guidance)
- Lack of clinical leadership
- Delays in triaging referrals
- Operating on less complex patients that can be managed in Primary Care (Basal Cell carcinomas)
- Lack of pathway standardisation due to Outpatient department space
- High discharge at first face to face outpatient appointment and conversion to minor procedure

Month discharge at first OPA	Percentage
April	24%
May	24%
June	23%
July	17%
August	15%
Average	**21%**

Conversion rate into daycase	Percentage
April	47%
May	51%
June	48%
July	56%
August	56%
Average	**52%**

- Teledermoscopy April – August (supported by Aneurin Bevan University Health Board)

Outcome	Numbers	Percentage
MOP	112	39%
Discharge	154	53%
F2F	17	6%
Repeat photos	5	2%
Total	**288**	**100%**

- Faster specialist review without requiring attendance at hospital.
- Earlier identification of patients requiring urgent treatment.
- Reduced travel burden, particularly for rural communities.
- More patients managed appropriately closer to home.

Electronic referrals with images improve diagnostic quality at first review.

Virtual follow-up clinics reduce unnecessary outpatient appointments.

Clinical Nurse Specialist and Advanced Health Practitioner clinics increase access whilst maintaining specialist oversight.



Assessment – Equitable

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Current Impact

Patients currently travel further and attend more appointments than necessary because see-and-treat pathways are limited

Rural communities may experience greater inconvenience due to repeated hospital visits.

.

Future Benefits

Minor surgery delivered in primary care provides care closer to home

Expansion of GPwER and enhances schemes will improve access

See and treat models reduce travel, waiting and inconvenience for patients



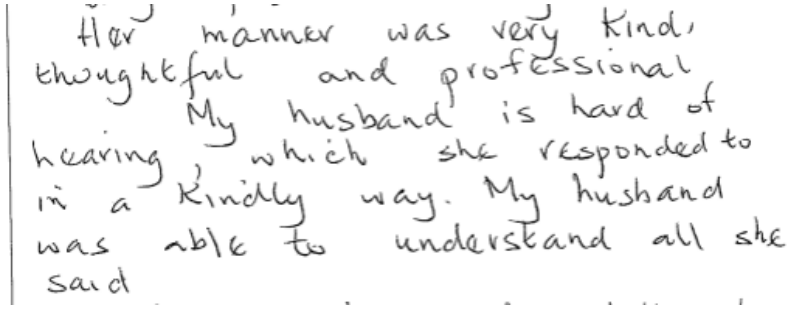
Assessment – Person Centred

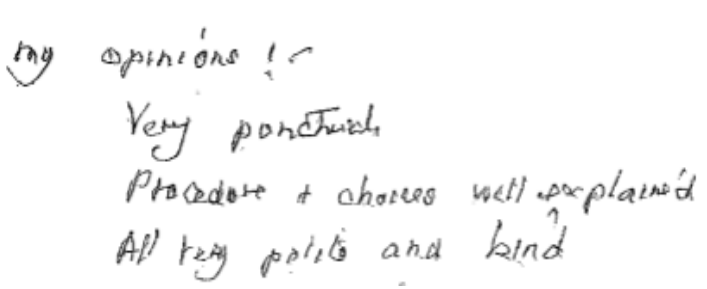
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Patient feedback indicates that despite significant pressures, patient interactions remain positive and person centred

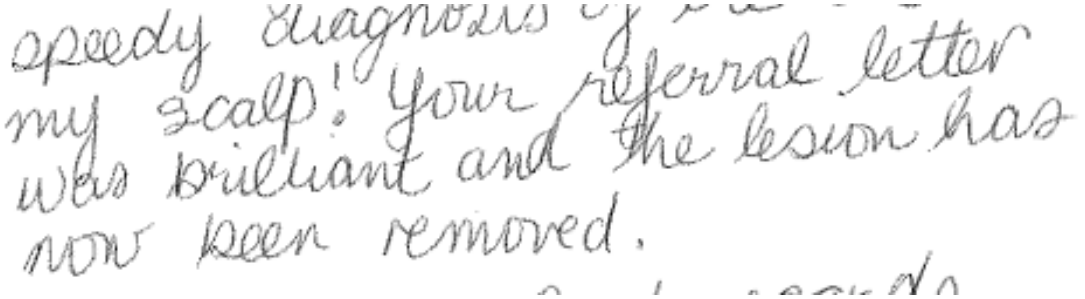
What patients tell us about their care:

- Clear explanations
- Compassionate communication
- Professional knowledgeable staff
- Confidence in treatment decisions





Patient attended minor op procedure at CICC 12/02 - wishes to thank all of the staff involved. The service was excellent. Thank you :)



Would like to pass on his thanks to the team that did his biopsy on 19/02 as he felt the team were fantastic.

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Teg Equitable

Person ganolog Person centred

Conclusion

Solutions

To improve access to specialist assessment and treatment through sustainable capacity requires sufficient infrastructure to undertake:

- See and Treat clinics
- High volume low complexity clinics

This will reduce waiting times, travel requirements and repeat appointments while providing care closer to home

Hybrid Model

The proposed hybrid model will support delivery of sustainable cancer and RTT pathways, improve patient access to timely care, reduce the risk of harm form prolonged waits and enhance patient experience whilst maintaining quality and safety standards.

Constraints

Regular and sufficient estate and support staff (clinic rooms, nursing, pathology).
Current performance is based on planning 1 month ahead due to reliance on theatre backfill





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5

5 - Never Events Assurance Report

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

For assurance

Attachments

Never Events QSEC Oct 2026.pdf



Never Events:

From patient safety signal to reliable clinical practice

QUALITY, SAFETY AND EXPERIENCE COMMITTEE

October 2026

Situation

The purpose of this report is to provide the Quality, Safety and Experience Committee (QSEC) with assurance that Never Event learning is being converted into reliable clinical practice through the Health Board's Quality Management System (QMS), Patient Safety Plan and established governance routes.

Assurance offered | Make-safe action, investigation, Duty of Candour and local improvement are in place; QSIG is strengthening the closed loop from learning to implementation and impact.

How assurance is controlled | Quality, Safety Intelligence Group (QSIG) triangulates patient-safety intelligence, subgroups test clinical-effectiveness standards and measures, and Clinical Care Groups (CCG) evidence implementation, compliance and sustained improvement.

QSEC can take assurance | that an accountable cross-site programme is active, with exception reporting through QSIG and escalation where evidence, trajectory or implementation is insufficient.

Safety-II and QMS lens | *learning from harm is combined with insight from everyday work and reliable practice, linking quality planning, control, improvement and assurance.*

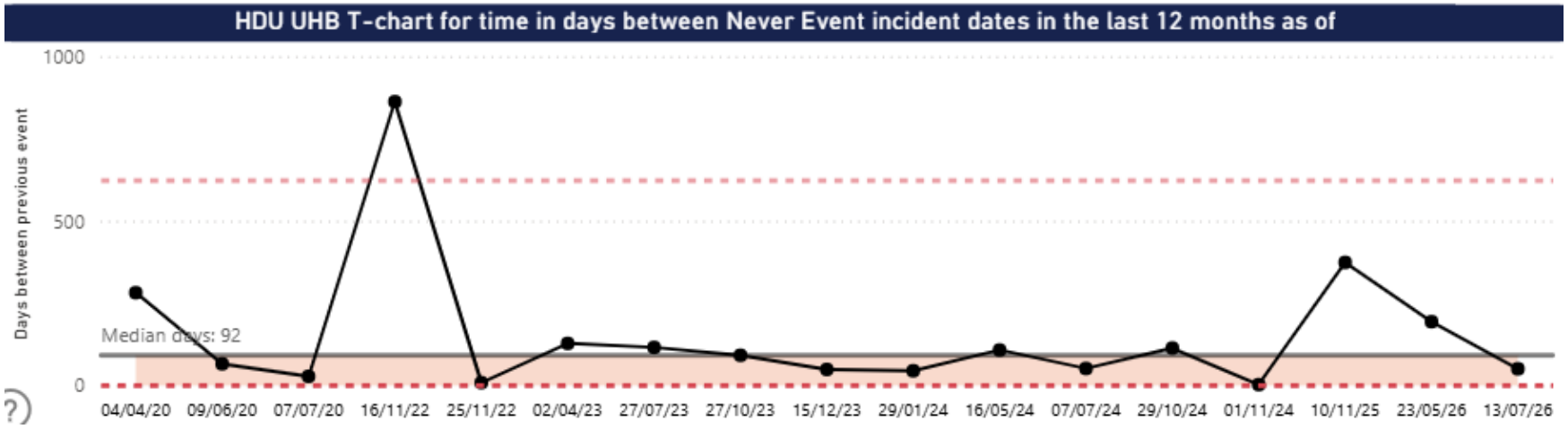


Recurring themes are becoming system controls

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Recurring Never Events have triggered a structured cross-site assurance and improvement response.

- **Current submitted position:** 16 events over six years; 13 closed and 3 open.
- **2026 concentration:** two retained items, one NG-tube event and one wrong implant.
- **Highest-volume themes:** retained items, wrong implants and NG-tube safety; recurring causes include procedural reliability, competency, documentation, human factors and weak challenge/escalation.
- **The QMS response:** patient safety identifies signals and system conditions; clinical effectiveness tests whether agreed controls are implemented, reliable and sustained.



Assurance is active while impact evidence develops

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Assurance available now: make-safe actions, investigations, Duty of Candour, NG huddles/checks and local control changes are in place.

- **Clinical-effectiveness strengthening:** QSIG is using the Effective Clinical Practice Advisory Panel and subgroup routes to define measures, test compliance and review repeat audit.
- **Clinical Care Group accountability:** CCGs own implementation, evidence controls, explain variation and confirm remedial action, ownership and timescales.
- **Safety-II approach:** event learning is combined with observation of everyday work, human factors and examples of reliable practice so changes fit the clinical system.
- **Governance route:** CCGs implement and report; subgroups provide expert scrutiny; QSIG triangulates and challenges; QSEC receives exception-based assurance.
- **QMS assurance:** planning, control, improvement and assurance are linked so activity is distinguished from measurable and sustained impact.



The QMS closes the loop from learning to assurance

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

1 — Safety signal
harm + everyday work

2 — Relevant standard
National / local

3 — Control measure
definition + threshold

4 — Baseline + observation
site + pathway

5 — CCG implementation
owner + trajectory

6 — Repeat test
reliability + impact

7 — Assurance
QSIG → QSEC

PATIENT SAFETY | CLINICAL EFFECTIVENESS | GOVERNANCE

QSEC receives assurance through QSIG (via the the Quality Assurance Report) when CCG implementation, subgroup scrutiny and repeat measurement show that learning is embedded and controls are reliable.

Clinical effectiveness tests delivery and impact

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Expected outcome: reliable safety-critical controls, reduced recurrence and confidence that learning is embedded in everyday practice.

- **1 Standard and control |** link each event to the national/local requirement and the safety-critical process that protects patients.
- **2 Measure set |** agree outcome, process, competency, exception and balancing measures with thresholds and reporting frequency.
- **3 Baseline and Safety-II insight |** combine audit with observation of how work is actually done across CCGs, sites, pathways and conditions.
- **4 CCG implementation |** standardise controls, build competence, address system barriers and evidence ownership, trajectory and local delivery.
- **5 Subgroup scrutiny |** the Effective Clinical Practice Advisory Panel and relevant groups test evidence, re-audit, exceptions and sustainability.
- **6 Assurance |** QSIG triangulates delivery and impact, holds CCGs to account and reports assurance or exceptions to QSEC (through the Quality Assurance Report).



Never events: 2020 to 31 August 2026

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

16 REPORTED EVENTS **11** CLOSED **3** LISTED OPEN

Scope: 16 reported Never Events from 2020–2026.

- **Organisational spread:** Planned Care (6), Integrated Medicine (5), Women & Children (4), and Mental Health & Learning Disabilities (1).
- **Reconciled category summary:** 7 retained items, 4 wrong implants, 3 NG-tube events, 1 wrong-route medication, 1 inpatient suicide.
- **Open line list:** 1 wrong implants, 1 NG-tube events, 1 retained item. They are all are dated 2026 and open within agreed investigation timescales.
- **Assurance implication:** QSIG is holding CCGs to account for implementing learning, with clinical-effectiveness scrutiny and repeat measurement used to evidence reliable practice.

See appendix for further detail

Controls are defined and implementation is under scrutiny

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Theme	Required control	Evidence now	Clinical-effectiveness test	Assurance
NG tubes	LocSSIP, care plan, competency, escalation	Briefings, huddles and checks reported; cross-site compliance not consolidated	Audit checklist adherence, competency and exceptions; repeat three-monthly	**DEVELOPING**
Implants	Three checks, final compatibility, loan-stock control	Changes reported; no consolidated observational compliance	Observe checks by site; audit loan stock, exceptions and corrective action	**DEVELOPING**
Retained items	Protected two-person count, reconciliation, escalation / imaging	Actions reported; sustained count reliability not yet proven	Observe count compliance; review escalation exceptions and recurrence	**DEVELOPING**

QSIG is tracking these evidence gaps through CCG assurance, the Effective Clinical Practice Advisory Panel and relevant subgroups; delayed implementation or weak evidence is escalated.

NG-tube assurance is being built through closed-loop testing

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

1	**Safety signal**	Recurrent NG-tube events and vulnerability at verification, documentation and escalation.
2	**Standard**	Patient Safety Alert/Patient Safety Notice/NG standards, LocSSIP, care plan, competency and escalation controls.
3	**Measures**	Checklist adherence, competency coverage, point-prevalence, exceptions and site variation.
4	**Change**	Briefings, huddles, pilot and local controls — each with an accountable owner and date.
5	**Proof**	Repeat cross-site audit at the agreed threshold, exceptions closed and no preventable recurrence.

Safety-II learning combines event review with how reliable care is achieved in everyday practice.

CURRENT POSITION

ACTIVE OVERSIGHT

Controls and improvement activity are in place. QSIG and subgroups are consolidating sustained cross-site compliance.

CCGs evidence implementation; clinical effectiveness tests measures and re-audit; QSIG escalates exceptions.

Safety-II and QMS strengthen reliability across the system

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Cross-cutting assurance: the response combines learning from harm with insight into how care succeeds, using the QMS to plan, control, improve and assure practice.

- **Safe —** standardised verification, counting, confirmation and escalation controls are being tested across NG, implant and retained-item pathways.
- **Timely —** QSIG tracks open investigations, exceptions and delayed implementation so learning cycles and risk reduction remain visible.
- **Effective —** clinical-effectiveness scrutiny links standards, competence, observation, audit and outcomes rather than relying on policy or training completion alone.
- **Efficient —** one controlled evidence route reduces duplicate reporting and directs improvement effort to variation, system barriers and unreliable controls.
- **Equitable —** CCG and site-level evidence identifies unwarranted variation and tests whether the same protection is dependable for every patient.
- **Person-centred —** Duty of Candour, patient/family experience and the practical impact of change remain part of the assurance judgement.
- **Human factors and culture:** the focus is on system conditions, speaking up, adaptability and spreading reliable practice—not attributing failure to individuals.



QSIG and subgroups assure QSEC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Established cross-site programme — one controlled evidence base, one measure set and one governance route.

1 Controlled evidence | Quality Assurance Team and CCG leads reconcile Datix Cymru, action tracking, audit and local intelligence; QSIG reviews gaps, contradictions and confidence.

2 Open-case oversight | CCG owners maintain trajectories, remove barriers and provide evidence for investigations and improvement actions within agreed timescales.

3 Reliable controls | NG, implant and retained-item controls are standardised and tested through audit, observation, competency evidence and exception review.

4 CCG accountability | CCGs implement learning, evidence compliance and impact, explain variance, and confirm remedial action, ownership and timescales.

5 Clinical effectiveness | the Effective Clinical Practice Advisory Panel and relevant subgroups scrutinise standards, measures, audit/re-audit and sustainability.

6 QSIG to QSEC | QSIG triangulates Safety-II intelligence, tests delivery confidence, holds CCGs to account and escalates material exceptions to QSEC.

Assurance rule: QSEC receives confidence on the system and delivery route now, with the strength of impact assurance increasing as repeat evidence matures.

Assurance to QSEC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

The QSEC is asked to:

- **TAKE ASSURANCE |** that active QMS governance arrangements connect Never Event learning, clinical-effectiveness scrutiny, CCG implementation and exception escalation.
- **NOTE |** reasonable assurance is available on response, governance and improvement controls; evidence of sustained clinical impact is developing through repeat measurement.
- **RECOGNISE |** the Effective Clinical Practice Advisory Panel and relevant QSIG subgroups are testing standards, measures, audit, competence and sustainability.
- **NOTE CCG ACCOUNTABILITY |** CCGs own implementation of learning and must evidence compliance, improvement, impact, remedial action and trajectories through QSIG.
- **RECEIVE |** exception-based assurance from QSIG (through the Quality Assurance Report), including material gaps, off-trajectory delivery or unresolved barriers requiring QSEC visibility.
- **CONFIRM ALIGNMENT |** with Safety II, the Health Board Patient Safety Plan and the QMS disciplines of planning, control, improvement and assurance.



Appendix: reconciled Never Event register

Ref	Date reported	Type of Never Event	CCG	Service	Status of investigation
HDD31339	2022	Wrong implant	Planned Care	T&O	Closed
HDD28883	2022	Retained product	Women's & Child	Gynaecology	Closed
HDD36192	2023	Retained product	Women's & Child	Obstetrics	Closed
HDD42362	2023	Wrong implant	Integrated Medicine	Medicine	Open
HDD47110	2023	Wrong implant	Planned Care	Ophthalmology	Closed
HDD49612	2023	Retained product	Women's & Child	Obstetrics	Closed
HDD51775	2024	Retained product	Integrated Medicine	Cardiology	Closed
HDD56679	2024	Wrong route medication	MH&LD	Inpatient Bryngolau	Closed
HDD58850	2024	Retained product	Women's & Child	Obstetrics Planned	Closed
HDD63532	2024	Inpatient Suicide	Integrated Medicine	Emergency Services	Closed
HDD72355	2024	NG	Planned Care	Critical Care	Open
HDD79894	2025	NG	Integrated Medicine	Emergency Services	Closed
HDD85819	2026	Retained	Planned Care	Theatres	Closed
HDD89857	2026	NG	Integrated Medicine	Gen Medicine	Open
HDD89763	2026	Wrong implant	Planned Care	Orthopaedics	Open
HDD90025	2026	Retained	Planned Care	Theatres	Open

Source: Datix Cymru 07/09/2026

HDU UHB Never Events occuring (by incident date, Jan-20 to Aug-26)

Year	2020												2021					
Never Event	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Administration of medication by the wrong route	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Misplaced naso- or oro-gastric tubes	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Retained foreign object post procedure	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0
Self harm - in-patient	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Wrong implant/prosthesis	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Wrong site surgery	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
Total Never Events	**0**	**0**	**0**	**1**	**0**	**1**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

HDU UHB Never Events occuring (by incident date, Nov-22 to Mar-24)

Year	2022		2023												2024			
Never Event	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Retained foreign object post procedure	1	0	0	0	0	1	0	0	1	0	0	0	0	1	1	0	0	
Wrong implant/prosthesis	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	
Total Never Events	**2**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**1**	**0**	**0**	**1**	**0**	**1**	**1**	**0**	**0**	

HDU UHB Never Events occuring (by incident date, Apr-24 to Aug-26)

Year	2024									2025									
Never Event	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	
Administration of medication by the wrong route	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Misplaced naso- or oro-gastric tubes	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	
Retained foreign object post procedure	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Self harm - in-patient	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	
Wrong implant/prosthesis	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Total Never Events	**0**	**1**	**0**	**1**	**0**	**0**	**1**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	

HDU UHB Never Events occuring (by incident date, Sep-25 to Aug-26)

Year	2025				2026							
Never Event	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Misplaced naso- or oro-gastric tubes	0	0	0	0	0	0	0	0	1	0	0	0
Retained foreign object post procedure	0	0	1	0	0	0	0	0	0	0	0	0
Wrong implant/prosthesis	0	0	0	0	0	0	0	0	0	0	1	0
Total Never Events	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**1**	**0**

Source: Beacon Dashboard 11/09/2026



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Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

The Duty of **Candour**

Openness and honesty should be at the heart of every relationship between those providing treatment and care and those experiencing it.





DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG

SAFE | SUSTAINABLE | ACCESSIBLE | KIND

6

6 - Patient Safety Plan 2026-2031

Cathie Steele (Hywel Dda UHB - Interim Assistant Director of Nursing Assurance and Safeguarding), Sharon Daniel (Hywel Dda UHB - Executive Director of Nursing, Quality & Patient Experience)

For approval

Attachments

QSEC SBAR Patient Safety Plan HDUHB.pdf

Patient Safety Plan HDUHB 2026-31 v1.2.pdf

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	**08 OCTOBER 2026**
TEITL YR ADRODDIAD: TITLE OF REPORT:	Hywel Dda University Health Board Patient Safety Plan 2026–2031
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Sharon Daniel, Executive Director of Nursing, Quality and Patient Experience
SWYDDOG ADRODD: REPORTING OFFICER:	Cathie Steele, Interim Assistant Director of Nursing, Assurance and Safeguarding

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this paper is to share the Hywel Dda University Health Board Patient Safety Plan 2026–2031 with the Quality, Safety and Experience Committee (QSEC), provide assurance on its alignment with the National Patient Safety Plan for NHS Wales and the Health Board's Quality Management System, and seek the Committee's support for the proposed approach to implementation, oversight and assurance.

Cefndir / Background

This Patient Safety Plan sets out Hywel Dda University Health Board's local response to the National Patient Safety Plan for NHS Wales 2026–2031. It translates the national ambition of listening, leading and learning for safer care into a local delivery framework across acute, community, primary care, mental health, women and children's services, commissioned services and partnerships. The plan uses the Health Board's Quality Management System to connect planning, improvement, control and assurance, ensuring that patient safety intelligence is identified early, acted on consistently, and reported with clear line of sight from services to Board.

The draft Patient Safety Plan was considered by the Formal Executive Team (FET) on 12 August 2026, where further clarification was requested on the local patient safety priorities and the proposed executive leadership arrangements. Further discussion on the plan was held on 16 September 2026.

Asesiad / Assessment

The Patient Safety Plan sets out the Health Board's local response to the National Patient Safety Plan for NHS Wales 2026–2031. It establishes patient safety as a whole-system organisational capability and uses the Quality Management System to connect planning,

improvement, control and assurance. This creates a clearer line of sight from frontline services and Clinical Care Groups to executive governance, QSEC and the Board.

The Plan adopts the seven national clinical safety priorities and identifies three additional local priorities: access, including service fragility; patient safety culture; and workforce and resource sustainability. These local priorities reflect the Health Board's intelligence on avoidable harm, experience, outcome variation, resilience and assurance, and ensure that access, operational pressure and resource constraints are recognised and managed where they create patient safety risk.

Delivery will be coordinated through the six national enabling functions of leadership, workforce, culture, information and insights, learning, improvement and research, and whole-system working. These will operate through existing programmes and governance arrangements rather than creating parallel structures. Overall accountability rests with the Executive Director of Nursing, Quality and Patient Experience, supported by relevant executive leads, named senior responsible owners and accountable Clinical Care Groups and functions. Detailed workstream leadership will be confirmed through Executive Team arrangements. Implementation will be phased, with foundations established during 2026–2027 and further enhancement and embedding through to 2031. QSIG will support oversight of integrated patient safety intelligence and delivery confidence, with progress and exceptions reported through executive governance to QSEC. Reporting will distinguish activity from impact and will include ownership, milestones, measures, risk and control position, dependencies, evidence gaps and assurance on whether outcomes are improving. QSEC's support will provide important committee-level endorsement of the strategic direction and the proposed governance and assurance approach.

The Plan will be supported by a dynamic Quality and Safety Position Statement that connects the Corporate Risk Register, operational risks, patient safety priorities, quality intelligence and organisational delivery arrangements. For QSEC, the Position Statement (narrated through the Quality Assurance Report) will provide a concise strategic view organised around the principal Board risks of Access, Fragile Services and Resource Sustainability. These will operate as cross-cutting lenses rather than additional programmes, enabling the Committee to consider where delayed or unreliable access is causing or transferring harm, where services may be unable to maintain safe and sustainable standards, and where workforce or financial constraints are affecting safety or limiting delivery of agreed controls.

The underlying delivery matrix will triangulate incidents and patient safety reviews; concerns, complaints, compliments and patient experience; mortality, clinical outcomes and avoidable harm; audit and regulatory findings; operational performance and access; workforce capacity, capability and staff experience; financial intelligence; corporate and operational risks; and evidence of improvement and control effectiveness. Evidence will be tested for alignment, contradiction, gaps and reliability. Reporting will distinguish fact, interpretation and executive judgement, and will record uncertainty where evidence is incomplete rather than provide false assurance.

To support effective scrutiny, the Position Statement will separate three judgements for each priority: the patient safety position, describing whether the underlying risk of harm is controlled or changing; delivery status, describing whether agreed actions and milestones are on track; and assurance confidence, describing whether the evidence is sufficiently timely, reliable and triangulated to support the reported judgement. The QSEC report will summarise the current position and direction of travel, principal concerns, evidence gaps, required decisions and any matters requiring escalation or formal risk consideration.

Clinical Care Groups and corporate functions will maintain local risks and controls, provide agreed evidence and measures, escalate deterioration and demonstrate whether actions are improving outcomes. The Quality and Safety Intelligence Group (QSIG will act as custodian of the integrated matrix, triangulating intelligence and testing the reported position, trajectory and assurance confidence. The Formal Executive Team (FET) will consider material exceptions, cross-organisational trade-offs, resource dependencies and residual risks before onward reporting. QSEC will receive the consolidated Position Statement, scrutinise whether principal quality and patient safety risks are understood, effectively controlled and improving, and provide assurance to the Board. Significant deterioration or emerging harm will be escalated between routine reporting cycles.

Argymhelliad / Recommendation

The Quality, Safety and Experience Committee is asked to:

- Receive the Hywel Dda University Health Board Patient Safety Plan 2026–2031
- Support the Plan's strategic direction, including adoption of the seven national clinical safety priorities and the three additional local priorities of access, patient safety culture, and workforce and resource sustainability;
- Support implementation through the Health Board's Quality Management System and existing governance arrangements, with clear executive sponsorship, named accountability and Clinical Care Group delivery;
- Endorse the approach to developing a Quality and Safety Position Statement and integrated delivery matrix as the basis for routine QSEC reporting; support QSIG's role as custodian of the detailed intelligence and FET's role in considering material exceptions, resource decisions and residual risks; and agree that QSEC will scrutinise the consolidated position, direction of travel, delivery status, assurance confidence, evidence gaps and required escalation in order to provide assurance to the Board.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	2.1 provide the Board with assurance that care across the Health Board is safe, timely, efficient, effective, equitable and person-centred.
Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply

Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Nodau Cynllunio 2026/27 Planning Goals 2026/27	6. Safe, Timely, High Quality Care
Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	4. Create an inclusive culture where every voice matters, individual needs are considered and staff well-being is promoted and supported 5. Foster a learning culture by sharing knowledge and applying new ways of working that enhance local and global well-being 6. Work with partners and communities to nurture and support everyone to achieve their best well-being
Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau) A Social Model for Health and Wellbeing: (*complete for strategic change and/or significant service changes)*	Not Applicable
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	National Patient Safety Plan for NHS Wales 2026–2031.
Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	Formal Executive Team discussion in August and September 2026.

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	There are no immediate additional financial or capital requirements arising from this paper. Delivery of the Patient Safety Plan will need to be aligned to existing

	organisational resources, with any specific financial implications identified through the relevant planning, prioritisation and business case processes as individual improvement actions are developed. Recognising workforce and resource sustainability as a local patient safety priority will support clearer understanding of the relationship between resources, service fragility, access and avoidable harm.
Ansawdd / Gofal Claf: **Quality / Patient Care:**	The Patient Safety Plan is expected to have a positive impact on quality and patient care by strengthening the Health Board's approach to identifying, understanding and reducing avoidable harm. The inclusion of local priorities will support a clearer focus on the issues most relevant to Hywel Dda UHB, including access, service fragility, patient safety culture, workforce and resource sustainability. The proposed executive leadership model will support clearer ownership, escalation and assurance, helping to ensure that patient safety risks are acted on consistently and that learning is translated into improvement.
Gweithlu: **Workforce:**	The Patient Safety Plan is expected to have a positive impact on the workforce by supporting clearer executive ownership of the workforce contribution to patient safety, including capability, education, role-based learning, staff experience and safety behaviours. It also recognises workforce and resource sustainability as a local patient safety priority, supporting more explicit consideration of the relationship between staffing, service fragility, access, staff wellbeing and avoidable harm. There are no immediate adverse workforce impacts arising from this paper; however, successful delivery will require alignment with existing workforce planning, organisational development and professional leadership arrangements.
Tegwch Iechyd: **Health Equity:**	The Patient Safety Plan is expected to have a positive impact on health equity by supporting a clearer understanding of variation in patient safety risks, outcomes and experience across services and populations. The inclusion of access, service fragility, workforce and resource sustainability as local patient safety priorities will help ensure that potential inequity in timely access to safe care is considered as part of prioritisation, escalation and assurance. An equity-focused health impact assessment has not been undertaken for this update, as the paper seeks agreement on the local priorities and executive leadership model rather than proposing a specific service change; however, equity considerations should

	be built into the delivery and monitoring of individual improvement actions.
Risg: **Risk:**	The paper supports a positive risk impact by strengthening the identification, ownership and escalation of patient safety risks through the Patient Safety Plan. The inclusion of local priorities, including access, service fragility, patient safety culture and workforce/resource sustainability, will support clearer alignment between operational risk, clinical risk and organisational assurance. The main risk is that, without clear executive ownership and delivery oversight, implementation may be inconsistent across services; this is mitigated through the proposed executive leadership model, alignment to the Quality Management System and reporting through existing governance routes, including QSEC and Board.
Cyfreithiol: **Legal:**	There are no immediate legal implications arising directly from this paper. The Patient Safety Plan supports the Health Board's statutory duties in relation to quality, safety, candour, concerns management and organisational accountability. Clearer executive ownership and assurance arrangements will support compliance with the Duty of Quality, Duty of Candour and wider requirements to identify, escalate and reduce avoidable harm. Any specific legal implications arising from individual improvement actions will be considered through the relevant governance, risk, policy or service change processes.
Enw Da: **Reputational:**	The Patient Safety Plan is expected to have a positive reputational impact by demonstrating that the Health Board is taking a structured, locally informed and executive-led approach to delivering the National Patient Safety Plan for NHS Wales. Clearer identification of local patient safety priorities, including access, service fragility, culture and workforce/resource sustainability, will support greater transparency, accountability and assurance. The main reputational risk would arise if delivery is not progressed consistently or if known patient safety risks are not demonstrably acted upon; this is mitigated through the proposed executive leadership model and existing governance routes for oversight and escalation.

Gyfrinachedd: **Privacy:**	There are no immediate privacy, confidentiality or information governance implications arising directly from this paper. The Patient Safety Plan does not propose the use or sharing of identifiable patient or staff information; however, delivery will rely on appropriate use of patient safety intelligence, incident data, concerns, complaints, audit and learning information. Any use of personal or sensitive information through individual improvement actions will be managed in line with existing information governance, confidentiality, data protection and records management requirements.
Cydraddoldeb: **Equality:**	The Patient Safety Plan is expected to have a positive impact on equality by supporting a more consistent approach to identifying and responding to patient safety risks across services and populations. The inclusion of access, service fragility, patient safety culture and workforce/resource sustainability as local priorities will support consideration of whether particular groups may experience differential risk, poorer access, or variation in outcomes and experience. EqIA screening has not been undertaken for this update, as the paper seeks agreement on local priorities and executive leadership arrangements rather than proposing a specific service change; however, equality considerations should be built into delivery, monitoring and evaluation of individual improvement actions.

Hywel Dda University Health Board Patient Safety Plan 2026–2031



Document owner	Executive Director of Nursing, Quality and Patient Experience
Lead author / portfolio	Interim Assistant Director of Nursing, Assurance and Safeguarding
Status	V1.2 (September 2026) – updated following Formal Executive Team discussion

Executive summary: This Patient Safety Plan sets out Hywel Dda University Health Board's local response to the National Patient Safety Plan for NHS Wales 2026–2031. It translates the national ambition of listening, leading and learning for safer care into a local delivery framework across acute, community, primary care, mental health, women and children's services, commissioned services and partnerships. The Plan uses the Health Board's Quality Management System (QMS) to connect planning, improvement, control and assurance, so that patient safety intelligence is identified early, acted on consistently and reported with a clear line of sight from services to the Board.

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1. Purpose and ambition

Hywel Dda University Health Board's ambition is to reduce avoidable harm, strengthen safety culture and embed learning into everyday practice so that people across Carmarthenshire, Ceredigion and Pembrokeshire receive care that is safe, timely, effective, efficient, equitable and person-centred. The plan responds directly to the National Patient Safety Plan for NHS Wales 2026–2031 and aligns with the Duty of Quality, Duty of Candour, Health and Care Quality Standards, Listening to People guidance, the NHS Wales Quality Outcomes Framework and the emerging national Clinical Governance Framework.

The local approach is built around three foundational commitments: listening to patients, families, carers, staff and partners; leading through visible, accountable and compassionate leadership; and learning through a consistent, evidence-based system that turns insight into improvement and assurance.

2. Strengthening System-Wide Patient Safety in Hywel Dda UHB

The National Patient Safety Plan for NHS Wales 2026–2031[1] establishes patient safety as an essential priority for every part of NHS Wales and sets a clear expectation that organisations move beyond isolated initiatives towards a unified, system-wide approach rooted in listening, leadership, learning, prevention and continuous improvement. For Hywel Dda UHB, this means strengthening patient safety as a core organisational capability across acute, community, primary care, mental health, maternity, commissioned and partnership services, rather than treating safety as a separate programme or retrospective reporting process.

The national plan places the QMS at the centre of patient safety, bringing planning, improvement, control and assurance together in one consistent model. Planning will define safety priorities, standards, resources and trajectories; improvement will support co-designed interventions to reduce avoidable harm; control will strengthen daily operational grip, escalation and reliability; and assurance will provide evidence that risks are understood, acted on and improving. The QMS will therefore connect intelligence from patients, families, staff, incidents, concerns, claims, audit, outcomes and operational pressures into a single learning and improvement cycle.

Using the QMS will provide a clearer line of sight from frontline teams to Clinical Care Groups, executive forums, the Quality, Safety and Experience Committee (QSEC) and the Board. This will support earlier identification of emerging risks, reduced unwarranted variation, focused improvement effort and clearer evidence of compliance and impact.

[1] performanceandimprovement.nhs.wales/functions/quality-safety-and-improvement/quality-and-safety/national-patient-safety-plan-for-nhs-wales-2026-2031/national-patient-safety-plan-for-nhs-wales-2026-2031/?ts=1784041586428



Fig 1: National Patient Safety Plan for NHS Wales 2026-2031

3. Strategic alignment

The Plan directly supports the Health Board's strategic objective of Great Care and Planning Goal 6, 'Safe, Timely and High-Quality Care'. Patient safety is not a separate subset of this objective; it is the outcome of delivering safe, timely, equitable and high-quality care across every pathway. The national priorities establish the common NHS Wales focus, while the additional local priorities respond to Hywel Dda UHB's specific intelligence on access, service fragility, culture, workforce and resource sustainability.

The Health Board will align local delivery to the national plan's six enablers: leadership, workforce, culture, information and insights, learning, improvement and research, and whole-system working. These enablers will be embedded through the Health Board's QMS and reflected in organisational, Clinical Care Group and service-level quality and safety plans.

- Planning for patient safety: setting clear local goals, priorities, standards, responsibilities and improvement trajectories.
- Improvement for patient safety: using quality improvement methods, co-production and evidence-based interventions to reduce harm.
- Control of patient safety: strengthening daily operational management, escalation, reliability of standards and response to emerging risks.
- Assurance of patient safety: providing clear evidence to care groups, executive forums, quality committees and Board that risks are understood, controlled and improving.

4. Responding to current escalation and assurance expectations

This Patient Safety Plan supports the Health Board's improvement and assurance response by strengthening quality governance, improving organisational grip and creating a more integrated understanding of the principal quality and safety risks facing the organisation.

The Plan will support a consolidated Quality and Safety Position Statement that brings together strategic risks, operational quality indicators, access-to-care risks, patient outcomes, regulatory

requirements, improvement actions and evidence of impact. It will complement, rather than duplicate, the Board Assurance Framework (BAF), Corporate Risk Register and performance reports, and will consider complaints, National Reportable Incidents (NRIs) and healthcare-associated infections alongside the wider quality and safety risk profile.

Access-to-care risks will be recognised as patient safety risks where delays, service fragility, pathway pressures or poor timeliness increase the likelihood of avoidable harm. This includes risks associated with urgent and emergency care, cancer, planned care, diagnostics, delayed pathways of care and other services where access and outcomes are closely connected.

This integrated narrative will support clearer prioritisation, more consistent escalation and stronger evidence that improvement actions are reducing risk and improving outcomes. It will also provide a consistent basis for engagement with NHS Wales Performance and Improvement, regulators, partners and internal governance forums.

5. Local patient safety priorities

Hywel Dda UHB will adopt the seven national clinical safety priorities as the foundation of its local Patient Safety Plan and deliver them through existing organisational programmes wherever possible. The three additional local priorities are clearly identified as access, patient safety culture, and workforce and resource sustainability. They do not constitute a parallel plan; they identify the conditions and risks that may affect successful delivery in Hywel Dda UHB, informed by local incident themes, concerns, claims, patient experience, staff feedback, audit, regulatory findings, clinical outcomes and operational risk intelligence.

National priority	Hywel Dda UHB local response	Early focus
Acute physical deterioration, including sepsis	Strengthen recognition, escalation and response across acute, community and primary care pathways through a formal deterioration and sepsis programme, with dedicated project leadership, governance infrastructure and clear alignment with the resuscitation training team.	National Early Warning Score 2 (NEWS2) reliability, sepsis screening, clinical escalation, Call for Concern, deterioration learning reviews, project plan, infrastructure and named Clinical Care Group (CCG) and service leads.
Deconditioning and frailty in the community	Reduce avoidable harm from falls, functional decline and delayed recovery through prevention, early intervention and integrated community care.	Frailty pathways, falls prevention, discharge-to-recover, community rehabilitation, care home safety intelligence.
Health care associated infections	Improve infection prevention and control reliability, surveillance, antimicrobial stewardship and outbreak learning.	Healthcare-associated infection (HCAI) reduction plans, infection prevention and control (IPC) audits, clinical environmental credentialling, environmental standards, antimicrobial improvement and outbreak governance.
Secondary care mental health safety	Strengthen safety measurement, therapeutic environments, ligature risk management and learning across inpatient and community mental health services.	Safety metrics, restrictive practice reduction, observation standards, incidents and concerns learning.

People with a learning disability and neurodivergence	Improve equitable access, reasonable adjustments, communication, safeguarding and learning from experience.	Reasonable adjustment compliance, annual health checks, diagnostic overshadowing prevention, family feedback.
Maternity and neonatal services	Respond to national assurance findings through strengthened governance, pathway reliability, workforce escalation and family-centred learning.	Triage, induction, neonatal escalation, postnatal support, maternity and neonatal safety intelligence.
Medicines safety	Develop a local medicines safety improvement programme aligned to the emerging national priority.	High-risk medicines, prescribing and monitoring, transitions of care, medication incidents and pharmacy assurance.

In addition to the national clinical safety priorities, Hywel Dda UHB will maintain local priorities where intelligence shows a significant relationship with avoidable harm, experience, outcome variation, resilience or assurance. A maintained position statement will explain how these priorities were identified, their alignment with national expectations and NHS Wales Performance and Improvement discussions, and how access, fragility, workforce and financial considerations inform prioritisation, escalation and assurance. Priorities will be tested through triangulation of quality, operational, workforce and financial intelligence, including evidence gaps, conflicting signals, likely trajectory and executive confidence.

Additional local priority	Patient safety rationale	Early focus
Access	Recognise delays, pathway pressures and service fragility as patient safety risks where they increase the likelihood of avoidable harm, deterioration, inequity or poor experience.	Urgent and emergency care, cancer, planned care, diagnostics, delayed pathways of care, harm reviews and triangulation with operational risk intelligence.
Patient safety culture	Strengthen a just, restorative and learning culture so that patients, families, carers and staff feel able to raise concerns, speak up, share learning and contribute to safer care.	Speaking Up Safely, Working in Confidence, Duty of Candour, Call for Concern, Listening to People, safety culture intelligence and shared learning from harm and excellence.
Workforce and resource sustainability	Understand and manage the relationship between workforce capacity, skill mix, wellbeing, financial resource, estates, equipment and digital constraints and the ability to deliver consistently safe care.	Workforce risk intelligence, safe staffing, skill mix, staff wellbeing, temporary staffing, service resilience, financial resource, capacity planning, equipment availability and resource-related escalation.

6. Delivery framework

Delivery will be coordinated through the six national enabling functions: leadership, workforce, culture, information and insights, learning, improvement and research, and whole-system working. These are not separate workstreams requiring additional governance; they are cross-cutting capabilities that support delivery of the seven national and three additional local priorities through existing programmes, groups and accountability arrangements. Patient safety objectives, measures and accountabilities will be incorporated into relevant programmes, including urgent and emergency care, hospital fragility, planned care transformation and other established service improvement arrangements. Overall accountability for the Plan rests with

the Executive Director of Nursing, Quality and Patient Experience. Each priority will have a Senior Responsible Owner, with additional executive sponsorship agreed where required, and Clinical Care Groups and executive functions accountable for delivery within their respective areas. Existing evidence and reporting will be reused wherever possible to avoid duplication or additional reporting burden. Delivery will be phased to establish foundations in 2026–2027, deliver enhancements between 2027 and 2031, and embed sustainability beyond 2031.

Health and Care Quality Standards Enabler	Local objective	What this means for Hywel Dda UHB	QMS link	Expected impact
Leadership	Visible, connected and accountable leadership for patient safety.	Clear executive ownership, Clinical Care Group accountability, named senior responsible owners, CCG/service leads for cross-cutting priorities, consistent escalation routes and Board-level oversight of patient safety priorities.	Planning and assurance.	Stronger accountability, clearer prioritisation, earlier escalation and greater confidence that risks are being actively managed.
Workforce	Staff have the skills, confidence and support to deliver safe care.	Local implementation of the national patient safety curriculum, role-based safety capability and support for clinical and non-clinical teams to recognise, respond to and reduce risk.	Planning and improvement.	More consistent safety behaviours, reduced variation and improved staff confidence in managing patient safety risks.
Culture	A just, restorative and learning safety culture.	Working in Confidence, Speaking Up Safely, Duty of Candour, Call for Concern and Listening to People are embedded as core mechanisms for openness, learning and improvement.	Control, learning and assurance.	Patients, families and staff feel able to raise concerns, and learning is acted on visibly and consistently.
Information and insights	A single view of patient safety intelligence.	Scheduled multidisciplinary triangulation of incidents, concerns, claims, mortality, audit, outcomes, workforce intelligence, financial intelligence, patient experience and operational risk to identify emerging themes and priorities, rather than relying only on review after harm has occurred.	Control and assurance.	Earlier identification of emerging risks, stronger surveillance and better targeted intervention where the risk of harm is greatest.
Learning, improvement and research	Learning drives measurable improvement.	Patient safety learning forums, improvement programmes, shared learning, audit, evaluation and research are used to reduce repeat harm and evidence the impact of change.	Improvement and assurance.	Reduced repeat incidents, stronger evidence of improvement and better spread of successful interventions across services.
Whole-system approach	Patient safety is connected across pathways,	Acute, community, primary care, mental health, maternity, commissioned services and partnership services are aligned around shared safety priorities,	Planning, control and assurance.	Reduced fragmentation, improved pathway safety and stronger whole-system

	services and partners.	escalation routes and learning systems.	management of harm and risk.

7. Hywel Dda implementation plan

Each of the seven national and three additional local priorities will be mapped to the six enabling functions through a single delivery matrix. The matrix will identify the Senior Responsible Owner, any required executive sponsor, the accountable Clinical Care Groups and executive functions, the existing programme or service route through which delivery will occur, the contribution required from each enabling function, milestones, measures, dependencies, risks and the evidence required to demonstrate impact. Workstream leadership and executive sponsorship will be confirmed following further Executive Team consideration. This approach will provide a clear line of sight from priority to action, accountability, assurance and outcome without creating parallel governance or additional reporting.

This implementation plan translates the national patient safety actions into local delivery through the integrated QMS cycle of planning, improvement, control and assurance.

7.1 Leadership

Local action	QMS link	Lead route	Timeline	Expected impact
Confirm executive sponsorship, named senior responsible owners and CCG and service leads for each patient safety priority, including cross-cutting national priorities such as acute deterioration and sepsis, deconditioning and frailty, learning disability and neurodivergence, and maternity and neonatal safety.	Planning and assurance	Executive Team and Quality, Safety and Experience Committee	Phase 1: 2026–2027	Clear accountability, improved prioritisation and stronger Board oversight.
Define patient safety responsibilities for Clinical Care Groups, service groups and corporate functions.	Planning and control	Clinical Care Group governance and executive quality routes	Phase 1: 2026–2027	Consistent ownership of safety risks, actions and improvement trajectories.
Strengthen escalation routes for emerging risks, deteriorating safety indicators and unresolved actions.	Control and assurance	Quality surveillance, risk management and executive escalation arrangements	Phase 1: 2026–2027	Earlier recognition of harm, clearer escalation and faster intervention.
Embed visible leadership for patient safety through executive WalkRounds, safety conversations and frontline learning.	Planning, learning and assurance	Executive leadership and Clinical Care Group leadership teams	Phase 1: 2026–2027	Improved trust, stronger safety culture and better understanding of everyday work.

7.2 Workforce

Local action	QMS link	Lead route	Timeline	Expected impact
Map local patient safety, innovation and service improvement training requirements against the national	Planning	Patient safety, workforce, education and	Phase 2: 2027–2028	Clear understanding of capability gaps

Patient Safety Curriculum, ensuring staff can use learning from incidents, excellence and everyday work to improve care rather than reinforce blame.		professional leadership routes		and priority learning needs.
Develop role-based patient safety learning for clinical and non-clinical staff, including incident learning, Duty of Candour, safeguarding, IPC, medicines safety and improvement skills.	Planning and improvement	Workforce and organisational development, clinical education and professional forums	Phase 2: 2027–2031	Improved confidence, consistency and safety behaviours across teams.
Build patient safety capability within Clinical Care Groups through improvement coaching, safety huddles, learning reviews and local safety dashboards.	Improvement and control	Clinical Care Group quality governance and improvement teams	Phase 2: 2027–2031	Greater local ownership of safety improvement and reduced variation in practice.
Use workforce intelligence, staff experience and operational pressures to inform patient safety risk assessment and improvement planning.	Planning, control and assurance	Workforce governance, quality surveillance and executive quality routes	Phase 2: 2027–2031	Better understanding of the relationship between workforce conditions and patient safety risk.

7.3 Culture

Local action	QMS link	Lead route	Timeline	Expected impact
Embed just, restorative and learning culture principles into incident review, concerns management, complaints, safeguarding and staff support processes.	Control, learning and assurance	Patient safety, concerns, safeguarding, workforce and clinical governance routes	Phase 1–2: 2026–2031	More open learning, improved staff experience and reduced blame-based responses.
Strengthen implementation of Speak Up Safely, Working in Confidence, Duty of Candour, Call for Concern and Listening to People.	Control and assurance	Executive quality routes, concerns governance and patient experience routes	Phase 1: 2026–2027	Patients, families and staff have clearer routes to raise concerns and receive timely responses.
Use safety culture intelligence from staff feedback, speaking-up themes, incidents, concerns and patient stories to identify areas requiring support.	Control, learning and assurance	Quality surveillance, workforce intelligence and Clinical Care Group governance	Phase 2: 2027–2031	Better targeting of cultural improvement and stronger evidence of psychological safety.
Share learning from excellence, improvement and everyday work as well as from harm events.	Learning and improvement	Patient safety learning forums and Clinical Care Group improvement routes	Phase 2: 2027–2031	Balanced Safety I and Safety II learning that builds resilience and spreads good practice.

7.4 Information and insights

Local action	QMS link	Lead route	Timeline	Expected impact
Develop a single patient safety intelligence model that triangulates incidents, concerns, claims, mortality, audit, patient experience, workforce indicators, financial intelligence, **operational**	Control and assurance	Quality surveillance, information, patient safety and Clinical Care	Phase 1: 2026–2027	Earlier identification of emerging and principal quality and safety risks, more reliable prioritisation of improvement effort, and

risk, access-to-care risks, regulatory intelligence and Board Assurance Framework risks, including explicit review of alignment, contradiction, evidence gaps and executive confidence**.**		Group governance routes		stronger evidence that actions are reducing risk and improving outcomes.
Align local patient safety measures to the Quality Outcomes Framework and Health and Care Quality Standards.	Planning and assurance	QMS dashboard development and executive quality reporting	Phase 1–2: 2026–2031	Clearer evidence of impact and better alignment with national reporting expectations.
Agree escalation triggers for deteriorating safety signals, repeated themes and areas of unwarranted variation.	Control and assurance	Quality surveillance, risk management and executive escalation arrangements	Phase 1: 2026–2027	More proactive response to risk before harm becomes sustained or widespread.
Schedule routine multidisciplinary patient safety control reviews to triangulate data, audit, outcomes, experience, workforce, finance and operational risk before issues escalate.	Control and assurance	Clinical Care Group quality governance, quality surveillance, audit and executive quality routes	Phase 1: 2026–2027	More proactive control of patient safety risks and reduced reliance on reactive review following harm events.
Develop service and care group dashboards that support daily management, local improvement and Board-level assurance.	Control, improvement and assurance	Clinical Care Group quality governance and QMS reporting routes	Phase 2: 2027–2031	Improved visibility of safety performance from frontline teams to Board.

7.5 Learning, improvement and research

Local action	QMS link	Lead route	Timeline	Expected impact
Establish a patient safety learning system, including CCG-based lessons learned and improvement forums, **that connects learning from incidents, concerns, claims, mortality, audits, inspections, patient experience**, **good practice** and innovation**.**	Learning, improvement and assurance	Patient safety learning forums, Clinical Care Groups and executive quality routes	Phase 1: 2026–2027	Reduced repeat harm and stronger organisational memory from safety learning.
Align local improvement programmes to the national clinical safety priorities and locally identified risk themes.	Planning and improvement	Improvement governance, Clinical Care Group delivery plans and Quality, and Safety Intelligent Group (QSIG) routes	Phase 1–2: 2026–2031	Improvement effort focused on the greatest risk of avoidable harm.
Use structured improvement methodology, co-production and measurement for priority safety programmes.	Improvement and assurance	Quality improvement teams, patient experience routes, innovation and service improvement training, CCG lessons learned forums and service-level governance	Phase 2: 2027–2031	More reliable delivery of change and stronger evidence that interventions are working.

Develop evaluation, innovation and research partnerships, including multi-professional research leadership and development routes for advanced and consultant clinical practice, to understand emerging patient safety risks and the impact of interventions.	Learning, improvement and assurance	Research, innovation, improvement, multi-professional research leadership, professional development and advanced and consultant clinical practice routes	Phase 2: 2027–2031	Improved evidence, stronger spread of learning, clearer multi-professional research capability, support for research funding and better long-term sustainability.

7.6 Whole-system approach

Local action	QMS link	Lead route	Timeline	Expected impact
Hywel Dda UHB will adopt the national clinical safety priorities and connect them across acute, community, primary care, mental health, maternity, commissioned and partnership pathways. Delivery will place particular emphasis on prevention, early identification and timely intervention where missed opportunities may result in avoidable deterioration or poorer outcomes. This includes identifying pathway risks before presentation at an emergency department, supporting access to the right care, at the right time and in the right place, and using intelligence across organisational boundaries to reduce fragmentation and improve pathway safety.	Planning, control and assurance	Clinical Care Groups, primary care, partnership and executive quality routes	Phase 1–2: 2026–2031	Reduced fragmentation and stronger management of pathway-level risk.
Strengthen safety assurance for independent contractor and commissioned services through proportionate intelligence, escalation and learning routes.	Planning and assurance	Primary care, commissioning, contract assurance and quality governance routes	Phase 2: 2027–2031	Improved whole-system visibility of safety risks beyond directly provided services.
Work with partners, including local authorities, Llais, regulators, regional networks and national programmes, to share intelligence and coordinate safety improvement.	Planning, learning and assurance	Partnership governance, regional networks and executive quality routes	Phase 1–2: 2026–2031	Better alignment of action across organisational boundaries and improved use of lived experience.
Review the implementation plan annually and refresh priorities at least every two years in line with national review points and emerging local intelligence.	Planning, improvement and assurance	Executive Team, QSEC and Board	Annual review and two-year refresh	Sustained relevance, continuous learning and stronger alignment to national and local priorities.

8. Measuring impact

Impact will be measured through a balanced set of outcome, process, experience, culture and assurance measures. National Quality Outcomes Framework measures will be used where available, supported by local measures and improvement trajectories. Reporting will show whether principal safety risks are improving, stable, deteriorating or uncertain, taking account of current controls, evidence gaps, confidence in the available intelligence and the likely direction of travel over the next three to six months. Measures will be reviewed annually and refreshed at two-year intervals to reflect national review points and emerging risks.

For each priority, reporting will include the accountable executive sponsor and senior responsible owner; agreed outcome, process, experience, culture and assurance measures; baseline and trajectory; delivery milestones; current risk and control position; dependencies; evidence of impact; and an overall assessment of whether delivery is on track, at risk or off track. Reports will distinguish activity from impact and identify decisions or escalation required from QSIG, the Formal Executive Team (FET) or QSEC.

If the Plan is successful, the Health Board will identify risks earlier, intervene before avoidable harm occurs, reduce unwarranted variation and repeat harm, and provide more timely, reliable and equitable care across pathways. Patients, families and staff will experience clearer routes to raise concerns and will see evidence that learning leads to change. Leaders will have an integrated view of safety, access, workforce and resource intelligence, with transparent ownership and stronger assurance that actions are improving outcomes.

A clinical environmental credentialling approach will be developed to describe what good looks like in clinical areas, supporting services to assess environmental safety, infection prevention standards, equipment readiness, patient flow, privacy, dignity and physical conditions as part of routine assurance and improvement.

- Outcome measures: avoidable harm, mortality indicators, HCAI rates, falls with harm, pressure damage, maternity and neonatal outcomes, medicines harm and mental health safety outcomes.
- Process measures: compliance with escalation standards, sepsis screening, IPC audit actions, medicines monitoring, Call for Concern implementation and safety huddle reliability.
- Experience measures: concerns themes, compliments, patient stories, Llais intelligence, patient-reported experience measures (PREMs), family feedback and staff speaking-up themes.
- Culture measures: staff survey safety culture indicators, civility and psychological safety measures, Duty of Candour compliance and just culture learning.
- Assurance measures: timeliness and quality of incident reviews, closure and impact of actions, audit compliance, regulatory findings, claims themes, access-to-care risk reporting, Board Assurance Framework alignment and triangulated evidence of improvement.

9. Governance and accountability

Overall executive accountability for the Patient Safety Plan rests with the Executive Director of Nursing, Quality and Patient Experience, supported by the Executive Medical Director, the Executive Director of Allied Health and Health Science and other executive leads whose portfolios contribute to individual priorities. Each priority and enabling workstream will have a named executive sponsor and senior responsible owner, with Clinical Care Groups and executive functions within their respective areas. Additional executive sponsorship will be agreed where a priority requires cross-portfolio leadership. The six enablers are enabling functions rather than separate delivery workstreams and will operate through existing governance, performance and improvement arrangements. Individual lead and supporting executive roles shown below are indicative and will be confirmed following further Executive Team consideration.

Indicative executive contribution by patient safety enabling function – subject to confirmation		
Area	**Indicative lead executive role**	**Supporting executive roles**
Leadership	Chief Executive	Executive Director of Nursing, Quality and Patient Experience
Workforce	Executive Director of Workforce and Organisational Development	Executive Director of Nursing, Quality and Patient Experience; Executive Medical Director; Executive Director of Allied Health and Health Science
Culture	Chief Executive	Executive Director of Workforce and Organisational Development; Executive Director of Nursing, Quality and Patient Experience
Information and insights	Executive Director of Nursing, Quality and Patient Experience	Director of Finance; Chief Operating Officer; Executive Medical Director; Executive Director of Allied Health and Health Science
Learning, improvement and research	Executive Medical Director	Executive Director of Nursing, Quality and Patient Experience; Executive Director of Allied Health and Health Science
Whole-system approach	Chief Operating Officer	Chief Executive; Executive Director of Nursing, Quality and Patient Experience; Executive Medical Director; Executive Director of Allied Health and Health Science

Delivery will be supported through patient safety, quality governance, safeguarding, infection prevention, clinical leadership, operational management and improvement functions. Clinical Care Groups and service groups will implement relevant actions, maintain oversight of local risks, escalate concerns promptly and demonstrate measurable impact through routine assurance arrangements.

The Plan will be governed through the QMS so that patient safety is embedded within strategic planning, operational control, improvement and assurance. The revised Plan will be presented to the Quality and Safety Intelligence Group (QSIG) in October 2026. QSIG will act as custodian of integrated patient safety intelligence, using its existing remit and information flows to triangulate patient safety data, review delivery confidence, identify emerging risks and exceptions, and agree how the priorities should be addressed through its meetings. The supporting position statement will be maintained as a live, forward-looking view that is reviewed in real time rather than as a retrospective account of performance or incidents. Existing evidence, governance minutes, dashboards and reports will be reused wherever possible so that implementation does not create duplicate work or additional reporting. A patient safety progress report will be presented to the Formal Executive Team (FET) at an agreed frequency, with exception escalation between reporting cycles where required, and onward assurance reporting to the Quality, Safety and Experience Committee (QSEC). Reporting will provide a clear line of sight from ward, team and service intelligence through Clinical Care Group governance to executive and Board-level scrutiny.

Governance arrangements will align strategic risks, operational quality indicators, access-to-care risks, patient outcomes, regulatory requirements, improvement actions and evidence of impact to support a consolidated Quality and Safety position for the Board and external stakeholders.

Reports will distinguish fact, interpretation and judgement; identify where assurance is strong or incomplete; and highlight risks that may be becoming normalised or require further action or escalation.

A coordinated communication and engagement campaign will bring the Plan to life for all staff groups and partners. Communications will explain what patient safety means in different roles, how the national and local priorities connect to everyday work, what staff and teams will be expected to do differently, and how progress and learning will be shared. The approach will use accessible ward-to-board messaging, staff stories, patient and family experience, executive and Clinical Care Group leadership channels, team conversations and regular feedback on improvements achieved.

10. Conclusion

Hywel Dda UHB’s Patient Safety Plan provides a clear local response to the National Patient Safety Plan for NHS Wales 2026–2031. It sets out how the Health Board will strengthen patient safety as a core organisational capability, using the Quality Management System to connect strategic planning, operational control, improvement activity and assurance reporting into one coherent approach.

By aligning national priorities with local risks, patient and staff experience, safety intelligence and Clinical Care Group delivery, the plan creates a stronger line of sight from frontline practice to Board-level assurance. Its success will depend on visible leadership, a just and learning culture, reliable data, whole-system collaboration and sustained improvement capability across all services and partners.

The intended outcome is a Health Board where avoidable harm is reduced, risks are identified earlier, learning is acted on consistently, and patients, families, carers and staff can see that their voices are shaping safer care. This plan should therefore be used as both a strategic framework and a practical delivery mechanism for embedding patient safety into everyday work across Hywel Dda UHB.

7

7 - Assurance

7.1

7.1 - Quality Assurance Report

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

For assurance

Attachments

3.1 QS Assurance Report Oct 2026 v1.0.pdf

3.1 App 1 PSOW annual letter (Eng).pdf

3.1 App 1 PSOW annual letter (Cymraeg).pdf

3.1 App 2 HIW overdue actions.pdf

3.1 App 3 2026.09.22 - Alun Jones letter to HDUHB - HIW Annual Report.pdf

3.1 App 3 2026.09.24 - HIW Annual Report 2025-2026 (W)3.pdf

3.1 App 3 2026.09.24 - HIW Annual Report 2025-2026.pdf



Quality and Safety Assurance Report

Quality, Safety and Experience Committee

October 2026

Situation

The purpose of this report is to provide the Quality, Safety and Experience Committee with assurance regarding the effectiveness of the Health Board's Quality Management System by:

- identifying emerging risks and variation
- reviewing the effectiveness of quality controls
- understanding learning from incidents, concerns, complaints and regulatory activity
- monitoring improvement actions and trajectories
- seeking assurance that learning is translated into sustainable improvement.



Appendices to this report

- Public Services Ombudsman Annual Letter
- HIW Improvement Actions – overdue
- HIW Annual Report

Assessment: reasonable assurance, targeted scrutiny required

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

OVERALL ASSURANCE VIEW

REASONABLE ASSURANCE

with targeted scrutiny required

The paper provides a clearer QMS line of sight and credible recovery trajectories. Assurance remains limited because several "impact" statements describe monitoring activity rather than demonstrated change in practice or patient outcomes.

TWO KEY POSITIVES

1. **NRI recovery is measurable**

   Open and overdue cases have reduced, the aged backlog has more than halved and performance is ahead of trajectory.

2. **Governance is becoming more explicit**

   CCG ownership, HIW escalation routes, reporting cadence and a common Standard–Data–Learning–Action–Impact logic strengthen line of sight.

TWO KEY CONCERNS

1. **HIW overdue actions are increasing**

   Overdue actions rose from 25 to 32, including 16 in Mental Health and Learning Disabilities; owners, recovery dates and required support need sharper visibility.

2. **Outcome evidence remains uneven**

   Some impact statements still describe reviews, reporting and planned assurance rather than evidenced improvement in practice, experience or harm.

QSEC FOCUS Confirm owners and recovery dates for overdue HIW actions • require measurable CCG outcomes • reconcile complaints baselines and definitions

Patient Safety Plan 2026–2031

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

HDUHB's local response to the National Patient Safety Plan

Hywel Dda UHB will reduce avoidable harm, strengthen safety culture and embed learning in everyday practice. The plan connects planning, improvement, control and assurance through one Quality Management System.

2026 Foundations & ownership

2027 Enhanced delivery

2031 Sustainable practice



Core test

Are risks identified earlier, acted on consistently and shown to be improving from services to Board?

What the plan establishes

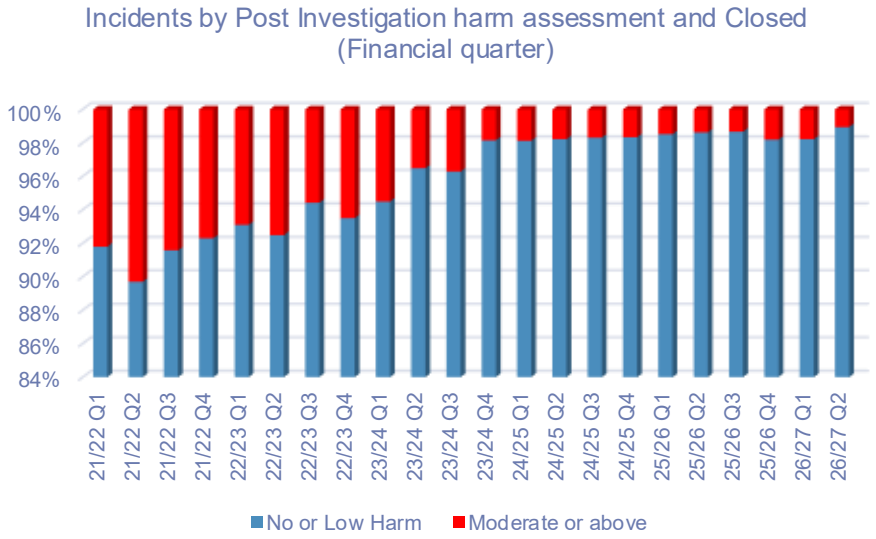
- Seven national clinical safety priorities
- Six enabling functions across the system
- Three local priorities: access, culture, workforce & resources
- Named executive, SRO and CCG accountability
- Listening, leading and learning as foundations
- Measures for outcomes, trajectory, risk and impact

QMS delivery cycle

Planning → **Improvement** → **Control** → **Assurance** → **Impact**

Patient Safety Incidents: headlines

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board



11,921
patient safety incidents

9,292
incidents closed

94 | 1.0%
moderate+ harm

Reporting period: 1 Sep 2025 – 31 Aug 2026

CCGs will use their top three lessons to create focused improvement plans, supported by monthly assurance.

1 Standard

Report, review and close incidents; convert learning into stronger controls.

2 Data

15,099 total; 11,921 patient safety; 9,292 closed; 94 moderate+ harm.

3 Learning

CCGs receive the top three lessons from incidents in their area.

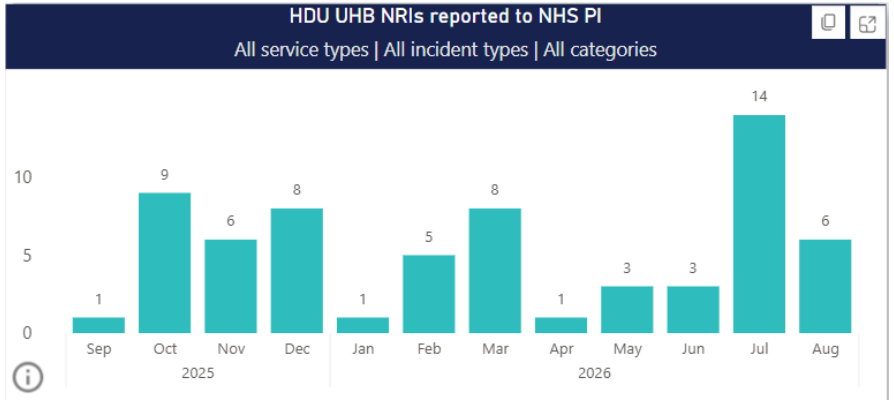
4 Action

Set improvement plans with owners, deadlines and assurance evidence.

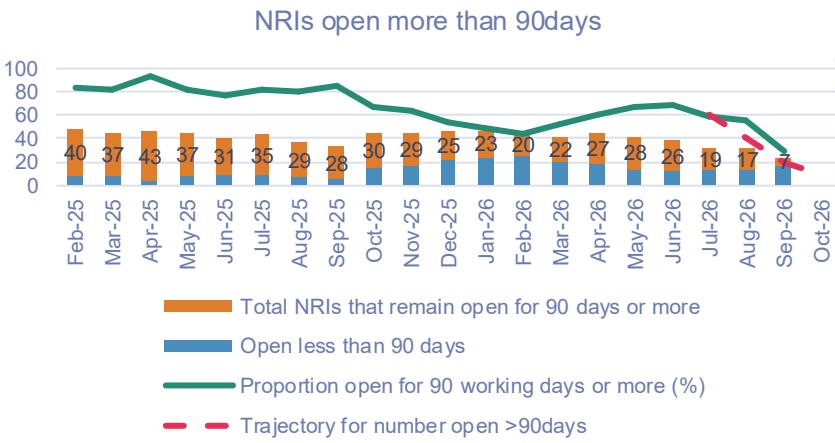
5 Impact

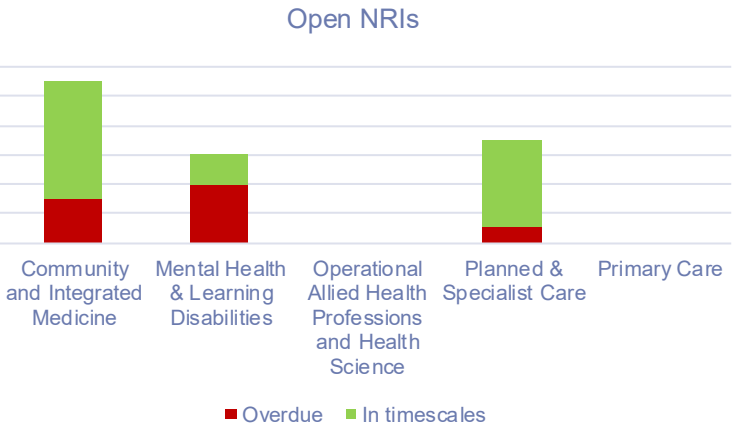
IMPACT NOT YET EVIDENCED — Compare recurrence and moderate-or-higher harm with the current baseline: 94 cases (1.0%).

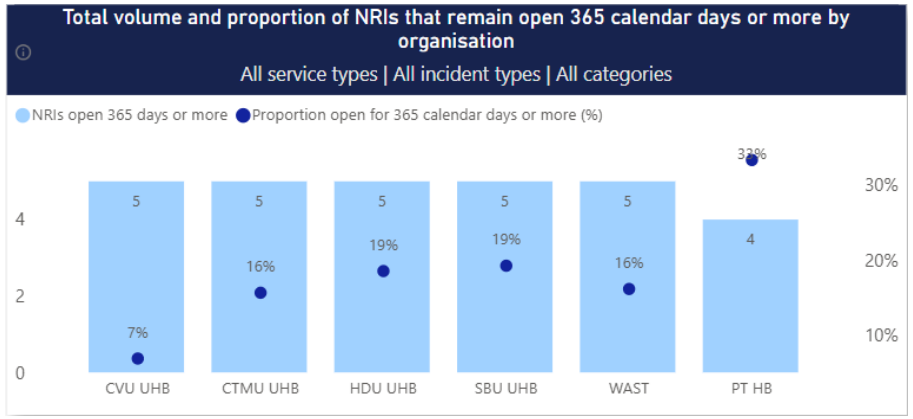
Nationally Reportable Incidents (NRIs)



Source: Beacon Dashboard 11/09/2026.







Source: Datix Cymru 07/09/2026

Note: NHS P&I have changed this to open more than 365 days. There has been improvement in month – last month position was 6 open more than 365 days. We have moved from being an outlier to middle position

Number of days since reporting to NHS Wales Performance and Improvement

	0-30days	31-60days	61-90days	91-120days	121-180days	>180days	Total
Community and Integrated Medicine	2	6	0	0	3	0	11
Mental Health & Learning Disabilities	1	1	0	0	0	4	6
Operational Allied Health Professions and Health Science	0	0	0	0	0	0	0
Planned & Specialist Care	2	4	1	0		0	7
Primary Care	0	0	0	0	0	0	0
Totals	5	11	1	0	3	4	24

Never Events

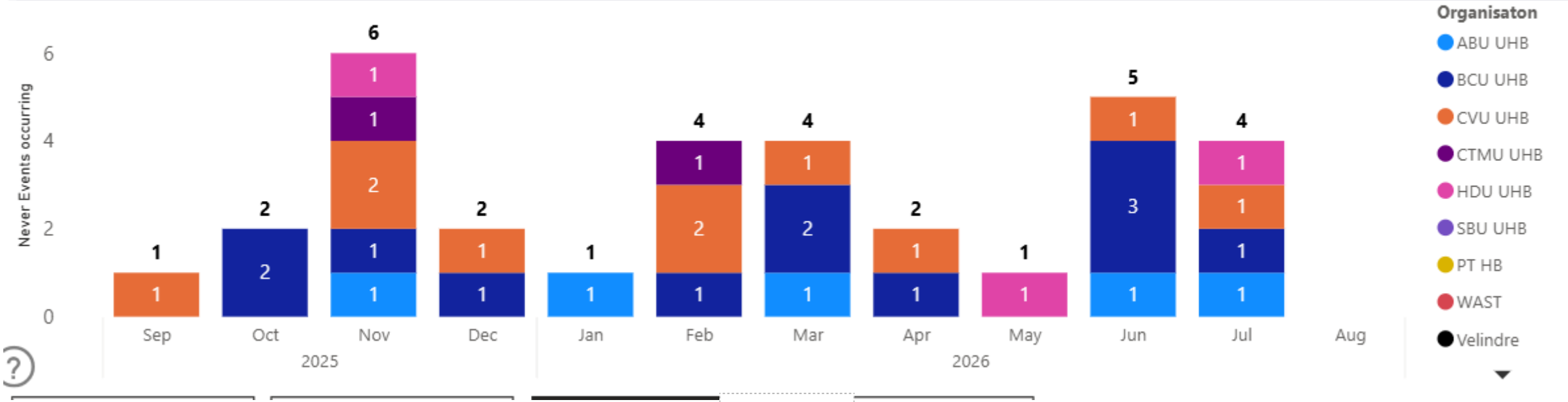
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

HDU UHB Never Events occuring (by incident date, Sep-25 to Aug-26)

Year	2025				2026							
Never Event	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Misplaced naso- or oro-gastric tubes	0	0	0	0	0	0	0	0	1	0	0	0
Retained foreign object post procedure	0	0	1	0	0	0	0	0	0	0	0	0
Wrong implant/prosthesis	0	0	0	0	0	0	0	0	0	0	1	0
Total Never Events	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**1**	**0**

Source: Beacon Dashboard 11/09/2026.

All Wales Never Events reported to NHS PI (Sep-25 to Aug-26)



Nationally Reportable Incidents: Changes, Actions and Trajectory

Direction: at 7 Sept 2026, 24 NRIs remain open; 8 are overdue; the ≥90-day backlog has improved from 29 in Aug 2025 to 7.

What has changed?

Open NRIs: 24, down from 32 in July.

Overdue reports: 8, down from 11 at the previous report.

Aged backlog: 7 open for ≥90 days

Aged proportion: 29%, down from 80.6% in Aug 2025.

Where action is needed

MH&LD: 4 of 6 open cases overdue (using date set internally for completion of the investigation); 4 are >180 days.

Community & Integrated Medicine: 3 of 11 open cases overdue; 3 are 120-180 days.

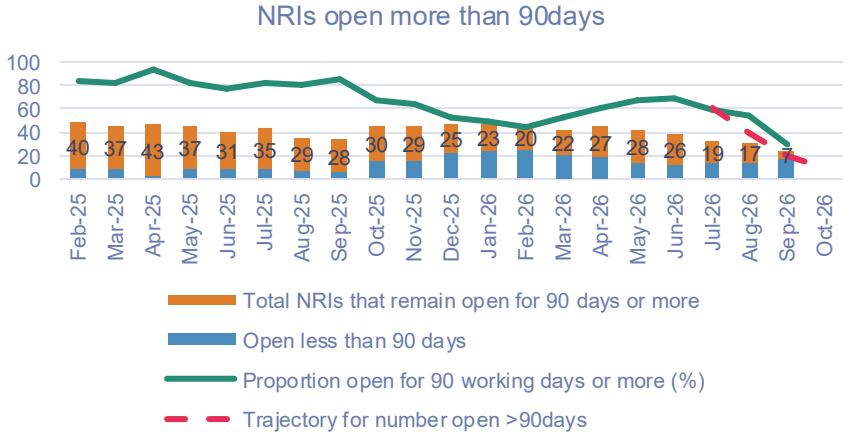
Planned & Specialist Care: 1 of 7 open cases overdue; none are over 90 days

Priority: close the 7 cases aged >120 days.

Trajectory / impact

September 2026 trajectory: 7 which is below the October target of 10 cases overdue.

Measure: overdue cases, ≥90-day cases and aged proportion.



1	Standard	Outcome reports are completed within 90 working days, with open cases reviewed through to closure.
2	Data	24 open NRIs; 7 overdue; 7 aged ≥90 days; 4 aged >180 days.
3	Learning	Delay is concentrated in MH&LD: 4 of 7 overdue cases - all aged >180 days.
4	Action	Prioritise the 7 >120-day cases; maintain named closure dates, review and escalation.
5	Impact	POSITIVE TRAJECTORY — The ≥90-day backlog reduced from 29 in August 2025 to 7 and is ahead of the October target of 10.

Data source – NRI Compliance 07-0-2026

Concentration of risk: MH&LD holds 4 of 7 overdue cases

Inquests and Regulation 28

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

All Wales Regulation 28 - Prevention of Future Death Reports since 2022 - all categories of report (as of 04/09/2026)

Date of report	Ref	Report link	ABU	BCU	CVU	CTM	HDU	SBU	PT	WAST	Welsh Gov.	Velindre	PHW	Total org.
05/02/2026	2026-0063													2
04/02/2026	2026-0055													1
02/02/2026	2026-0050													1
13/01/2026	2026-0016													1
16/12/2025	2025-0628													1
24/10/2025	2025-0538													1
06/10/2025	2025-0492													2
12/09/2025	2025-0464													1
02/09/2025	2025-0445													1
31/07/2025	2025-0394													1
28/07/2025	2025-0384													1
22/07/2025	2025-0370													1
22/07/2025	2025-0373													1
21/05/2025	2025-0236													1
21/05/2025	2025-0238													1
21/05/2025	2025-0240													1
11/04/2025	2025-0189													1
19/03/2025	2025-0153													1
17/03/2025	2025-0145													1
07/03/2025	2025-0127													1
06/03/2025	2025-0126													1
24/02/2025	2025-0105													1
21/02/2025	2025-0103													1
17/01/2025	2025-0032													1
Total Reports			**41**	**64**	**29**	**29**	**8**	**13**	**6**	**46**	**15**	**2**		**10**

Source: Beacon Dashboard 10/09/2026

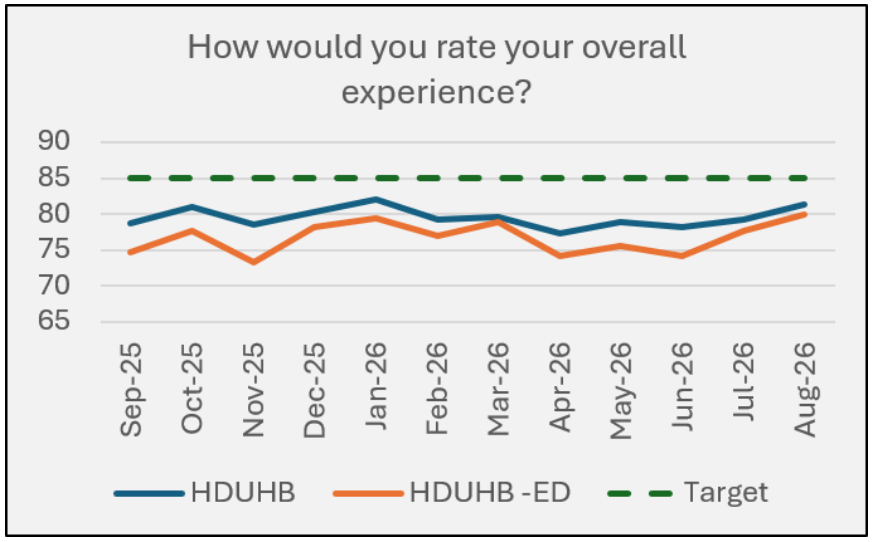
Report Key

Report sent to single health board/trust:

Report sent to multiple health boards/trusts:

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

People's Experience Feedback



Question Presented	Overall Positive Rating (%)
Did you feel well cared for?	83.32%
Were things explained to you in a way you could understand?	90.62%
Were you able to communicate in your preferred language?	95.40%

- Feedback on staff attitude and capability is overwhelmingly positive, with particular focus on the professionalism and competence of staff members.
- Similarly to previous reports, feedback throughout the organisation shows over 90% of feedback is positive.
- A large proportion of the negative comments for Accident and Emergency departments relate to the comfort of visitors, with issues such as temperature, noise and space being main contributing factors.
- Radiology services across the Health Board struggle with negative reactions to wait times, however there is strong positive insight with relation to helpfulness, emotional and physical support and compassion.
- Feedback for specialties under Therapies and Health sciences show sustained positive experience in areas such as privacy, dignity and respect, as well as communication between staff and patients.
- Hospital parking and access arrangements continue to be a recurring theme, contributing to stress before appointments and treatment.
- A significant area for improvement is waiting – comment analysis of responses shows an 8-fold increase in negative comments compared to the second most popular comment category.

1 Standard

Patient experience feedback is captured, themed and used to improve communication, compassion and care environment.

2 Data

Feedback values compassion, clear communication and teamwork; challenges focus on waits and ED environment.

3 Learning

Patients feel reassured by staff attitudes and behaviours; waits increase negative experiences.

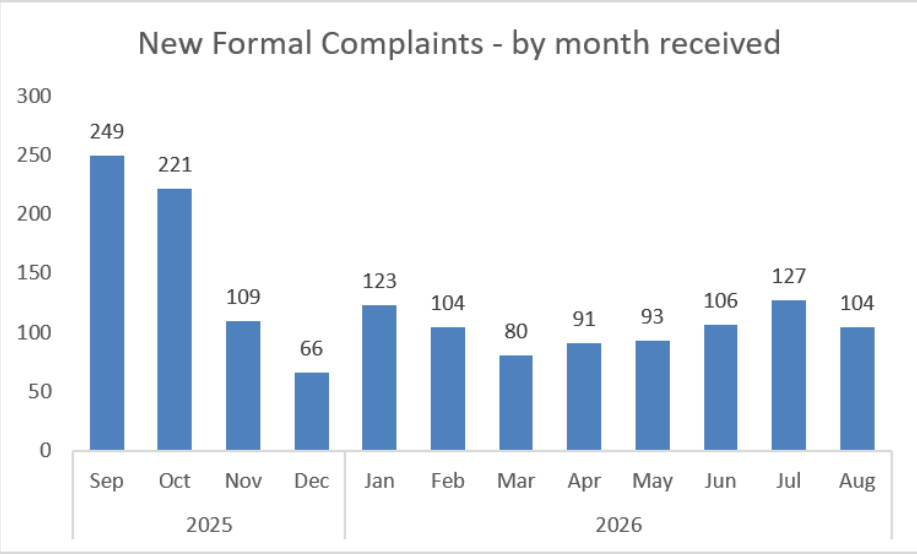
4 Action

Pay particular attention to wait times, improve environments and share feedback themes with teams for action.

5 Impact

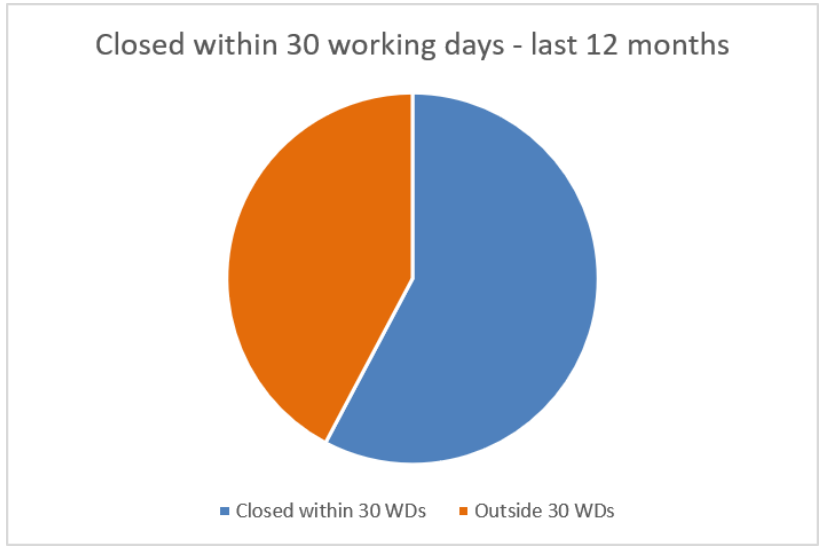
OUTCOME SNAPSHOT — Nearly 9 in 10 report a positive experience; 95% can communicate in their preferred language. Trend is not yet evidenced.

Health Board Overview: Complaints Management



Main themes from complaints in rolling twelve months:

Clinical treatment = 731
Communication = 140
Appointments = 139
Staff attitude = 78



The main reason giving rise to complaints remain consistent, with clinical treatment, appointments/ waiting times, communication and behaviour being the main themes. Thirty-working days performance – from the LTP cases closed between April-July 69% met the 30 working days (cases received & closed between 1 April and 31 July - including early resolution).

The reduction in the overall number of complaints received reflects the drive towards early resolution, improved coordination of information requests and enquiries, plus assistance from the Waiting List Support Service with a noticeable drop coinciding with the start of LTP and the implementation of more robust integrated triage process.

Health Board Overview: Outcomes and Closure Trajectory

In the last rolling 12 months, 69 cases have been escalated to Redress due to failings in care that may have caused harm to patients. Listen from Events (LFE) reports are produced following these events.

Update of Listening to People (LTP)

Of those people responding to our LTP survey (sent at the close of a complaint) the feedback has been positive, with respondents saying that they felt listened to and finding the discussion helpful in resolving their concerns.

Responding to the remaining Putting Things Right (PTR) complaints

The Health Board aims to close all remaining open PTR complaints by the end of September 2026 and is monitoring performance against with reference to a trajectory of monthly targets. Currently 68 cases are open.

Ombudsman feedback:

The PSOW have issued 3 x final reports since April 2026 which have all been **not upheld** (Datix 23787, 19958 & 18520). Also, one investigation was **discontinued** as settlement agreed (22049)

A potential **Public Interest report** around the standard of colo-rectal surgery has been received and is currently being discussed with the PSOW following clinician comments (Datix 8625 / 21591).

There are two investigations which have been **upheld / partly upheld** but are still at the draft report stage obtaining comments (18301 & 24337)

1 Standard

Complaints are triaged and resolved under PTR / LTP, with redress and learning where harm may have occurred.

2 Data

Complaints reducing; 36% closed within 30WD. Main themes: clinical treatment, assessment, communication. 52 redress; 8 PTR left.

3 Learning

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

4 Action

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

5 Impact

IMPACT EVIDENCED — 83% felt listened to and found discussions helpful. Response volume, baseline and target are required to test sustainability.

Public Services Ombudsman for Wales: Annual Letter 2025–26

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

172
complaints received

160
complaints closed

27%
of closures required intervention

118
new recommendations

81%
of due recommendations met on time

KEY FINDINGS

- **Clinical treatment in hospital dominated —** 90 complaints, representing 52% of those received.
- **Two public-interest reports were published —** one on continuity of epilepsy care and one on risk assessment and management; all recommendations from both are now complete.
- **Hywel Dda's intervention rate was 27% —** higher than the 22% health-board-wide rate reported in the letter.

ACTION REQUESTED BY PSOW

- **Present** the Annual Letter and associated data to the Board at the next available opportunity and notify PSOW of the date.
- **Review** local and PSOW data to identify trends and strengthen compliance with recommendations.
- **Apply learning** from the highlighted public-interest and own-initiative reports.
- **Provide** the 2025–26 Duty of Candour and Quality Annual Report, then share the outcome and proposed action plan with PSOW.

ASSURANCE FOCUS

Sustain timely delivery of agreed recommendations; test complaint investigations for curiosity, objectivity and rigour; and ensure openness and Duty of Candour when harm occurs.

Appendix – PSOW Annual Letter

NHS Wales Performance and Improvement - letters requesting for assurance

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Date of letter	Ref	Matter
22/07/2026		Prolonged stay in ED – patient with Mental Health issues

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

Health Inspectorate Wales (HIW) – letters requesting for assurance

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Date of letter	HIW ref	Matter
08/09/2026	18213	GGH Emergency Department • infection prevention and control, • environmental cleanliness, • issues regarding the patient's privacy and dignity.
26/08/2026	19781	ENT services in GGH • Referral to ENT declined • ENT procedure room unavailable
04/08/2026	17934	Antenatal clinics in PPH and GGH: • Shortage of doctors • Suitability of virtual clinics
06/07/2026	17564	WGH Mental Health assessment and prolonged wait for assessment in A&E
26/06/2026	17488	BGH • Welsh language provision • MCA assessment
25/06/2026	17497	GGH - Derwen Ward • Staffing model • Treatment room • Workload pressures • Care delivery and patient safety • Internal escalation
10/06/2026	17243	PPH Concerns regarding Section 136 suite in Bryngofal Ward

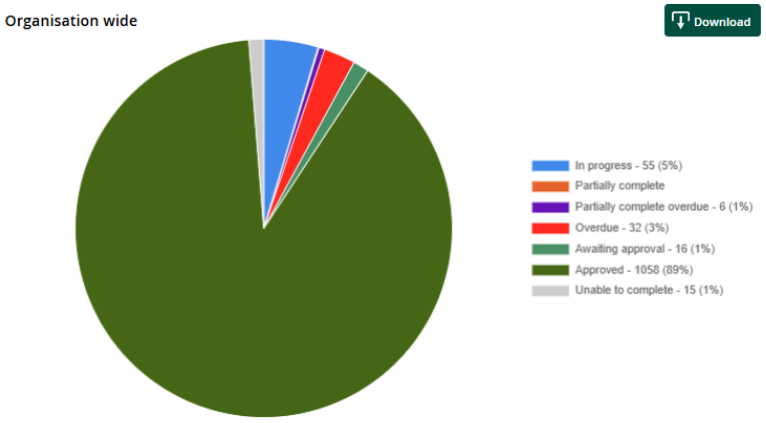
Date of letter	HIW ref	Matter
14/04/2026	16659	• O2 provision / care community • Monitoring of O2 provision • Unsafe O2 management
25/02/2026	16228	• GGH Palliative • Added a bed to a 2 bedroom • Felt lack of care & self discharge
27/01/2026	15863	PPH ward 4 • Personal care for a patient during a 6 day length of stay on ward 4 • Governance and oversight in place on the ward
22/01/2026	15877	GGH • Inside isolation room environment hygiene • Ward environment IPC • Shared spaces hygiene • Wheelchair storage areas hygiene • Cleaning supervision concerns hygiene
24/11/2025	15323	Theatres GGH • Staff training and experience • Staffing levels, burnout and turnover • Patient safety risks and incident reports • Staff wellbeing and morale • Senior management and culture concerns
23/10/2025	15014	A&E GGH • poor hygiene and infection control practice, • lack of response to concerns raised about hygiene and safety, • personal safety risks and insufficient staff training, • inadequate incident follow up • general concerns relating to staff training not being addressed
08/10/2025	13391	Update on CSP consultation for Critical Care

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

HIW Quality Checks/Inspections: Reviews and inspections

Improvement Actions relating to HIW reviews

Source: AMaT 30/09/2026



	Overdue	Partially complete (overdue)
Community and Integrated Medicine	5	2
Digital	1	
Estates and Facilities	0	
Mental Health and Learning Disabilities	16	1
Operational Allied Health and Health Science	7	
Planned and Specialist Care	1	2

	Position as at 30/09/2026	Position as at 12/07/2026
Overdue	32	25
Partially complete (overdue)	6	6
Partially complete	1	1
In progress	55	16
Rejected (to be resubmitted)	0	0

Open HIW inspections

No. of inspections	MD	SD	WN	PIR	Actions							
					In progress	Partially complete	Partially complete (Overdue)	Overdue	Unable to complete	Completed (awaiting approval)	Rejected	Completed
12	157/245 (64%)	0/4 (0%)	0	0	55	1	6	32	9	16	0	344

Note for each open inspection, an action is created for the QAS Team to confirm with HIW closure of the inspection actions (this is not included within the HIW inspection report). Therefore. if actions are overdue, the action for QAST will also be overdue.

HIW Quality Checks/Inspections: Open reviews and inspections

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Code	Title	MD	SD	WN	PIR	Actions							
						In progress	Partially complete	Partially complete (Overdue)	Overdue	Unable to complete	Completed (awaiting approval)	Rejected	Completed
Healthcare Inspectorate Wales (HIW)/2026/840	Diagnostic Imaging Department, Bronglais General Hospital	3/26 (12%)	0	0	0	37	0	0	0	0	0	0	8
Healthcare Inspectorate Wales (HIW)/2026/833	Enlli Ward- Bronglais Hospital	1/16 (6%)	0/4 (0%)	0	0	9	0	1	12	0	11	0	2
Healthcare Inspectorate Wales (HIW)/2025/716	HIW Cwm Seren LSU & PICU	10/15 (67%)	0	0	0	2	0	0	2	0	2	0	15
Healthcare Inspectorate Wales (HIW)/2025/628	HIW Derwen Ward 04054	28/32 (88%)	0	0	0	1	1	0	2	1	1	0	119
Healthcare Inspectorate Wales (HIW)/2022/19	HIW GGH IRMER Inspection (Nov 2022)	19/21 (90%)	0	0	0	0	0	0	2	0	0	0	34
Healthcare Inspectorate Wales (HIW)/2023/29	HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)	19/40 (48%)	0	0	0	0	0	0	2	4	0	0	27
Healthcare Inspectorate Wales (HIW)/2025/750	HIW Improvement plan – Community Learning Disability Team	2/6 (33%)	0	0	0	4	0	0	1	0	1	0	4
Healthcare Inspectorate Wales (HIW)/2024/86	HIW IRMER Diagnostic Imaging x-ray department Withybush Hospital January 2024	7/9 (78%)	0	0	0	0	0	1	1	1	0	0	11
Healthcare Inspectorate Wales (HIW)/2024/498	IRMER Regulations	7/9 (78%)	0	0	0	0	0	0	3	0	0	0	7
Healthcare Inspectorate Wales (HIW)/2025/587	Joint Inspection of Child Protection Arrangements (Pembrokeshire)	17/21 (81%)	0	0	0	0	0	3	4	0	0	0	27
Healthcare Inspectorate Wales (HIW)/2025/595	Mynydd Mawr Ward, Prince Philip HospitaL 03921	21/24 (88%)	0	0	0	0	0	1	2	2	0	0	53
Healthcare Inspectorate Wales (HIW)/2025/596	Nuclear Medicine IRMER WGH 03909	23/26 (88%)	0	0	0	2	0	0	1	1	1	0	37

HIW Recommendations made by HIW in Q2 2026/27

Main themes of learning from HIW inspections

Governance, oversight and assurance — stronger monitoring, accountability, central records, audit and timely follow-up.
Consistent documentation — close recurring gaps in referrals, checks, evaluations, observations, plans, consent and equipment records.
Training and competency — improve mandatory compliance, access, professional entitlements and competency sign-off.
Policies and procedures — timely review, version control and full legislative and practice coverage.
Legal and regulatory compliance — IR(ME)R, lawful consent, medicines governance and timely DoLS authorisations.
Medicines and emergency readiness — temperature monitoring, correct storage/classification and reliable emergency-equipment checks.
Patient safety, dignity and accessibility — address environmental risk, privacy, access, cleanability and safe handovers.
Patient involvement and experience — support participation, therapeutic engagement and meaningful activities.
Learning culture — improve incident feedback, shared learning, supervision and response to staff concerns.

Central message: embed learning through standardised systems and sustained assurance—not isolated actions. The repeated life-support training issue is a clear example: Enlli compliance remains approximately 50% despite similar previous inspection findings.

5 Impact

IMPACT NOT YET EVIDENCED — Track repeat HIW findings, training compliance, documentation audit results and recurrence of safety failures against agreed baselines and targets.

Health board-wide learning from the inspections undertaken

- Standardisation is essential
- Audit must demonstrate sustained improvement
- Governance needs clear escalation and accountability
- Training requires a systemic response
- Record keeping remains a major improvement area
- Policies and procedures must remain current
- Clear professional roles improve safety
- Learning must be routinely shared
- Interim controls are needed while permanent solutions develop
- Patient and staff voices should shape improvement

1 Standard

HIW actions and identified trends help define the standards and quality expectations required across services.

2 Data

HIW actions, themes and trends identified across multiple areas highlight recurring priorities and emerging areas of concern

3 Learning

Cross-cutting themes and trends can be used to support organisational learning and continuous improvement across the Health Board.

4 Action

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

HIW inspection actions: ownership and assurance

Actions are actively monitored, escalated and held open until completion is evidenced.

2× monthly

Quality Assurance & Safety review and follow-up for every open action.

Quarterly

Progress reporting to HIW continues until completion evidence is accepted.

Escalation routes

- Direct owner communication
- Targeted overdue escalation
- CCG governance agendas
- Power BI priority reporting

! Accountability focus

QSEC concerns about ownership, accountability and timely completion triggered stronger escalation and governance controls.

The assurance cycle turns monitoring data into accountable action and verified closure.

1 Standard

Every open HIW action follows a defined twice-monthly review and follow-up standard.

2 Data

Power BI identifies overdue actions and priorities requiring immediate attention.

3 Learning

QSEC review exposes recurring ownership, accountability and timeliness barriers.

4 Action

Owners are contacted; overdue actions escalate and enter CCG governance agendas.

5 Impact

IMPACT NOT YET EVIDENCED — Quarterly reporting confirms closure activity; future reports must show fewer overdue actions and repeat findings after closure.

Appendix — HIW overdue actions

HIW Annual Report 2025–26: compassionate care is strong, but recurring risks persist

Published 24 September 2026 • Independent national evidence with direct relevance to Health Board assurance

216
onsite inspections

4,407
patient, family / carer and public surveys

783
concerns received • +40 year on year

NATIONAL ASSURANCE PICTURE

- **Clear strength —** patients generally experience compassionate, person-centred care from committed staff.
- **Persistent concern —** core safety processes, governance, workforce capacity, flow / access and care environments remain variable.
- **Overall judgement —** services often respond to findings, but improvement is too slow and is not always embedded or sustained.

DIRECT RELEVANCE TO HYWEL DDA

- **Glangwili maternity —** HIW found positive culture, patient experience and effective core systems, with progress since 2022.
- **Local gaps —** earlier national incident reporting, consistent SBAR, audit evidence of learning and impact, mandatory training, medicines management and equipment checks.
- **Assurance test —** local action should reduce repeat findings and demonstrate sustained change in practice and outcomes.

QSEC ASSURANCE IMPLICATION

The report supports reasonable assurance that risks are identified and acted on, but confirms targeted scrutiny is still required: CCG plans should evidence fewer repeat findings, timely closure and sustained patient or practice outcomes.

Appendix — HIW overdue actions

Thirlwall Inquiry — Health Board considerations

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Final report published 15 September 2026 • 17 overarching recommendations

WHY IT MATTERS

- **The Inquiry found** profound failures in management, governance and safeguarding, with opportunities missed to act on concerns.
- **The learning is system-wide:** boards must be able to detect early safety signals, listen to staff and families and act with urgency, curiosity and openness.
- **The implications are broader —** learning extends beyond maternity and neonatal services to every service and profession.

HEALTH BOARD'S PLANNED CONSIDERATIONS

- **Assess across the organisation —** begin with a CCG baseline and engage other CCGs, senior professional forums and leadership teams.
- **Complete targeted gap analyses —** perinatal and neonatal services against relevant BAPM standards; safeguarding against the Wales Safeguarding Procedures; and child, infant and unexpected-death reporting.
- **Test safeguards and escalation —** how concerns, incident trends and soft intelligence are recognised, triangulated, escalated and acted on, including speaking-up support and mortality review.
- **Strengthen learning and voice —** evidence that learning from incidents, complaints, claims, inquests and reviews is sustained, and that patients, families and staff inform decisions.
- **Use established governance —** CCGs and senior leadership, then QSIG/FET and QSEC, while aligning local action with emerging national NHS Wales direction.

ASSURANCE FOCUS

Clear owners, timescales and measurable actions; reliable identification of patterns of harm; effective coordination across safeguarding, workforce, clinical governance, police and regulators; and evidence that concerns are heard and acted on.

The Thirlwall Inquiry | Examining the events at the Countess of Chester Hospital and their implications following the trial, and subsequent convictions, of former neonatal nurse Lucy Letby of murder and attempted murder of babies at the hospital

Recommendations and scrutiny priorities

The Committee is asked to:

1. Take reasonable assurance regarding the effectiveness of the Quality Management System controls described within this report.

2. Note the two principal positives identified by the paper: measurable NRI recovery and clearer QMS / CCG governance and accountability.



Authors

Collation of report: Cathie Steele, Interim Assistant Director of Nursing, Assurance and Safeguarding

Sections:

1. Patient Safety Incidents – Cathie Steele, Interim Assistant Director of Nursing, Assurance and Safeguarding
2. Nationally reportable incidents – Cathie Steele, Interim Assistant Director of Nursing, Assurance and Safeguarding
3. Patient experience – Louise O'Connor, Assistant Director for Legal Services and Patient Experience
4. Complaints Management – Louise O'Connor, Assistant Director for Legal Services and Patient Experience
5. Healthcare Inspectorate – Caroline Burgin, Patient Safety and Assurance Manager



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

The Duty of **Candour**

Openness and honesty should be at the heart of every relationship between those providing treatment and care and those experiencing it.





DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG

SAFE | SUSTAINABLE | ACCESSIBLE | KIND

Ombwdsmon
Ombudsman
Cymru · Wales

Ask for: Complaints Standards
01656 641150
Caseinfo@ombudsman.wales

Date: 17 September 2026

Dr Neil Wooding
Chair
Hywel Dda University Health Board

By email only
Neil.Wooding@wales.nhs.uk

Dear Dr Wooding

Annual Letter 2025-26

Our role

As the Public Services Ombudsman for Wales, we independently consider complaints about public services and investigate alleged breaches of the councillor Code of Conduct. We also set complaints handling standards for public bodies, drive continuous learning from complaints and undertake investigations into public services on our own initiative.

Purpose of this Annual Letter

This letter provides an update on our work for this period, and highlights key trends in Welsh health and public service complaints. It details performance specific to your organisation and outlines the positive actions we would like you to take.

Overview - a record-breaking year

This letter, as always, coincides with the publication of our Annual Report, which holds special significance this year as we mark our 20th anniversary. We closed our busiest year on record where the office received 4,507 duly made complaints across its public services and Code of Conduct remits — 27% more than last year, 47% more than 3 years ago, and 3 times as many as 20 years ago.

To meet this demand, we closed a record number of complaints, 29% more than last year and 43% more compared with 3 years ago. We intervened in 568 of complaints that we closed.

ombwdsmon.cymru
0300 790 0203
1 Ffordd yr Hen Gae, CF 35 5LJ
Rydym yn hapus i dderbyn ac ymateb i ohebiaeth yn y Gymraeg.

ombudsman.wales
0300 790 0203
1 Ffordd yr Hen Gae, CF 35 5LJ
We are happy to accept and respond to correspondence in Welsh.

Finding swift resolutions to complaints, where possible, remains important to us and benefits all parties involved. This year, 85% of our interventions included an element of Early Resolution, a process we hope has proved valuable to both your organisation and to complainants.

Despite the increased volume of cases, our case handling times remained efficient. Initial assessments and Early Resolutions were completed within 4 weeks - well ahead of our 6 week target. Additionally we maintained a downward trend in our average investigation time which was 54 weeks this year from 64 weeks in 2023-24.

Overview of health board complaints

During 2025-26, we received 1,351 complaints about health boards marking a significant 42% increase from the previous year. Clinical treatment in hospitals remains the most frequent source of concern. Additionally, complaint handling accounted for approximately 14% of complaints. While this represents a positive decline from 18% 2 years ago, specific concerns in this area are detailed below.

We intervened in 22% of health board complaints that we closed – compared to 27% last year.

Performance specific to your organisation

During 2025-26, we received 172 complaints about your organisation and closed 160 complaints (some of which may have been carried over from the previous year).

We intervened in 27% of the complaints we closed about your organisation.

We published 2 public reports in the public interest.

These related to:

- The Health Board's failure to make adequate provision for care after a specialist service for epilepsy patients ended meaning that a number of the patients and their families had no accessible care for a significant period of time (202401728).

- The failure to assess and manage risks posed to a patient before, and in particularly during COVID-19 restrictions. The significant failings identified led to a serious deterioration of the patients sight and devastating consequences for her and her family (202403251).

I am pleased that compliance with the recommendations made in these public interest reports is now complete.

Overall, we made 118 new recommendations to your organisation in the cases closed this year.

There were 118 recommendations that fell due during this period. Your organisation complied with 81% of these within the agreed timescales.

Detailed data on the complaints we handled about your organisation in this period can be found in the appendices below.

Improving compliance with our recommendations

We always take time to ensure that recommendations and timescales are agreed with public bodies before finalising them. Therefore we expect agreed deadlines to be met. Timely compliance is not, however, as high as it should be; with only 69% of our recommendations across Wales complied with on time as at 31 March 2026. Promptly delivering agreements to resolve injustice or hardship for individuals, and implementing systemic learning on time, is vital to build and maintain public trust in both our office and your organisation.

We recognise that unexpected challenges arise that make deadlines difficult to meet. In response to feedback from public bodies, we have adapted our approach moving forward: if you request a reasonable extension on or before the original deadline, and you meet that new date, it will be recorded as complied with on time. We hope this is a welcome adjustment that will help demonstrate a more accurate compliance rate over the coming years.

Supporting improvement of public services – key themes and our own initiative work

When an investigation reveals serious systemic risks that may affect many individuals, or offer wider sector lessons, we publish a public interest report. We published 9 such reports during this period, the vast majority concerning health boards. If you have not already done so, I encourage you to read these reports for their valuable insights - here.

Tragically, we have seen some instances of both individual shortcomings and wider systemic failures causing injustice to citizens in Wales. Key themes in this period have included: poor waiting list management (including inappropriate removal of patients from waiting lists); poor prescribing practice failures where we have seen communication and process breakdown between medical and pharmacy teams; and delays and clinical failures in urgent cancer referrals and ophthalmology.

We have also seen concerning complaint handling failures. Some health board complaint investigations have shown a lack of curiosity, objectivity and rigour which are essential to robust and thorough complaint investigation. In addition, we have seen failures to remain open and transparent with service users who have experienced harm, falling short of duty of candour requirements.

I strongly encourage all health boards and trusts to read the 5 public interest reports and recommendations issued during this period, and to use these insights to proactively strengthen your own complaint handling practices where appropriate.

We continue to expand the use of our own initiative powers. These allow us to investigate emerging issues proactively, addressing administrative failings before they multiply.

This year we issued a follow up report on public bodies' compliance with our previously published report on carers. You will recall I shared my original report with you given your role in identifying, assessing and supporting carers, especially during hospital discharge, and working collaboratively with others as part of an integrated system. Our follow up report can be found here.

Ongoing own initiative investigations

As at March 2026, we were conducting a further 4 own initiative investigations which focus, among other things, on:

- potential maladministration and service failure in health care
- how social landlords deal with complaints about disrepair and damp and mould.

We expect to complete this work later in 2026, and will determine then if the findings warrant publication in the public interest.

Our Complaints Standards Work

By the end of March 2026, all local authorities, health boards and 21 housing associations in Wales were operating under our model complaints policy. During 2025-26, we initiated the transition for the remaining housing associations and we expect them to be fully compliant by the end of September 2026.

Organisations that are already compliant, or will be shortly, account for 85% of new complaints about public services which we receive.

Our free complaint handling training remains highly requested; we delivered 58 sessions to public bodies across Wales this year, bringing our total since 2020 to over 600 sessions and 10,000 participants.

More broadly we expect to publish the data on complaints handled by local authorities in Wales during 2024-25 and 2025-26 in the Autumn.

Action we would like your organisation to take

To build on findings from this period, can I ask that your organisation takes the following actions:

- Present this Annual Letter and associated data to the Board at the next available opportunity and notify me of the planned meeting dates.

- Review the data in this letter, alongside your own data to better understand your performance, identify trends, and review your compliance with recommendations made by my office.

- Read the reports highlighted in this letter to extract relevant learning for your own Authority.

- Provide my office with a copy of your Annual Report for 2025-26 on the Duty of Candour and Quality.

- Inform me of the outcome of your considerations and proposed action plan at the earliest opportunity.

I would like to thank you, and your officers, for your continued openness and engagement with my office.

Yours sincerely

Michelle Morris
Public Services Ombudsman

Cc. philip.kloer@wales.nhs.uk
ombudsman.liaisonemail.hdd@wales.nhs.uk

Information Sheet

Glossary of terms a guide to some of the terms used within our Annual Letters and Appendices**.**

Appendix A shows the number of complaints we received for all health boards in 2025-26. These complaints are contextualised by the population of each authority.

Appendix B shows the categorisation of each complaint received, and what proportion of received complaints represents for the Health Board.

Appendix C shows intervention rates for all health boards in 2025-26. An intervention is categorised by either an upheld complaint (either public interest or non-public interest), an early resolution, or a voluntary settlement.

Appendix D shows outcomes of the complaints we closed for the Health Board in 2025-26. This table shows both the volume, and the proportion that each outcome represents for the Health Board.

Appendix E shows the compliance performance of each health board.

Annual Letters - Glossary of terms

Term	Definition
Complaints received	The number of duly made complaints we receive about a Public Body.
Duly made complaint	A complaint about public services is duly made when: • the organisation is within our jurisdiction and • the organisation has replied or had the opportunity to reply and • the events complained about happened less than a year ago, or the complainant became aware of them less than a year ago (unless there was a good reason the complainant could not complain sooner) and • the complainant is entitled to bring a complaint and • we have the details we need e.g. name, contact details, organisation being complained about, we can understand the complaint. A complaint about a local councillor is duly made when: • we have the details we need e.g. name and contact details of the complainant, the name of the councillor and the Local Authority they are a member of • we have a signed declaration from the complainant and any third parties whose evidence has been submitted.
Early Resolution	A matter which is closed without investigation because there is an obvious solution and the body agrees to carry out action to resolve the matter. The body must give us evidence that it has taken action within the timeframe agreed.
Intervention	Cases which we have closed and we have either: • Upheld the complaint after investigation. • Resolved the complaint by way of Voluntary Settlement. • Resolved the complaint by way of Early resolution.

Voluntary Settlement	A matter which has progressed to investigation stage but closed without the investigation being completed because we agree that action which the body has voluntarily suggested it will take is appropriate to resolve the matter. The body must give us evidence that it has taken action within the timeframe agreed.
Uphold	A matter we have closed after investigation and where we found that something went wrong.
% of interventions	The number of public service complaints we closed that involved Early Resolution/Voluntary Settlement and those which we upheld following an investigation, divided by the total number of duly made public service complaints we closed in the reporting period.
Upheld %	The proportion of the complaints in which we intervened that we upheld in the reporting period, shown as a percentage.
Cases Closed	The number of complaints we closed during the reporting period. This may be different from the number we received because there may be some complaints we received in the previous reporting period but which we closed in this reporting period.
Recommendation	These are actions which we ask bodies to take within agreed timescales when we find something has gone wrong. These may be actions to help the individual complainant or systemic actions to help improve services for all service users. We can make recommendations as part of an Early Resolution, Voluntary Settlement or when upholding a complaint following investigation. When we make recommendations, organisations must provide evidence to us that they have complied.
Recommendations made	The number of recommendations we made to bodies during the reporting period. (1 April 2025 to 31 March 2026)
Recommendations falling due	The number of recommendations which needed to be complied with within the reporting period (1 April 2025 to 31 March 2026). Some recommendations will have been made in the previous reporting period but fell due within this reporting period.

Recommendations complied with in line with agreed target date %	The number of recommendations which were complied with by the agreed timescale as set out in Early Resolution, Voluntary Settlement or Investigation report (applicable for those falling due in 2025-26).
Population	Population is included to provide context, based upon the size of an organisation. However, it is recognised that complaints can be made by people who are not included in the population figure, for example, residents from outside the health board or local authority area, or non-contract holders. • For **local authorities**, population refers to the estimated total number of people living in the local authority area. The figures are taken from the StatsWales.[1] • For **housing associations**, population refers to the total stock at social rent, shown in units. This includes general needs stock, sheltered stock, other supported stock and extra care stock with non self-contained bedsits, hostels and shared housing. This figure is taken from StatsWales.[2] • For **health boards**, population refers to the estimated total number of people living in the health board area. The figures are taken from StatsWales.[3]

[1] Population estimates by local authority, year, sex and age | StatsWales
[2] Social landlord housing stock, including social and non social housing | StatsWales
[3] Population estimates by local health boards, year, sex and age | StatsWales

Appendix A – Complaints received (overview)

Health Board	Complaints Received	Population	Received per 1,000 residents
Aneurin Bevan University Health Board	263	601,686	0.44
Betsi Cadwaladr University Health Board	283	697,115	0.41
Cardiff and Vale University Health Board	230	519,662	0.44
Cwm Taf Morgannwg University Health Board	173	449,346	0.39
Hywel Dda University Health Board	172	389,160	0.44
Powys Teaching Health Board	31	135,059	0.23
Swansea Bay University Health Board	199	394,553	0.50
Welsh Ambulance Services University NHS Trust	37	-	-
Total	**1388**	**3,186,581**	**0.44**

Appendix B – Complaints received (by organisation)

Hywel Dda University Health Board	Complaints Received	% share
Admissions/discharge and transfer procedures	3	2%
Adult Mental Health	6	3%
Ambulance Services	0	
Appointment procedures (including outpatients)	4	2%
Care Homes	0	
Child and Adolescent Mental Health	4	2%
Clinical treatment in hospital	90	52%
Clinical treatment outside hospital; Dentist	0	
Clinical treatment outside hospital; GP	4	2%
Clinical treatment outside hospital; Other	2	1%
Clinical treatment outside hospital; Physiotherapist	0	
Complaints Handling	0	
Confidentiality	0	
Continuing care	2	1%
De-Registration	0	
Disclosure of personal information / data loss	1	1%
Finance and Taxation	0	
Funding	3	2%
Gender Identity Funding	0	
Health	31	18%
Housing	0	
Independent Health Care providers	0	
Medical records/standards of record-keeping	1	1%
Medication; Prescription dispensing	1	1%
Non-medical services	1	1%
Nosocomial (Framework)	0	
Other	7	4%
Other miscellaneous	0	
Out of Hours GP care	0	
Patient list issues	4	2%
Poor/No communication or failure to provide information	0	
Prisoner Care	0	
Recruitment and appointment procedures	0	
Referral to treatment time	3	2%
Rudeness/inconsiderate behaviour/staff attitude	5	3%
Services for vulnerable adults (eg with learning difficulties. or with mental health issues)	0	
Various Other	0	
Whistle-blowing	0	
Total	**172**	

Appendix C – Cases with PSOW intervention (overview)

Health Board	No. of interventions	No. of closures	% of interventions
Aneurin Bevan University Health Board	64	254	25%
Betsi Cadwaladr University Health Board	57	272	21%
Cardiff and Vale University Health Board	38	216	18%
Cwm Taf Morgannwg University Health Board	32	172	19%
Hywel Dda University Health Board	43	160	27%
Powys Teaching Health Board	7	28	25%
Swansea Bay University Health Board	49	195	25%
Welsh Ambulance Services University NHS Trust	8	36	22%
Total	**298**	**1333**	**22%**

Appendix D – Complaint outcomes (by organisation)

Hywel Dda University Health Board		% Share
Complaint investigation discontinued (with early resolution at assessment stages)	0	
Complaint investigation discontinued (without settlement)	0	
Decision not to investigate complaint	55	34%
Early resolution	36	23%
Matter out of jurisdiction	28	18%
Non-public interest report issued: complaint not upheld	5	3%
Non-public interest report issued: complaint not upheld with early resolution at assessment stage	1	1%
Non-public interest report issued: complaint upheld	3	2%
Non-public interest report issued: complaint upheld with early resolution at assessment stage	1	1%
Premature	29	18%
Public interest report issued: complaint upheld	2	1%
Public Interest report issued: complaint upheld with early resolution at assessment stage	0	
Special Interest Report	0	
Voluntary settlement	0	
Total	**160**	

Appendix E – Compliance performance comparison

Health Board	Number of recommendations made on complaints closed in 2025-26	Number of recommendations falling due in 2025-26	% of recommendations, complied with in line with agreed target date
Aneurin Bevan University Health Board	175	142	70%
Betsi Cadwaladr University Health Board	157	137	61%
Cardiff and Vale University Health Board	86	92	71%
Cwm Taf Morgannwg University Health Board	94	93	72%
Hywel Dda University Health Board	118	118	81%
Powys Teaching Health Board	9	10	70%
Swansea Bay University Health Board	143	144	60%
Welsh Ambulance Services University NHS Trust	23	36	83%

Ombwdsmon
Ombudsman
Cymru · Wales

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Dyddiad: 17 Medi 2026

Dr Neil Wooding
Cadeirydd
Bwrdd Iechyd Prifysgol Hywel Dda

Drwy ebost yn unig
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Annwyl Dr Wooding

Llythyr Blynyddol 2025-26

Ein Rôl

Fel Ombwdsmon Gwasanaethau Cyhoeddus Cymru, rydym yn ystyried cwynion am wasanaethau cyhoeddus yn annibynnol, ac yn ymchwilio i honiadau o dorri Cod Ymddygiad cynghorwyr. Rydym hefyd yn gosod safonau ar gyfer trin cwynion ar gyfer cyrff cyhoeddus, yn ysgogi dysgu parhaus o gwynion ac yn cynnal ymchwiliadau i wasanaethau cyhoeddus ar ein liwt ein hunain.

Pwrpas y Llythyr Blynyddol hwn

Mae'r llythyr hwn yn darparu diweddariad ar ein gwaith am y cyfnod yma, ac yn tynnu sylw at dueddiadau allweddol yng nghwynion am Fyrddau Iechyd Cymru a'r gwasanaethau cyhoeddus. Mae'n manylu ar berfformiad sy'n benodol i'ch sefydliad ac yn amlinellu'r camau gweithredu cadarnhaol yr hoffem i'ch sefydliad eu cymryd.

Trosolwg – blwyddyn o dorri recordiau

Mae'r llythyr hwn, fel bob un, yn cydfynd â'n cyhoeddiad o'r Adroddiad Blynyddol sydd ag arwyddocâd arbennig y flwyddyn hon wrth i ni nodi ein 20fed penblwydd. Gwnaethom gau ein blwyddyn prysuraf erioed wrth i'r swyddfa dderbyn 4,507 o gwynion dilys ar draws ei chylchoedd gwasanaethau cyhoeddus a Chod Ymddygiad - 27% yn fwy na llynedd, 47% yn fwy na 3 mlynedd yn ôl, a 3 gwaith cymaint ag 20 mlynedd yn ôl.

I gwrdd â'r galw hyn, gwnaethom gau nifer record o gwynion, 29% yn fwy na'r llynedd a 43% yn fwy o gymharu â 3 mlynedd yn ôl. Gwnaethom ymyrryd mewn 568 o gwynion a gaewyd.

Mae dod o hyd i ddatrysiad cyflym i gwynion, lle bo modd, yn parhau i fod yn bwysig i ni ac yn fuddiol i bob parti dan sylw. Eleni, roedd 85% o'n hymyriadau'n cynnwys elfen o Ddatrysiad Cynnar, proses rydyn ni'n gobeithio sydd wedi adlewyrchu'n werthfawr i'ch sefydliad ac i achwynwyr.

Er gwaethaf cynnydd yn y nifer o achosion, parhaodd ein hamseroedd trin achosion i fod yn effeithlon. Cwblhawyd asesiadau cychwynnol a Datrysiadau Cynnar o fewn 4 wythnos – ymhell o flaen ein targed o 6 wythnos. Yn ogystal, gwnaethom gynnal tuedd i lawr ar ein hamser ymchwilio cyfartalog o 54 wythnos eleni i lawr o 64 wythnos yn ystod 2023-24.

Trosolwg o gwynion Byrddau Iechyd

Yn ystod 2025-26, cawsom 1,351 o gwynion am fyrddau iechyd gan wneud cynnydd sylweddol o 42% o'r flwyddyn gynt. Triniaeth glinigol mewn ysbytai sy'n parhau fel y pryder mwyaf cyffredin. Yn ogystal, roedd ymdrin â chwynion yn cyfrif am tua 14% o gwynion. Er bod hyn yn cynrychioli gostyngiad cadarnhaol o 18% 2 flynedd yn ôl, manylir ar bryderon penodol yn y maes hwn isod.

Gwnaethom ymyrryd mewn 22% o gwynion am fyrddau iechyd a gaewyd – o'i gymharu â 27% y llynedd.

Perfformiad sy'n benodol i'ch sefydliad

Yn ystod 2025-26, cawsom 172 o gwynion am eich sefydliad a gwnaethom gau 160 o gwynion (gall rhai ohonynt fod wedi eu cario o'r flwyddyn flaenorol).

Gwnaethom ymyrryd mewn 27% o'r cwynion a gaewyd am eich sefydliad.

Gwnaethom gyhoeddi 2 adroddiad cyhoeddus er budd y cyhoedd.

Mae'r rhain yn ymwneud â:

- Methiant y Bwrdd Iechyd i wneud darpariaeth ddigonol ar gyfer gofal ar ôl i wasanaeth arbenigol ar gyfer cleifion epilepsi ddod i ben yn golygu nad oedd gan nifer o'r cleifion a'u teuluoedd ofal hygyrch am gyfnod sylweddol o amser (202401728).

- Methiant i asesu a rheoli risgiau a berir i glaf cyn, ac yn enwedig yn ystod cyfyngiadau COVID-19. Arweiniodd y methiannau sylweddol a nodwyd at ddirywiad difrifol yng ngolwg y claf a chanlyniadau dinistriol iddi hi a'i theulu (202403251).

Rwy'n falch bod cydymffurfiaeth â'r argymhellion a wnaed yn yr adroddiadau budd y cyhoedd hyn bellach wedi'i gwblhau.

Yn gyfangwbl, gwnaethom 118 o argymhellion i'ch sefydliad yn yr achosion a gaewyd eleni. Roedd yna 118 o argymhellion a oedd yn ddyledus yn ystod y

cyfnod hwn. Cyflawnwyd 81% o argymhellion oedd angen eu cwblhau o fewn yr amserlen y cytunwyd arni.

Gallwch ddod o hyd i wybodaeth fanwl am gwynion am eich sefydliad a gafodd eu hymchwilio gennym eleni yn yr Atodiadau isod.

Gwella cydymffurfiaeth â'n hargymhellion

Rydyn ni bob tro'n cymryd ein hamser i sicrhau bod ein hargymhellion a'n hamserlenni'n cael ei gytuno gan gyrff cyhoeddus cyn eu cwblhau. Felly, rydym yn disgwyl i'r terfynau amser y cytunwyd arnynt gael eu cyrraedd. Fodd bynnag, nid yw cydymffurfiaeth amserol mor uchel ag y dylai fod; a dim ond 69% o'n hargymhellion ledled Cymru y cydymffurfiwyd â nhw ar amser ar 31 Mawrth 2026. Mae cyflawni cytundebau'n brydlon i ddatrys anghyfiawnder neu galedi i unigolion a gweithredu dysgu systematig ar amser yn hanfodol i feithrin a chynnal ymddiriedaeth y cyhoedd yn ein swyddfa ac yn eich sefydliadau.

Rydym yn cydnabod bod heriau annisgwyl yn gallu codi sy'n gwneud hi'n anodd cwrdd â therfynau amser. Mewn ymateb i adborth gan gyrff cyhoeddus, rydym wedi addasu ein dull wrth symud ymlaen; os ydych yn gofyn am estyniad rhesymol ar neu gyn y dyddiad cau, ac rydych yn cwrdd â'r dyddiad newydd hwnnw, bydd yn cael ei gofnodi fel un sydd wedi'i gydymffurfio mewn pryd. Gobeithiwn fod hwn yn addasiad sydd wedi ei groesawu a fydd yn helpu i arddangos mwy o gyfraddau cydymffurfio cadarnhaol dros y blynyddoedd sydd i ddod.

Cefnogi gwelliant gwasanaethau cyhoeddus – themâu allweddol a'n gwaith ar ei liwt ei hun

Pan fydd ymchwiliad yn datgelu risgiau systematig difrifol sy'n gallu effeithio ar nifer o unigolion, neu'n rhoi gwersi i'r sector ehangach, rydym yn cyhoeddi adrodd er budd y cyhoedd. Cyhoeddom 9 adroddiad er budd y cyhoedd yn ystod y cyfnod hwn, gyda'r mwyafrif helaeth yn ymwneud â'r Byrddau Iechyd. Os nad ydych yn barod wedi gwneud, rwy'n eich annog i ddarllen yr adroddiadau hyn i gael eu mewnwelediadau gwerthfawr - yma.

Yn drasig, rydym wedi gweld rhai achosion o ddiffygion unigol a methiannau systematig ehangach gan achosi anghyfiawnder i ddinasyddion yng Nghymru. Mae themâu allweddol yn ystod y cyfnod yma wedi cynnwys: rheolaeth wael o restrau aros (gan gynnwys tynnu cleifion oddi ar restrau aros yn amhriodol); methiannau gwael mewn arferion rhagnodi lle gwelsom fethiant mewn cyfathrebu a phrosesau rhwng timau meddygol a fferyllol; ac oediadau a methiannau clinigol mewn atgyfeiriadau canser brys ac offthalmoleg.

Rydym hefyd wedi gweld methiannau sy'n peri pryder wrth ymdrin â chwynion. Mae rhai ymchwiliadau i gwynion am Fyrddau Iechyd yn dangos diffyg chwilfrydedd, gwrthrychedd a thrylwyredd, sy'n hanfodol ar gyfer ymchwiliad

cadarn a thrylwyr i gwynion. Yn ogystal, rydym wedi gweld methiannau sy'n

parhau i fod yn agored a thryloyw gyda defnyddwyr gwasanaeth sydd wedi profi niwed, a methu â chyflawni gofynion didwylledd.

Rwy'n annog yn gryf bob Bwrdd Iechyd ac Ymddiriedolaeth i ddarllen y 5 adroddiad a'r argymhellion budd y cyhoedd a gyhoeddwyd yn ystod y cyfnod hwn, ac i ddefnyddio'r mewnwelediadau hyn i gryfhau eich arferion trin cwynion eich hun yn rhagweithiol lle bo'n briodol.

Rydym yn parhau i ehangu defnydd ein pwerau ei liwt ei hun. Mae'r rhain yn ein galluogi i ymchwilio i faterion sy'n codi yn rhagweithiol, gan fynd i'r afael â methiannau gweinyddol cyn iddynt gynyddu.

Eleni gwnaethom gyhoeddi adroddiad dilynol ar gydymffurfiaeth cyrff cyhoeddus â'n hadroddiad wnaethom gyhoeddi'n flaenorol ar ofalwyr. Fe gofiwch i mi rannu fy adroddiad gwreiddiol gyda chi o ystyried eich rôl wrth nodi, asesu a chefnogi gofalwyr, yn enwedig yn ystod rhyddhau o'r ysbyty, a gweithio ar y cyd ag eraill fel rhan o system integredig. Gellir dod o hyd i'n hadroddiad dilynol yma.

Ymchwiliadau parhaus ar ei liwt ei hun

Ym mis Mawrth 2026, roeddem yn cynnal 4 ymchwiliad pellach ar ei liwt ei hun a oedd yn canolbwyntio, ymhlith pethau eraill, ar:

- camweinyddu posibl a methiant gwasanaeth mewn gofal iechyd
- sut mae landlordiaid cymdeithasol yn delio â chwynion am ddiffyg atgyweirio a lleithder a llwydni.

Rydym yn disgwyl cwblhau'r gwaith hwn yn hwyrach yn 2026, a byddwn yn penderfynu bryd hynny a yw'r canfyddiadau'n cyfiawnhau cyhoeddi er budd y cyhoedd.

Ein gwaith Safonau Cwynion

Erbyn diwedd mis Mawrth 2026, roedd pob awdurdod lleol, byrddau iechyd a 21 o gymdeithasau tai yng Nghymru yn gweithredu o dan ein polisi cwynion enghreifftiol. Yn ystod 2025-26, fe gychwynnom y broses bontio ar gyfer y cymdeithasau tai sy'n weddill ac rydym yn disgwyl iddynt gydymffurfio'n llawn erbyn diwedd mis Medi 2026.

Mae sefydliadau sydd eisoes yn cydymffurfio, neu a fydd yn fuan, yn cyfrif am 85% o gwynion newydd am wasanaethau cyhoeddus a dderbyniwn.

Mae ein hyfforddiant trin cwynion sydd am ddim yn parhau i fod yn boblogaidd iawn; ac rydym wedi darparu 58 sesiwn arall i gyrff cyhoeddus ledled Cymru eleni gan ddod â'n cyfanswm ers 2020 i 600 sesiwn a 10,000 o gyfranogwyr.

Yn ehanghach, rydym yn disgwyl i gyhoeddi'r data ar gwynion a gafodd eu trin gan gymdeithasau tai yng Nghymru yn ystod 2024-25 a 2025-26 yn yr Hydref.

Camau yr hoffem i'ch sefydliad eu cymryd

Er mwyn adeiladu ar ganfyddiadau o'r cyfnod hwn rwy'n gofyn bod eich sefydliad yn cymryd y camau gweithredu canlynol:

- Cyflwyno'r Llythyr Blynyddol hwn i'r Bwrdd Llywodraethu neu'r Pwyllgor Archwilio ar y cyfle cynharaf ac i roi gwybod i mi am unrhyw ddyddiadau cyfarfodydd a gynlluniwyd.

- Adolygu'r data yn y llythyr hwn ynghyd â'ch data eich hun, er mwyn deall perfformiad eich cwynion yn well, i adnabod tueddiadau ac i adolygu'ch cydymffurfiad â'r argymhellion a wnaed gan fy swyddfa.

- Darllen yr adroddiadau a amlygwyd yn y llythyr hwn i dynnu gwersi perthnasol i'ch Cymdeithas eich hun.

- Darparu copi o'ch Adroddiad Blynyddol ar gyfer 2025-26 ar Ddyletswydd Gonestrwydd ac Ansawdd i'm swyddfa.

- Rhoi gwybod i mi am ganlyniad eich ystyriaethau a'ch cynllun gweithredu arfaethedig ar y cyfle cyntaf.

Hoffwn ddiolch i chi, a'ch swyddogion, am eich agoredrwydd parhaus a'ch ymgysylltiad â'm swyddfa.

Yn gywir

Michelle Morris
Ombwsdmon Gwasanaethau Cyhoeddus

Cc. philip.kloer@wales.nhs.uk
ombudsman.liaisonemail.hdd@wales.nhs.uk

Taflen Wybodaeth

Gerifa o dermau - canllaw i rai o'r termau a ddefnyddir yn ein Llythyrau Blynyddol a'n Atodiadau.

Mae **Atodiad A** yn dangos nifer y cwynion a dderbyniom am y byrddau iechyd i gyd yn 2025-26. Mae'r cwynion hyn wedi'u roi mewn cyd-destun gan boblogaeth pob awdurdod.

Mae **Atodiad B** yn dangos categoreiddio pob cwyn a dderbyniwyd, a pha gyfran o'r cwynion a dderbyniwyd sy'n cynrychioli'r Bwrdd Iechyd.

Mae **Atodiad C** yn dangos cyfraddau ymyrraeth ar gyfer pob bwrdd iechyd yn 2025-26. Caiff ymyrraeth ei chategoreiddio naill ai yn ôl cwyn a gadarnhawyd (naill ai er budd y cyhoedd neu nad yw er budd y cyhoedd), datrysiad cynnar, neu setliad gwirfoddol.

Mae **Atodiad D** yn dangos canlyniadau'r cwynion a gaewyd gennym ar gyfer y Bwrdd Iechyd yn 2025-26. Mae'r tabl hwn yn dangos y cyfaint a'r gyfran y mae pob canlyniad yn ei chynrychioli ar gyfer y Bwrdd Iechyd.

Mae **Atodiad E** hyn yn dangos perfformiad cydymffurfio pob bwrdd iechyd.

Llythyrau Blynyddol - Geirfa o dermau

Term	Diffiniad
Cwynion a gafwyd	Nifer y cwynion a wnaed yn briodol a dderbyniwn am Gorff Cyhoeddus.
Cwyn a wnaed yn briodol	Gwneir cwyn am wasanaethau cyhoeddus yn briodol pan: • mae'r sefydliad o fewn ein hawdurdodaeth a • mae'r sefydliad wedi ymateb neu wedi cael cyfle i ymateb a • mae'r digwyddiadau y cwynwyd amdanynt wedi cymryd lle llai na blwyddyn yn ôl, neu daeth yr achwynydd yn ymwybodol ohonynt lai na blwyddyn yn ôl (oni bai bod rheswm da pam na allai'r achwynydd gwyno'n gynt) a • mae gan yr achwynydd hawl i gyflwyno cwyn a • mae gennym y manylion sydd eu hangen arnom e.e. enw, manylion cyswllt, y sefydliad y cwynir amdano, gallwn ddeall y gŵyn. Gwneir cwyn am gynghorydd lleol yn briodol pan: • mae gennym y manylion sydd eu hangen arnom e.e. enw a manylion cyswllt yr achwynydd, enw'r cynghorydd a'r Awdurdod Lleol y maent yn aelod ohono • mae gennym ddatganiad wedi'i lofnodi gan yr achwynydd ac unrhyw drydydd partïon y mae eu tystiolaeth wedi'i chyflwyno.
Datrysiad Cynnar	Mater sy'n cael ei gau heb ymchwiliad oherwydd bod ateb amlwg a bod y corff yn cytuno i gymryd camau i ddatrys y mater. Rhaid i'r corff roi tystiolaeth i ni ei fod wedi cymryd camau o fewn yr amserlen y cytunwyd arni.
Ymyriad	Achosion a gaewyd gennym ac rydym naill ai wedi: • Cadarnhau'r gŵyn ar ôl ymchwiliad. • Datrys y gŵyn drwy Setliad Gwirfoddol. • Datryswyd y gŵyn drwy Ddatrysiad Cynnar.
Setliad Gwirfoddol	Mater sydd wedi symud ymlaen i'r cam ymchwilio ond a gaewyd heb i'r ymchwiliad gael ei gwblhau oherwydd ein bod ni'n cytuno bod y camau y mae'r corff wedi awgrymu'n wirfoddol y bydd yn eu cymryd yn briodol i ddatrys y mater. Rhaid i'r corff roi tystiolaeth i ni

	ei fod wedi cymryd camau o fewn yr amserlen y cytunwyd arni.
Cadarnhau	Mater a gaewyd gennym ar ôl ymchwiliad a lle rydym wedi canfod bod rhywbeth wedi mynd o'i le.
% o ymyriadau	Nifer y cwynion gwasanaeth cyhoeddus a gaewyd gennym a oedd yn cynnwys Datrysiad Cynnar/Setliad Gwirfoddol a'r rhai a gadarnhawyd gennym yn dilyn ymchwiliad, wedi'i rannu â chyfanswm nifer y cwynion gwasanaeth cyhoeddus a wnaed yn briodol a gaewyd gennym yn ystod y cyfnod adrodd.
% a gadarnhawyd	Y gyfran o'r cwynion y gwnaethom ymyrryd ynddynt a gadarnhawyd gennym yn ystod y cyfnod adrodd, a ddangosir fel canran.
Achosion wedi'u cau	Nifer y cwynion a gaewyd gennym yn ystod y cyfnod adrodd. Gall hyn fod yn wahanol i'r nifer a dderbyniwyd gennym oherwydd efallai bod rhai cwynion a dderbyniwyd gennym yn y cyfnod adrodd blaenorol ond a gaewyd gennym yn y cyfnod adrodd hwn.
Argymhelliad	Dyma gamau gweithredu rydym yn gofyn i gyrff eu cymryd o fewn amserlenni y cytunwyd arnynt pan fyddwn yn canfod bod rhywbeth wedi mynd o'i le. Gall y rhain fod yn gamau gweithredu i helpu'r achwynydd unigol neu'n gamau gweithredu systemig i helpu i wella gwasanaethau i bob defnyddiwr gwasanaeth. Gallwn wneud argymhellion fel rhan o Ddatrysiad Cynnar, Setliad Gwirfoddol neu wrth gadarnhau cwyn yn dilyn ymchwiliad. Pan fyddwn yn gwneud argymhellion, rhaid i sefydliadau ddarparu tystiolaeth i ni eu bod wedi cydymffurfio.
Argymhellion a wnaed	Nifer yr argymhellion a wnaethom i gyrff yn ystod y cyfnod adrodd. (1 Ebrill 2025 i 31 Mawrth 2026)
Argymhellion sy'n dod i ben	Nifer yr argymhellion yr oedd angen cydymffurfio â nhw o fewn y cyfnod adrodd (1 Ebrill 2025 i 31 Mawrth 2026). Bydd rhai argymhellion wedi'u gwneud yn y cyfnod adrodd blaenorol ond roeddent yn ddyledus o fewn y cyfnod adrodd hwn.
Cydymffurfiwyd â'r argymhellion yn unol â'r dyddiad	Nifer yr argymhellion y cydymffurfiwyd â nhw erbyn yr amserlen y cytunwyd arni fel y nodir yn yr adroddiad

targed y cytunwyd arno %	Datrysiad Cynnar, Setliad Gwirfoddol neu Ymchwiliad (yn berthnasol i'r rhai sy'n ddyledus yn 2025-26).
Poblogaeth	Mae poblogaeth wedi'i gynnwys i roi cyd-destun, yn seiliedig ar faint sefydliad. Fodd bynnag, cydnabyddir y gall pobl nad ydynt wedi'u cynnwys yn y ffigur poblogaeth wneud cwynion, er enghraifft, trigolion o'r tu allan i ardal y bwrdd iechyd neu'r awdurdod lleol, neu bobl nad ydynt yn ddeiliaid contract. • Ar gyfer **awdurdodau lleol** , mae poblogaeth yn cyfeirio at gyfanswm amcangyfrifedig y bobl sy'n byw yn ardal yr awdurdod lleol. Mae'r ffigurau wedi'u cymryd o StatsCymru.[1] • Ar gyfer **cymdeithasau tai**, mae poblogaeth yn cyfeirio at gyfanswm y stoc ar rent cymdeithasol, a ddangosir mewn unedau. Mae hyn yn cynnwys stoc anghenion cyffredinol, stoc gwarchodedig, stoc â chymorth arall a stoc gofal ychwanegol gyda lletyau un ystafell nad ydynt yn hunangynhwysol, hosteli a thai a rennir. Mae'r ffigur hwn wedi'i gymryd o StatsCymru.[2] • Ar gyfer **byrddau iechyd** , mae poblogaeth yn cyfeirio at gyfanswm amcangyfrifedig y bobl sy'n byw yn ardal y bwrdd iechyd. Mae'r ffigurau wedi'u cymryd o StatsCymru.[3]

[1] Amcangyfrifon poblogaeth yn ôl awdurdod lleol, blwyddyn, rhyw ac oedran | StatsCymru
[2] Stoc tai landlordiaid cymdeithasol, gan gynnwys tai cymdeithasol a thai nad sy'n rhai cymdeithasol …
[3] Amcangyfrifon poblogaeth yn ôl bwrdd iechyd lleol, blwyddyn, rhyw ac oedran | StatsCymru

Atodiad A – Cwynion a dderbyniwyd (trosolwg)

Bwrdd Iechyd	Cwynion a Gafwyd	Poblogaeth	Derbyniwyd fesul 1000 o drigolion
Bwrdd Iechyd Prifysgol Aneurin Bevan	263	601686	0.44
Bwrdd Iechyd Prifysgol Betsi Cadwaladr	283	697115	0.41
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro	230	519662	0.44
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg	173	449346	0.39
Bwrdd Iechyd Prifysgol Hywel Dda	172	389160	0.44
Bwrdd Iechyd Addysgu Powys	31	135059	0.23
Bwrdd Iechyd Prifysgol Bae Abertawe	199	394553	0.50
Ymddiriedolaeth Brifysgol GIG Gwasanaethau Ambiwlans Cymru	37	-	-
Cyfanswm	**1388**	**3186581**	**0.44**

Atodiad B – Cwynion a dderbyniwyd (yn ôl sefydliad)

Bwrdd Iechyd Prifysgol Hywel Dda	Cwynion a Gafwyd	% rhannu
Gweithdrefnau derbyn/rhyddhau a throsglwyddo	3	2%
Iechyd Meddwl Oedolion	6	3%
Gwasanaethau Ambiwlans	0	
Gweithdrefnau apwyntiad (gan gynnwys cleifion allanol)	4	2%
Cartrefi gofal	0	
Iechyd Meddwl Plant a Phobl Ifanc	4	2%
Triniaeth glinigol mewn ysbyty	90	52%
Triniaeth glinigol y tu allan i ysbyty; Deintydd	0	
Triniaeth glinigol y tu allan i ysbyty; Meddyg Teulu	4	2%
Triniaeth glinigol y tu allan i ysbyty; Eraill	2	1%
Triniaeth glinigol y tu allan i ysbyty; Ffisiotherapydd	0	
Ymdrin â chwynion	0	
Cyfrinachedd	0	
Gofal Parhaus	2	1%
Dadgofrestriad	0	
Datgelu gwybodaeth bersonol / colli data	1	1%
Cyllid a Threthiant	0	
Ariannu	3	2%
Cyllid Hunaniaeth Rhywedd	0	
Iechyd	31	18%
Tai	0	
Darparwr Gofal Annibynnol	0	
Cofnodion Meddygol/Safonau cadw cofnodion	1	1%
Meddyginiaeth > Dosbarthu presgripsiynau	1	1%
Gwasanaethau anfeddygol	1	1%
Dim tystiolaeth o galedi neu anghyfiawnder	0	
Eraill	7	4%
Eraill Amrywiol	0	
Gofal Meddyg Teulu y Tu Allan i Oriau	0	
Materion rhestr glaf	4	2%
Cyfathrebu gwael/ Dim cyfathrebu neu fethiant i ddarparu gwybodaeth	0	
Gofal Carcharorion	0	
Gweithdrefnau recriwtio ac apwyntio	0	
Amser rhwng atgyfeirio a thriniaeth	3	2%
Anfoesgarwch/ ymddygiad anystyriol/ agwedd staff	5	3%
Gwasanaethau i oedolion Agored i Niwed (ee gydag anawsterau dysgu. neu â materion iechyd meddwl)	0	
Amrywiol Eraill	0	
Chwythu'r Chwiban	0	
Cyfanswm	**172**	

Atodiad C – Achosion lle ymyrrodd OGCC (trosolwg)

Bwrdd Iechyd	Nifer yr ymyriadau	Nifer y cwynion a gaewyd	% o ymyriadau
Bwrdd Iechyd Prifysgol Aneurin Bevan	64	254	25%
Bwrdd Iechyd Prifysgol Betsi Cadwaladr	57	272	21%
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro	38	216	18%
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg	32	172	19%
Bwrdd Iechyd Prifysgol Hywel Dda	43	160	27%
Bwrdd Iechyd Addysgu Powys	7	28	25%
Bwrdd Iechyd Prifysgol Bae Abertawe	49	195	25%
Ymddiriedolaeth Brifysgol GIG Gwasanaethau Ambiwlans Cymru	8	36	22%
Cyfanswm	**298**	**1333**	**22%**

Atodiad D – Canlyniadau cwynion (yn ôl sefydliad)

Bwrdd Iechyd Prifysgol Hywel Dda		% rhannu
Rhoddwyd gorau i'r ymchwiliad i'r gŵyn (gyda datrysiad cynnar yn ystod y camau asesu)	0	
Rhoddwyd y gorau i ymchwilio'r gŵyn (heb setliad)	0	
Penderfynu peidio ymchwilio cwyn	55	34%
Datrys yn gynnar	36	23%
Mater tu hwnt i awdurdodaeth	28	18%
Adroddiad nid er budd y cyhoedd wedi'i gyhoeddi: y gŵyn heb ei chadarnhau	5	3%
Adroddiad nid er budd y cyhoedd wedi'i gyhoeddi: y gŵyn heb ei chadarnhau gyda datrysiad cynnar yn ystod y cam asesu	1	1%
Adroddiad nid er budd y cyhoedd wedi'i gyhoeddi: y gŵyn wedi'i chadarnhau	3	2%
Adroddiad nad yw er budd y cyhoedd wedi'i gyhoeddi: y gŵyn wedi'i chadarnhau a'i datrys yn gynnar yn y cam asesu	1	1%
Cynamserol	29	18%
Adroddiad Budd y Cyhoedd wedi'i gyhoeddi: y gŵyn wedi ei chadarnhau	2	1%
Adroddiad Budd y Cyhoedd wedi'i gyhoeddi: y gŵyn wedi'i chadarnhau gyda datrysiad cynnar yn ystod y cam asesu	0	
Adroddiad Budd Arbennig	0	
Setliadau gwirfoddol	0	
Cyfanswm	**160**	

Atodiad E – Cymhariaeth perfformiad cydymffurfio

Bwrdd Iechyd	Nifer yr amgymhellion a wnaed ar gwynion y caewyd yn 2025-26	Nifer yr amgymhellion sy'n ddyledus yn 2025-26	% yr argymhellion, y cydymffurfiwyd â dyddiad targed cytûn
Bwrdd Iechyd Prifysgol Aneurin Bevan	175	142	70%
Bwrdd Iechyd Prifysgol Betsi Cadwaladr	157	137	61%
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro	86	92	71%
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg	94	93	72%
Bwrdd Iechyd Prifysgol Hywel Dda	118	118	81%
Bwrdd Iechyd Addysgu Powys	9	10	70%
Bwrdd Iechyd Prifysgol Bae Abertawe	143	144	60%
Ymddiriedolaeth Brifysgol GIG Gwasanaethau Ambiwlans Cymru	23	36	83%

Inspection Code	Inspection Title	Inspection Date	Recommendation	Reference Number	Action	Clinical Care Group	Original Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2025/587	Joint Inspection of Child Protection Arrangements (Pembrokeshire)	17/03/2025	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.	Healthcare Inspectorate Wales (HIW)/2025/587/MD5/2	All services to put in place improvement plans to achieve 85% compliance across all professional groups with Level 3 training by 31st March 2026	Planned and Specialist Care	30/09/2025	Partially complete (Overdue)	As this action 'sits' within Nursing, Medical Quality, Safety & patient Experience the ADoN OM will be the overall action lead, assisted by IA, AMD. CCGs to identify targeted improvement plans and report to Strategic Safeguarding Steering Group November 2025. Achieving required 85% compliance remains a significant challenge. Expectation to achieve significant compliance improvement by 28.03.26 30/03/2026 update from PE updated from medical perspective new clinical lead have been appointed for acute paeds and SBCU who has been tasked with reviewing the medical training of child protection. A new lead doctor for SG has been appointed who will work with the individual clinical leads reviewing training requirements. There is quarterly delivery group SG meeting where nurse training is reviewed and areas of non compliance is addressed with the senior nurse managers. (Non-Compliance is <85%) 28/07/2026 PG has delegated responsibility to OM. Action owner amended.
Healthcare Inspectorate Wales (HIW)/2025/587	Joint Inspection of Child Protection Arrangements (Pembrokeshire)	17/03/2025	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.	Healthcare Inspectorate Wales (HIW)/2025/587/MD5/8	All services to put in place improvement plans to achieve 85% compliance across all professional groups with Level 3 training by 31st March 2026- Above plans (JICPA / 09) to be reported to Strategic Safeguarding Steering Group Achieving 85% compliance remains challenging. Aim to do so by 28.03.36 28/07/2026 PG has delegated responsibility to OM. Action owner amended.	Planned and Specialist Care	30/11/2025	Partially complete (Overdue)	As this 'sits in Nursing, Medical, Quality & patient Experience the Assistant Director of Nursing, Quality, Safety & patient Experience should be the overall action lead, assisted by the Care Group Associate Medical Director, IA. 30/03/2026 update from PE updated from medical perspective new clinical lead have been appointed for acute paeds and SBCU who has been tasked with reviewing the medical training of child protection. A new lead doctor for SG has been appointed who will work with the individual clinical leads reviewing training requirements. There is quarterly delivery group SG meeting where nurse training is reviewed and areas of non compliance is addressed with the senior nurse managers. (Non-Compliance is <85%) 28/07/2026 PG has delegated responsibility to OM. Action owner amended.
Healthcare Inspectorate Wales (HIW)/2025/587	Joint Inspection of Child Protection Arrangements (Pembrokeshire)	17/03/2025	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.	Healthcare Inspectorate Wales (HIW)/2025/587/MD17/1	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.	Planned and Specialist Care	31/12/2025	Overdue	A review planning group has been established. 12/01/2026 - safe guarding lead and clinical lead appointments out to advert. The plan is to implement a new pathway in March 2026. 13/04/26 - Named Doctor for Safeguarding and Clinical Lead for Acute paediatrics both appointed and roles commenced in March 2026. The ability to develop a sustainable and effective SG pathway is proving challenging due to the availability of clinicians and the complexity/ acuity of ward/ on-call work- which is compounded by absence and vacancy. Immediate focus is on the improvement of safeguarding training which is being revised and realigned to RCPCh standards with training dates identified over the coming months. Where safeguarding cases are difficult to secure and additional capacity is needed, this is temporarily supported by the Head of Safeguarding and service delivery teams to secure reviews in as timely a fashion as possible. The work to develop a sustainable pathway continues and is now led by the new named doctor- with service support- but is reliant on successful recruitment/ onboarding- and resolution of other issues. Given the complexities and risks involved, this issue has now been escalated to the Deputy Director of Nursing, Quality & Patient Experience 28/4/26 The CCG Clinical Lead agreed that a six-week interim rota would be put in place to support COW in managing CP medicals, while options for a more sustainable, permanent model are considered. 18/05/2026- Dr Faumy Hassan has taken on role of safeguarding lead for HB.

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

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Philip Kloer and Neil Wooding
Chief Executive and Chair
Hywel Dda University Health Board

22 September 2026

EMBARGO: Healthcare Inspectorate Wales (HIW)
Update: Annual Report 2025–2026

Dear Philip and Neil,

I would like to inform you that HIW will be publishing its **2025–2026 Annual Report** at **00:01 on Thursday 24 September 2026**. Please find a copy of the report attached. Please note that media outlets and key stakeholders will receive a copy under embargo on **Wednesday 23 September 2026**.

This report provides an independent assessment of the quality, safety and experience of healthcare services in Wales. It brings together the findings from our regulatory, inspection and review work during 2025–2026, highlighting areas of progress, the key challenges facing healthcare services, and where focused action is needed to drive improvement across the system.

This report marks the final year of delivery under our previous strategy and provides an important reflection point for our organisation. Looking ahead, our Strategy for 2026–2030 sets out how HIW will build on the insights and learning from our work, strengthening our role as an independent and influential voice, providing assurance, identifying areas for improvement and supporting positive change across healthcare services in Wales.

I am proud of the organisation I lead and the contribution HIW continues to make in providing independent assurance and insight, helping to drive improvement and support better outcomes for people using healthcare services across Wales.

Should you wish to discuss any aspect of the report, please do not hesitate to get in touch.

Yours sincerely,

A Jones

Alun Jones
Chief Executive
Healthcare Inspectorate Wales

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Adroddiad Blynyddol

2025-2026

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Amdanom ni

Ni yw rheoleiddiwr annibynnol gofal iechyd a'r arolygiaeth ar gyfer gwasanaethau'r GIG yng Nghymru. Ein rôl yw gwirio bod gofal iechyd yn ddiogel, yn effeithiol ac yn diwallu anghenion pobl a chymunedau.

Ein diben

Rydym yn gwirio diogelwch ac ansawdd gofal iechyd ledled Cymru.

Ein Gweledigaeth

Dyfodol lle mae gofal iechyd yng Nghymru yn ddiogel, yn effeithiol ac o ansawdd uchel i bawb.

Ein gwerthoedd

Mae ein gwerthoedd yn llywio ein gwaith o ddydd i ddydd ac yn sicrhau bod pobl yn parhau wrth wraidd popeth a wnawn.

Rydym yn:

- **Annibynnol:** rydym yn ddiduedd, yn penderfynu pa waith rydym yn ei wneud a lle rydym yn ei wneud
- **Gwrthrychol:** rydym yn rhesymol ac yn deg ac yn gweithredu ar sail tystiolaeth
- **Pendant:** rydym yn gwneud dyfarniadau clir ac yn cymryd camau i wella safonau gwael ac amlygu'r arferion da rydym yn dod ar eu traws
- **Cynhwysol:** rydym yn gwerthfawrogi ac yn annog cydraddoldeb ac amrywiaeth drwy ein gwaith
- **Cymesur:** rydym yn ystwyth ac yn gwneud ein gwaith lle mae ei angen fwyaf.



Mae ein pedair blaenoriaeth strategol yn nodi sut y byddwn yn gweithio tuag at ein gweledigaeth o ddyfodol lle mae gofal iechyd yng Nghymru yn ddiogel, yn effeithiol, ac o ansawdd uchel i bawb.

1. Rhoi Pobl yn Gyntaf

Byddwn yn canolbwyntio ar y risgiau mwyaf y mae pobl a chymunedau yn eu hwynebu wrth iddynt ddefnyddio gwasanaethau gofal iechyd nawr ac yn y dyfodol.

2. Dysgu a Gweithio Gyda'n Gilydd

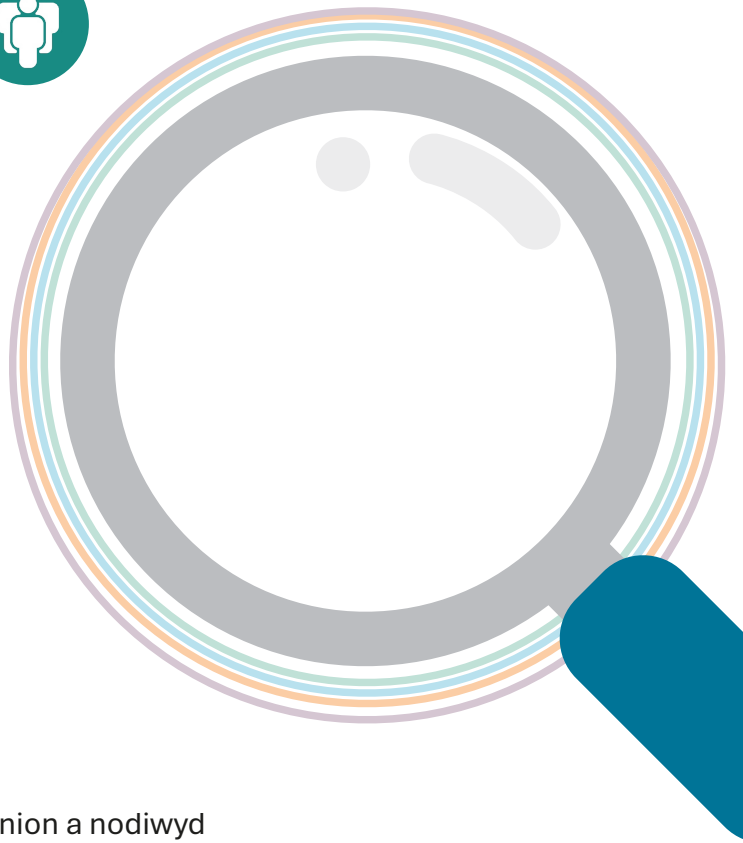
Byddwn yn cydweithio â phartneriaid er mwyn rhannu gwersi a ddysgwyd ac ysgogi gwelliannau parhaus.

3. Buddsoddi yn Ein Pobl

Byddwn yn sicrhau bod ein pobl yn teimlo eu bod yn cael eu cefnogi, eu gwerthfawrogi a'u grymuso.

4. Cymryd Camau sydd o Bwys

Byddwn yn cymryd camau i wella ansawdd a diogelwch gofal iechyd ar gyfer dyfodol Cymru.



Mae'r adroddiad hwn yn adlewyrchu'r gweithgarwch a gyflawnwyd yn erbyn y blaenoriaethau a'r amcanion a nodiwyd yng **Nghynllun Strategol 2022–2025 AGIC**, a oedd yn llywodraethu'r cyfnod a gwmpesir gan yr adroddiad hwn.

Yr hyn a wnawn

Cofrestru, rheoleiddio ac arolygu gwasanaethau gofal iechyd annibynnol, gan gymryd camau gorfodi lle na chaiff safonau eu cyrraedd.

Monitro pryderon ac atgyfeiriadau diogelu, gan weithredu'n gyflym wrth i risgiau gael eu nodi.

Arolygu gwasanaethau'r GIG ledled Cymru i sicrhau ansawdd, diogelwch ac effeithiolrwydd.

Argymell gwelliannau – ar unwaith ac ar gyfer yr hirdymor – i atgyfnerthu gofal ym mhob rhan o'r sector annibynnol a sector y GIG.

Cynnal adolygiadau i archwilio materion allweddol yn drwyadl a llywio gwelliannau.

Cymryd camau gorfodi rheoliadol er mwyn sicrhau bod darparwyr gofal iechyd annibynnol yn bodloni gofynion deddfwriaethol.

01 Rhagair



Alun Jones
Prif Weithredwr

Croeso i'n Hadroddiad Blynyddol ar gyfer 2025-2026.

"Mae llawer i'w gydnabod o ran ymrwymiad y gweithlu a'r gofal tosturiol a ddarperir. Ar yr un pryd, mae heriau parhaus sy'n effeithio ar ansawdd a diogelwch gwasanaethau, a phrofiadau ohonynt. Nid yw'r heriau hyn yn rhai newydd. Maent yn themâu sy'n codi dro ar ôl tro drwy ein harolygiadau, y pryderon a gawn, a wybodaeth ehangach am y system."

Mae gofal iechyd yng Nghymru yn newid. Mae'r galw yn cynyddu, mae gwasanaethau'n datblygu, ac mae pobl yn disgwyl cael gofal diogel o ansawdd uchel lle bynnag y byddant yn ei gael, a hynny'n gwbl briodol. O ystyried hyn, mae Arolygiaeth Gofal Iechyd Cymru (AGIC) yn rhoi sicrwydd annibynnol ar ansawdd a diogelwch gofal iechyd, a phrofiadau o ofal iechyd, ledled Cymru.

Dros y flwyddyn ddiwethaf, mae ein gwaith wedi cynnwys 216 o arolygiadau ar y safle ac ymgysylltu uniongyrchol â miloedd o bobl ledled Cymru, gan gynnwys 4,407 o ymatebion i arolygon gan gleifion, teuluoedd a gofalwyr, a 1,628 o ymatebion gan staff gofal iechyd. Mae hyn yn rhoi dealltwriaeth bwysig i ni o'r ffordd y caiff gofal ei ddarparu, a phrofiadau ohono.

Rydym wedi gweld cynnydd parhaus yn nifer y pryderon a godwyd, gyda chyfanswm o 783 wedi'u codi y flwyddyn hon yn unig. Mae hyn yn dangos ymwybyddiaeth a hyder cynyddol ymhlith pobl o ran eu gallu i siarad am eu profiadau, ac mae'n rhoi gwybodaeth bwysig i ni am y pwysau a wynebir gan wasanaethau gofal iechyd.

Mae'r adroddiad hwn yn fwy na chrynodeb o'n gwaith. Mae'n rhoi cipolwg clir, sy'n seiliedig ar dystiolaeth, ar y ffordd y mae gwasanaethau gofal iechyd yn gweithio, y meysydd lle mae gwelliannau'n cael eu gwneud, a'r meysydd lle mae angen cymryd camau pellach. Bwriedir iddo gefnogi'r rhai sy'n darparu gofal iechyd, y rhai sy'n gyfrifol am oruchwylio, a'r rhai sy'n llunio polisi, drwy nodi'r sefyllfa bresennol a'r materion y mae angen rhoi sylw penodol iddynt.

Darlun clir o bwysau parhaus

Mae gwasanaethau gofal iechyd y GIG ledled Cymru yn parhau i weithredu o dan bwysau parhaus. Mae'r galw'n uchel o hyd, ac mae gallu cleifion i gael gofal yn amrywio ledled Cymru. Mae llif cleifion is-optimaidd drwy'r system yn parhau i leihau'r capasiti sydd ar gael mewn lleoliadau gofal brys, gofal mewn argyfwng a gofal wedi'i gynllunio. Mae heriau o ran y gweithlu yn amlwg o hyd mewn gwasanaethau, gan effeithio ar gadernid a chynaliadwyedd y gofal a ddarperir.

Yn y cyfamser, mae anawsterau wrth geisio cael gofal sylfaenol yn cyfrannu at alw cynyddol mewn rhannau eraill o'r system, ac mae cyfyngiadau ar y gweithlu yn effeithio ar gysondeb a dibynadwyedd gofal mewn lleoliadau gwahanol.

Mae'r pryderon a godwyd gyda ni yn adlewyrchu'r darlun ehangach hwn. Rydym yn parhau i weld cymhlethdodau cynyddol, gyda

llawer o bryderon yn ymwneud â sawl rhan o'r system. Mae themâu fel y gallu i gael gofal, oedi cyn cael triniaeth, darpariaeth iechyd meddwl, a phwysau ar y gweithlu yn codi dro ar ôl tro.

Mae'r un problemau hyn wedi'u nodi mewn gwybodaeth ehangach am y system. Maent wedi'u deall yn dda. Yr hyn sy'n peri pryder sylweddol o hyd yw pa mor araf mae gwelliannau'n cael eu gwneud a'r graddau maent yn cael eu cynnal dros amser. Ar drothwy cyfnod newydd o lywodraeth yng Nghymru, mae disgwyliad clir y caiff newid ei gyflawni'n gyflymach ac y bydd gwelliannau'n arwain at fanteision parhaol i gleifion.

Cryfder y gweithlu

Ym mhob rhan o'n gwaith, rydym yn parhau i weld safonau uchel o dosturi a phroffesiynoldeb ymhlith staff gofal iechyd. Mae cleifion yn aml yn cael eu trin ag urddas a pharch, ac rydym yn gweld staff yn mynd gam ymhellach yn rheolaidd i wella a chefnogi gofal cleifion. Mae hyn yn gryfder sylweddol o fewn y system o hyd.

Fodd bynnag, ni all ansawdd gofal ddibynnu ar ymrwymiad yn unig. Mae heriau o ran y gweithlu, dibyniaeth ar staff dros dro, a phwysau ar hyfforddiant a chyfleoedd datblygu, yn effeithio ar sefydlogrwydd a chynaliadwyedd gwasanaethau. Dros amser, mae hyn yn peri risg i gleifion a staff. Rhaid sicrhau bod cefnogi'r gweithlu a chreu'r amodau i ddarparu gofal cynaliadwy yn ffocws canolog o hyd.

Cymryd camau lle nad yw safonau yn cael eu cyrraedd

Rydym wedi parhau i fabwysiadu dull ymatebol a chymesur, gan ganolbwyntio ar y meysydd sy'n peri'r risg fwyaf ac ymateb i broblemau sy'n dod i'r amlwg wrth iddynt godi. Y flwyddyn hon, gwelwyd lefelau uwch o weithgarwch uwchgyfeirio yng ngwasanaethau'r GIG a gweithgarwch gorfodi yn y sector gofal iechyd annibynnol. Lle nad yw safonau wedi cael eu cyrraedd mewn gwasanaethau gofal iechyd annibynnol, rydym wedi cymryd camau i ddiogelu cleifion, gan gynnwys cyfyngu ar wasanaethau neu eu hatal lle bo angen.

Yng ngwasanaethau'r GIG, mae trefniadau uwchgyfeirio strwythuredig yn cael eu defnyddio'n fwy gweithredol i reoli risg a chefnogi gwelliannau, gan helpu i sicrhau bod problemau'n cael eu nodi'n gynnar a'u datrys. Er bod gwasanaethau yn aml yn ymateb yn gadarnhaol i'n canfyddiadau, mae'r ffaith bod problemau'n codi eto yn bryder o hyd. Nid yw gwelliannau bob amser yn cael eu hymgorffori neu eu cynnal, a rhaid mynd i'r afael â hyn er mwyn cyflawni cynnydd ystyrlon.

Gofal iechyd annibynnol: Risgiau a heriau newydd

Mae'r sector gofal iechyd annibynnol yng Nghymru yn parhau i ehangu a newid.

Bu twf mewn amrywiaeth eang o wasanaethau, gan gynnwys gofal sylfaenol preifat, triniaethau esthetig a gwasanaethau iechyd a llesiant eraill. Mae hyn yn cynnig mwy o ddewis i gleifion. Fodd bynnag, mae ein gwaith yn tynnu sylw at risgiau parhaus, yn enwedig lle mae darparwyr newydd yn ymuno â'r farchnad heb ddealltwriaeth lawn o'r safonau sy'n ofynnol i ddarparu gofal diogel.



Ochr yn ochr â hyn, rydym wedi gweld cynnydd sylweddol mewn gweithgarwch cofrestru; cafwyd 705 o achosion cofrestru o gymharu â 528 y llynedd, a chynyddodd cyfanswm y gwasanaethau cofrestredig o 746 i 771. Rhwng mis Ebrill 2023 a mis Mawrth 2026, roedd dros hanner yr holl dwf net mewn gwasanaethau cofrestredig i'w briodoli i glinigau annibynnol ac asiantaethau meddygol. Cynyddodd nifer y gwasanaethau hyn o 42 i 78 dros y cyfnod, sef cynnydd o bron 86%. Mae hyn yn adlewyrchu newid sylweddol yn natur darpariaeth gofal iechyd annibynnol yng Nghymru, gyda nifer cynyddol o wasanaethau yn darparu ymgyngoriadau meddygol preifat, diagnosteg, cymorth rheoli pwysau, cymorth llesiant a thriniaethau esthetig.

Mae'r twf hwn yn arwain creu cyfleoedd a heriau. Wrth i'r sector ehangu, felly hefyd y mae'r angen am weithgarwch rheoleiddio effeithiol i sicrhau bod cleifion yn cael gofal diogel o ansawdd uchel lle bynnag y byddant yn dewis cael gofal iechyd. Mae'r gwasanaethau cofrestru a rheoleiddio yn chwarae rôl allweddol wrth sicrhau bod darparwyr yn ddiogel i weithredu, a bod trefniadau ar waith i oruchwylio'r gofal y mae pobl yn ei gael yn barhaus.

Mae'r defnydd cynyddol o wasanaethau sy'n cynnig cymorth rheoli pwysau, cymorth llesiant a thriniaethau esthetig yn creu heriau newydd o safbwynt rheoleiddio, ac yn dangos cyfyngiadau mewn fframwaith a luniwyd ar gyfer marchnad gofal iechyd wahanol iawn.

Rydym yn parhau i weld problemau yn ymwneud â gwasanaethau anghofrestredig ac ymarfer anniogel, yn enwedig mewn meysydd fel triniaethau esthetig, lle mae defnydd cynyddol o driniaethau risg uwch.

Mae cyflymder y newid yn y sector yn dangos cyfyngiadau'r fframwaith rheoleiddio presennol yn gynyddol. Wrth i ddarpariaeth gofal iechyd ddatblygu, nid yw gweithgarwch rheoleiddio bob amser wedi datblygu i'r un graddau.



Rydym yn croesawu datblygiadau mewn rhannau eraill o'r DU i atgyfnerthu mesurau diogelwch mewn meysydd fel triniaethau cosmetig anfeddygol a thriniaethau esthetig, gan gydnabod yr angen i weithgarwch rheoleiddio ddatblygu yn unol â modelau gofal sy'n newid. Wrth i'r sector gofal iechyd annibynnol barhau i ddatblygu, mae'n bwysig bod y fframwaith rheoleiddio yng Nghymru yn addas at y diben, yn cynnig mesurau diogelu effeithiol i gleifion, ac yn cynnal hyder y cyhoedd mewn gwasanaethau gofal iechyd. Rydym wedi codi ein pryderon parhaus gyda swyddogion yn y llywodraeth, ac edrychwn ymlaen at gydweithio'n gadarnhaol i bennu ffordd ymlaen.

Iechyd meddwl: Blaenoriaeth genedlaethol

Unwaith eto, un o'r pryderon mwyaf parhaus a nodwyd drwy ein gwaith oedd ystadau iechyd meddwl. Rydym yn parhau i weld staff ymroddedig yn darparu gofal tosturiol i rai o'r bobl fwyaf agored i niwed mewn cymdeithas, a hynny yng ngwasanaethau'r GIG ac mewn gwasanaethau annibynnol. Fodd bynnag, mewn rhannau o ystâd iechyd meddwl y GIG mae'r pryderon mwyaf sylweddol a hirdymor yn ymwneud â'r amgylchedd gofal yn cael eu nodi.

Mae cyflwr ac addasrwydd rhai o gyfleusterau iechyd meddwl y GIG yn parhau i godi pryderon am ddiogelwch, preifatrwydd, urddas a'r gallu i ddarparu gofal cwbl therapiwtig. Mae cleifion sy'n wynebu salwch meddwl difrifol yn aml ar eu mwyaf bregus. Maent yn haeddu cael gofal mewn amgylcheddau sy'n hybu adferiad, yn cynnal urddas ac yn cefnogi eu llesiant.

Er bod llawer o wasanaethau iechyd meddwl annibynnol yn gweithredu o amgylcheddau mwy modern sydd mewn cyflwr da ar y cyfan, mae rhai heriau'n bodoli o hyd ym mhob sector. Fodd bynnag, mae gormod o wasanaethau'r GIG yn parhau i weithredu o adeiladau na chawsant eu dylunio ar gyfer modelau gofal modern ac y byddai'n anodd eu hystyried yn dderbyniol yn y system gofal iechyd sydd ohoni.



Mae'r angen i fuddsoddi a gwella wedi'i ddeall yn dda. Yr her yn awr yw cyflawni newid ar y cyflymder sydd ei angen. Heb gamau gweithredu parhaus, mae risg y bydd cleifion a staff yn parhau i gael eu siomi gan amgylcheddau nad ydynt yn adlewyrchu'r safonau gofal y dylai Cymru anelu at eu cyrraedd.

Y cyfleoedd sydd o'n blaen

Ar drothwy cyfnod newydd o lywodraeth yng Nghymru, mae cyfle i fynd i'r afael â rhai o'r heriau hirdymor a wynebir gan wasanaethau gofal iechyd. Mae'r dystiolaeth a nodir yn yr adroddiad hwn yn rhoi asesiad cryf ac annibynnol o'r sefyllfa bresennol, gan dynnu sylw at y meysydd lle mae angen cymryd camau penodol a'r meysydd lle mae angen cyflymu gwelliannau.

Mae'r adroddiad hwn yn adlewyrchu'r flwyddyn gyflawni olaf o dan ein **strategaeth flaenorol**. Mae **Ein Strategaeth ar gyfer 2026-2030** yn nodi gweledigaeth feiddgar o ran y ffordd y byddwn yn atgyfnerthu ein rôl fel llais annibynnol a dylanwadol, gan barhau i ganolbwyntio ar ansawdd, diogelwch a gwella ar draws gwasanaethau gofal iechyd i bobl Cymru.

Y flwyddyn nesaf, byddwn yn bwrw ymlaen â rhaglen waith fawr i drawsnewid y ffordd rydym yn cael sicrwydd ac yn arolygu gwasanaethau mamolaeth a gwasanaethau newyddenedigol yng Nghymru. Bydd hyn yn cyflwyno dull mwy cydgysylltiedig, gyda ffocws cryfach ar lwybrau gofal cyfan, gan gefnogi trefniadau mwy cyson ar gyfer goruchwylio ansawdd a diogelwch mewn gwasanaethau. Bydd y gwaith hwn hefyd yn helpu i lywio'r ffordd y byddwn yn arolygu gwasanaethau cymhleth a risg uchel y GIG yn y dyfodol, gan sicrhau bod ein dull yn parhau i adlewyrchu realiti darpariaeth gofal iechyd fodern.

Cyflwr Gofal Iechyd yng Nghymru

Mae ein hadroddiad blynyddol yn rhoi darlun clir o gyflwr gofal iechyd yng Nghymru.

Mae llawer i'w gydnabod o ran ymrwymiad y gweithlu a'r gofal tosturiol a ddarperir. Ar yr un pryd, mae heriau parhaus sy'n effeithio ar ansawdd a diogelwch gwasanaethau, a phrofiadau ohonynt. Nid yw'r heriau hyn yn rhai newydd. Maent yn themâu sy'n codi dro ar ôl tro drwy ein harolygiadau, y pryderon a gawn, a gwybodaeth ehangach am y system.

Bydd angen ymdrech barhaus, atebolrwydd clir a chamau gweithredu cydlynol ym mhob rhan o'r system er mwyn mynd i'r afael â'r heriau hyn. O ystyried hyn, bydd AGIC yn parhau i roi sicrwydd annibynnol, tynnu sylw at ymarfer da a meysydd sy'n peri pryder, a defnyddio ei llais i lywio gwelliannau.

Diolch

Yn olaf, hoffwn ddiolch i bobl Cymru am barhau i rannu eu profiadau â ni. Mae eu lleisiau yn ganolog i'n gwaith ac yn sicrhau ein bod yn canolbwyntio ar y meysydd pwysicaf.

Hoffwn ddiolch i aelodau'r tîm yn AGIC. Mae eu proffesiynoldeb, eu hymroddiad a'u hymrwymiad yn cefnogi effaith ein gwaith a'n gallu i wella gofal iechyd i bobl Cymru.

Os bydd gennych unrhyw sylwadau ar yr adroddiad hwn, cysylltwch â ni.

Alun Jones

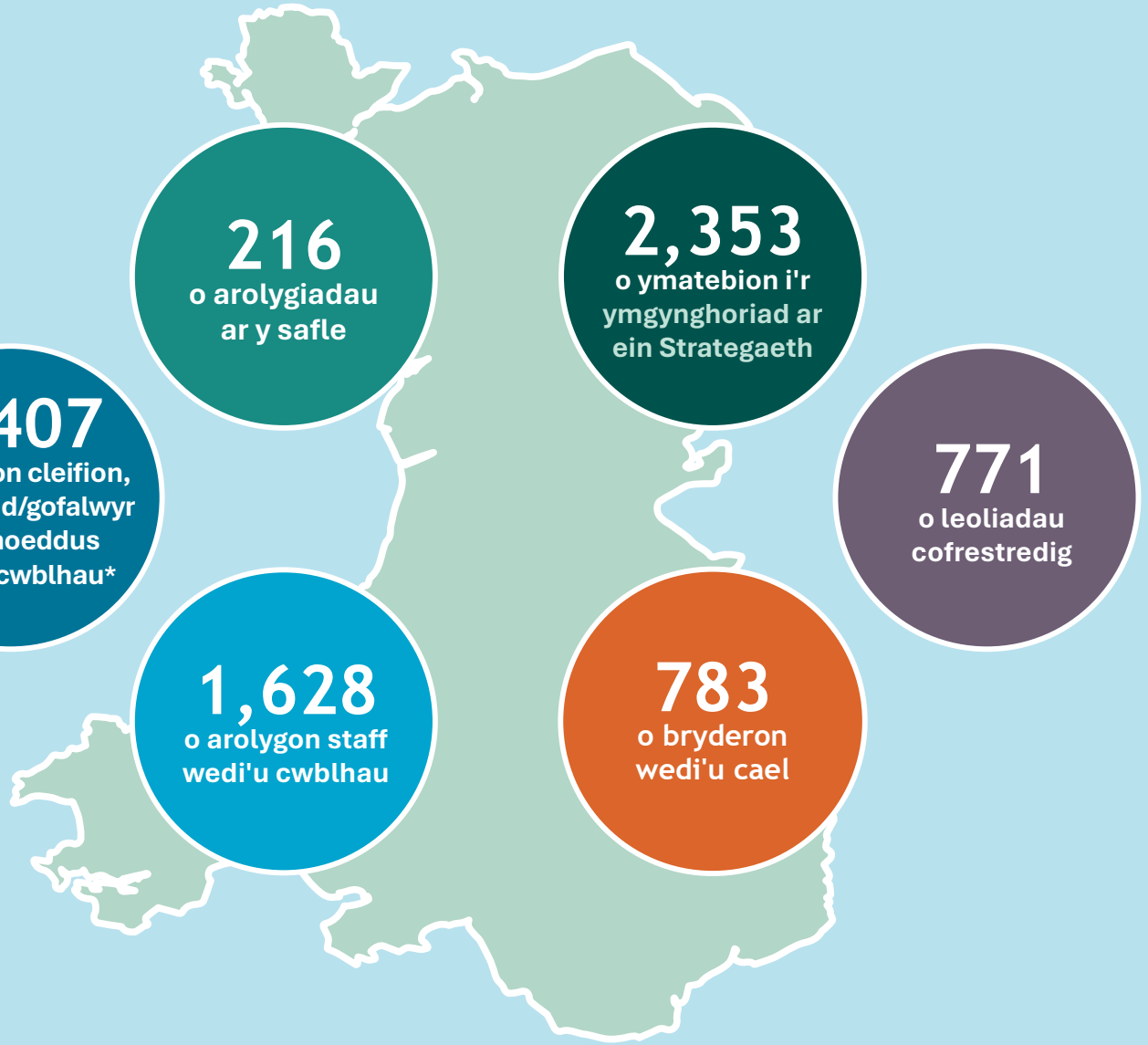
Prif Weithredwr
Arolygiaeth Gofal Iechyd Cymru



02

AGIC mewn niferoedd

2025–2026 yn Rhifau



Cynnydd o **30%** yn ymatebion cyffredinol cleifion. Mae'r nifer mwyaf o ymatebion yn deillio o arolygiadau o bractisau meddygon teulu a phractisau deintyddol.

Llinell amser ein gweithgarwch

2025

Ebrill

11 o arolygiadau wedi'u cynnal

Mai

17 o arolygiadau wedi'u cynnal

- Gwelliannau wedi'u nodi yn Uned Gofal Dementia Ysbyty Cwm Cynon
- Datganiad Sefyllfa ar Ofal mewn Coridorau
- Rydym wedi cyhoeddi ein Cynllun Gweithredol 2025–2026
- Canmol Gwasanaethau Mamolaeth yng Nghanolfan Eni Ysbyty Castell-nedd Port Talbot, ond gan nodi meysydd i'w gwella ymhellach
- Cyhoeddi rhybudd i ddarparwr a oedd yn defnyddio gwasanaethau laser anghofrestredig

Mehefin

16 o arolygiadau wedi'u cynnal

- Arolygiad yn Nodi Cryfderau ond Mae Angen Gwelliannau yn Uned Famolaeth Ysbyty Gwynedd
- Hyrwyddo Iechyd Meddwl a Llesiant yn Sioe 2025
- Cyhoeddi rhybudd i ddarparwr a oedd yn defnyddio gwasanaethau laser anghofrestredig
- Arolygiad ar y cyd yn nodi cryfderau trefniadau amddiffyn plant Sir Benfro a'r heriau y mae'n eu hwynebu oherwydd galw cynyddol

Medi

17 o arolygiadau wedi'u cynnal

- Helpwch i Lywio Strategaeth AGIC ar gyfer 2026–2030 – Mae'r Ymgynghoriad Bellach ar Agor
- Canmol Canolfan Eni am ofal wedi'i deilwra at yr unigolyn ac arweinyddiaeth gryf, gan nodi meysydd i'w gwella

Awst

13 o arolygiadau wedi'u cynnal

- Datganiad Safbwynt ar Adolygiad dan Arweiniad Teuluoedd Grŵp Cymorth Mamolaeth Bae Abertawe o Wasanaethau Mamolaeth
- Cyhoeddi rhybudd i ddarparwr a oedd yn defnyddio gwasanaethau laser anghofrestredig
- Canmol Diwylliant Cadarnhaol a Gofal Mamolaeth Cynhwysol yn Ysbyty Glangwili, gyda Meysydd i'w Gwella wedi'u nodi
- Gwybodaeth o'n Harolygiadau: Themâu Allweddol mewn Practisau Meddygon Teulu

Gorffennaf

22 o arolygiadau wedi'u cynnal

- Canmoliaeth i ofal ond mae angen gwneud rhagor o welliannau mewn uned iechyd meddwl arbenigol yng Nghaerdydd
- Gofal Brys Dan Bwysau: Canmol staff er gwaethaf yr heriau parhaus yn Ysbyty Gwynedd
- Canslo Cofrestriad ar gyfer Practis Deintyddol Preifat ar Ynys Môn

Hydref

14 o arolygiadau wedi'u cynnal

- Arolygiaeth Gofal Iechyd Cymru yn galw am ofal iechyd diogel, urddasol ac effeithiol
- Gwybodaeth o'n Harolygiadau: Themâu Allweddol mewn Practisau Deintyddol
- Bwletin Arsylwi – Hydref 2025

Tachwedd

18 o arolygiadau wedi'u cynnal

- Arolygiad o Adran Achosion Brys Ysbyty Brenhinol Morgannwg yn Datgelu Cynnydd a Heriau Parhaus
- Gwasanaethau Iechyd Meddwl yng Nghymru: Heriau Parhaus a Chyfleoedd ar gyfer Gwella
- Arolygiaeth Gofal Iechyd Cymru ac Arolygiaeth Gofal Cymru yn cwblhau archwiliad sicrwydd o wasanaethau anableddau dysgu yn Nhorfaen

Rhagfyr

12 o arolygiadau wedi'u cynnal

- Diolch am roi eich barn ar ein Strategaeth ar gyfer 2026–2030!
- Arolwg AGIC yn Amlinellu Gofal Tosturiol yn Uned Famolaeth Pen-y-bont ar Ogwr Ynghyd â Meysydd i'w Gwella
- Staff Adran Achosion Brys Ysbyty Bronglais yn cael eu canmol am ofal tosturiol er gwaethaf y pwysau gweithredol sylweddol

Mawrth

30 o arolygiadau wedi'u cynnal

- Adroddiad Blynyddol: Trefniadau Diogelu wrth Amddifadu o Ryddid yng Nghymru 2024– 2025

Chwefror

18 o arolygiadau wedi'u cynnal

- Arolygiad yn Nodi Arferion Cadarnhaol ond Meysydd Amlwg i'w Gwella ar Wardiau Iechyd Meddwl yng Nghaerfyrddin
- Datganiad Sefyllfa ar yr Asesiad Sicrwydd Mamolaeth a Newyddenedigol Cenedlaethol
- Gwrando ar Gymru: Yr Hyn y Gwnaethoch ei Ddweud Wrthym yn Ein Hymgynghoriad ar y Strategaeth

Ionawr

2026

28 o arolygiadau wedi'u cynnal

- Arolygiad yn nodi gofal cryf sy'n canolbwyntio ar y claf ochr yn ochr â meysydd i'w gwella mewn Uned Iechyd Meddwl yn y Fenni
- Arolygiad yn Nodi Rhai Newidiadau Cadarnhaol ond Heriau Parhaus yn Uned Iechyd Meddwl Ysbyty Gwynedd
- Arolygiaeth Gofal Iechyd Cymru ac Arolygiaeth Gofal Cymru yn cwblhau archwiliad sicrwydd o wasanaethau anableddau dysgu yn Sir Gaerfyrddin
- Arolygiad yn canfod bod staff ymroddedig ar wardiau iechyd meddwl Abertawe wrth iddynt wynebu materion parhaus o ran diogelwch ac urddas

03

Rheoleiddio gwasanaethau gofal iechyd annibynnol

Cipolwg ar: Ein gweithgarwch y flwyddyn hon

Rydym yn gyfrifol am gofrestru a rheoleiddio gwasanaethau gofal iechyd annibynnol er mwyn sicrhau eu bod yn ddiogel, yn effeithiol ac yn canolbwyntio ar yr unigolyn. Gwnaethom gynnal 137 o arolygiadau o amrywiaeth eang a chynyddol o ofal, o bractisau deintyddol preifat a chlinigau laser cosmetig i ysbytai annibynnol ac unedau iechyd meddwl.



Mae rheoleiddio yn rhoi sicrwydd bod gwasanaethau'n cyrraedd safonau clir o ran diogelwch, ansawdd a llywodraethu. Mae hefyd yn sicrhau, pan na fydd gofal yn cyrraedd y safonau gofynnol, y gellir cymryd camau i ddiogelu pobl a llywio gwelliannau.

Sector amrywiol ac sy'n datblygu

Mae llawer o wasanaethau yn gweithredu ochr yn ochr â gofal y GIG. Er enghraifft, mae rhai ysbytai annibynnol yn darparu triniaethau i gleifion ag anghenion cymhleth a ariennir gan y GIG, ac mae llawer o bractisau deintyddol yn cynnig cymysgedd o ofal y GIG a gofal preifat. Rydym hefyd wedi gweld cynnydd yn nifer y gwasanaethau sy'n cynnig triniaethau dewisol fel triniaethau laser, cymorth rheoli pwysau, a chymorth menopos. Wrth i'r sector hwn dyfu, mae'n bosibl y bydd yn fwy anodd i bobl ddeall pa wasanaethau sy'n cael eu rheoleiddio a pha fesurau diogelu sydd ar waith. Mae hyn yn golygu bod gweithgarwch rheoleiddio clir a gweladwy yn gynyddol bwysig.

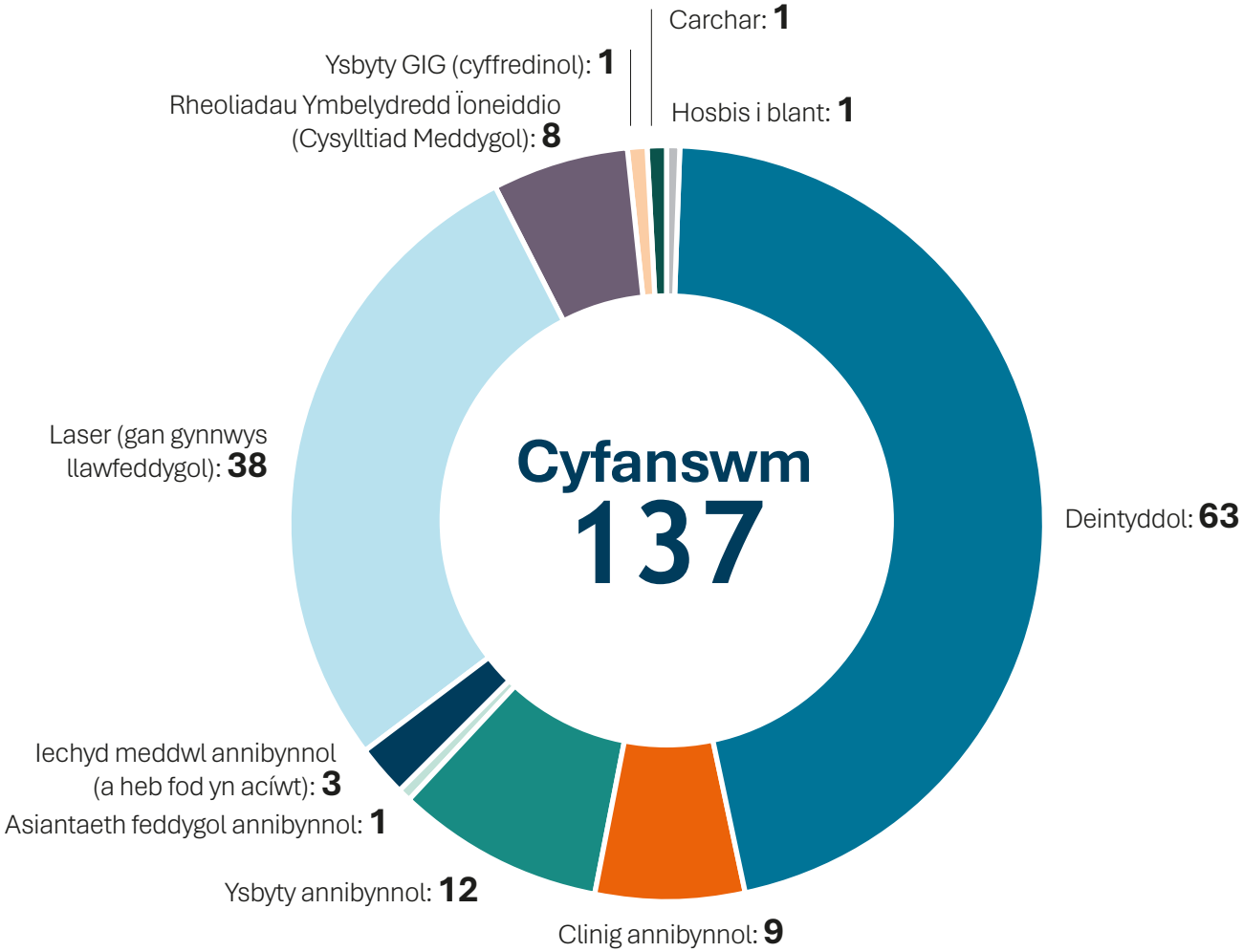


Cydbwyso arloesedd a diogelwch

O safbwynt AGIC, mae'r sector hwn yn creu cyfleoedd a heriau. Mae darparwyr annibynnol yn aml yn cynnig hyblygrwydd ac arloesedd, a all fod o fudd i gleifion, ond dim ond pan fydd hynny'n cael ei gefnogi gan drefniadau llywodraethu cadarn, atebolrwydd clir, ac ymrwymiad i ansawdd, diogelwch a gwelliannau parhaus. Gall arloesi wella dewis a mynediad, ond ni ddylai fod ar draul diogelwch. Mae rheoleiddio yn chwarae rôl allweddol wrth gynnal y cydbwysedd hwn a sicrhau bod safonau'n cael eu cymhwyso'n rheolaidd.



Arolygiadau o wasanaethau gofal iechyd annibynnol



Ein rôl fel rheoleiddiwr

Yn ogystal â nodi risgiau, nod ein harolygiadau yw helpu darparwyr i wella. Rydym yn rheoleiddio gwasanaethau er mwyn sicrhau eu bod yn cyrraedd y safonau sy'n ofynnol yn ôl y gyfraith ac yn darparu gofal sy'n ddiogel, yn barchus ac yn ymateb i anghenion pobl.

Mae hyn yn cynnwys asesu a yw gwasanaethau'n ddiogel i weithredu cyn iddynt gael eu cofrestru, eu monitro dros amser, a chymryd camau lle nad ydynt yn cyrraedd safonau ac yn bodloni gofynion deddfwriaethol.

Wrth i'r sector barhau i dyfu ac arallgyfeirio, erys AGIC yn ymrwymedig i wneud yn siŵr bod pawb yng Nghymru, ni waeth ble maent yn cael gofal, yn gallu disgwyl cael gofal iechyd diogel, urddasol o ansawdd uchel.

Uchafbwyntiau cofrestru

Y flwyddyn hon, cynyddodd ein gweithgarwch cofrestru yn sylweddol, gan adlewyrchu twf a newid parhaus yn y sector gofal iechyd annibynnol yng Nghymru.

Cafodd **705** **o achosion cofrestru** (i fyny o 528 y flwyddyn ddiwethaf)

Cynyddodd cyfanswm nifer **y gwasanaethau cofrestredig o 746 i 771**

Cafodd **285** **o geisiadau eu cymeradwyo**

ond **75** **ni chafodd** (cafodd 35 eu dychwelyd a chafodd 40 eu tynnu'n ôl)

57 **o wasanaethau eu datgofrestru** yn ystod y flwyddyn.

Bu twf sylweddol yn y sector gofal iechyd annibynnol. Mae nifer y ceisiadau yn y maes hwn wedi cynyddu'n sylweddol, gyda gwasanaethau gofal iechyd annibynnol newydd yn cyfrif am oddeutu 75% o'r holl geisiadau a gafwyd.

Rhwng mis Ebrill 2023 a mis Mawrth 2026, roedd dros hanner yr holl dwf net mewn gwasanaethau cofrestredig i'w briodoli i glinigau annibynnol ac asiantaethau meddygol yn unig. Cynyddodd nifer y gwasanaethau hyn o 42 i 78 dros y cyfnod, sef cynnydd o bron 86%.

Mae hyn yn adlewyrchu newid sylweddol yn natur darpariaeth gofal iechyd annibynnol yng Nghymru, gyda nifer cynyddol o wasanaethau yn darparu ymgyngoriadau meddygol preifat, diagnosteg, cymorth rheoli pwysau, cymorth llesiant a thriniaethau esthetig. Gall y newidiadau hyn gynnig mwy o ddewis i bobl sy'n cael gofal, ond maent hefyd yn creu heriau newydd lle nad yw gwasanaethau'n dod o fewn cwmpas fframweithiau rheoleiddio presennol a luniwyd ar gyfer marchnad gofal iechyd wahanol iawn.

Cynyddodd nifer y **clinigau annibynnol ac asiantaethau meddygol o**

58 i 78

sef cynnydd o draean yn ystod y flwyddyn a bron dwywaith y nifer a gofnodwyd ym mis Ebrill 2024

Mae nifer y ceisiadau am glinigau annibynnol wedi treblu ers 2023/24.

O fewn gwasanaethau deintyddol, mae'r newid i ddarpariaeth breifat yn parhau:

Cynyddodd cyfran y gwasanaethau preifat yn unig o

21% i 26%

Mae cyfran y practisau sy'n cynnig gwasanaethau'r GIG wedi gostwng o

86% i 74%

dros ddwy flynedd.

Mae'r cynnydd hwn mewn gweithgarwch wedi arwain at gynnydd mewn gofynion gweithredol:

Dros **40%**

yn fwy o ymweliadau cofrestru ar y safle

Cynnydd o **35%**

yn nifer y cyfweliadau â rheolwyr cofrestredig.

Cawsom 271

o ymholiadau cofrestru, gan barhau â thuedd ar i fyny.

Gan ddarparwyr newydd sy'n ymuno â'r farchnad y daw'r ymholiadau hyn yn aml.

Nodwyd tueddiadau cymysg ar draws mathau o wasanaethau

Lleihaodd nifer y **practisau deintyddol** ychydig o

513 i 510

Cynyddodd nifer y **gwasanaethau laser/IPL o**

121 i 125

er bod y twf wedi arafu

Cynyddodd nifer y**r ysbytai annibynnol o**

28 i 31

I bobl sy'n defnyddio'r gwasanaethau hyn, mae cofrestru yn fesur diogelu pwysig. Mae'n dangos bod darparwr wedi cael ei asesu yn erbyn y safonau gofynnol, a bod y gofal a ddarperir yn cael ei oruchwylio'n barhaus.

Mae'r gwaith hwn yn tynnu sylw at fwlch parhaus mewn deddfwriaeth. Ar hyn o bryd, nid yw'n ofynnol i rai gwasanaethau gofrestru, yn enwedig y rhai a arweinir gan weithwyr proffesiynol anfeddygol fel nyrsys neu fferyllwyr, hyd yn oed wrth ymgymryd â gweithgareddau tebyg i ddarparwyr rheoleiddiedig.

Ysbytai, hosbisau a chlinigau annibynnol

Rydym yn arolygu ac yn rheoleiddio gwasanaethau gofal iechyd annibynnol yng Nghymru er mwyn sicrhau eu bod yn bodloni'r gofynion cyfreithiol a nodir yn Neddf Safonau Gofal 2000, Rheoliadau Gofal Iechyd Annibynnol (Cymru) 2011 a'r Safonau Gofynnol Cenedlaethol ar gyfer Gwasanaethau Gofal Iechyd Annibynnol yng Nghymru. Mae arolygiadau yn rhan allweddol o'n rôl i ddiogelu cleifion a hyrwyddo gofal o ansawdd uchel mewn sector amrywiol sy'n tyfu.



Ein nod yw arolygu ysbytai annibynnol bob dwy flynedd a chlinigau bob tair blynedd. Caiff hosbisau eu hadolygu'n rheolaidd hefyd, ond mae'n bosibl y byddwn yn ymweld ag unrhyw wasanaeth yn amlach os caiff pryderon eu codi neu os bydd newidiadau sylweddol.

Ysbytai a hosbisau annibynnol

Yn 2025-2026, gwnaethom gwblhau dau arolygiad o ysbytai annibynnol a dau arolygiad o hosbisau i oedolion.

Ar y cyfan, dangosodd ein gwaith sicrwydd ac arolygu fod gwasanaethau yn darparu gofal diogel ac effeithiol, a chafwyd adborth cadarnhaol gan gleifion, gofalwyr a staff. Dywedodd cleifion wrthym eu bod yn teimlo eu bod yn cael eu cefnogi'n dda, a gwelsom staff yn rhyngweithio â chleifion mewn ffordd garedig, gefnogol ac urddasol.

Gwelsom waith amlddisgyblaethol da, gyda thimau o staff yn ymrwymedig i ddarparu gofal tosturiol, diogel ac effeithiol i gleifion.

Roedd yr adborth a gafwyd yn adlewyrchu'r profiad cadarnhaol hwn, a dywedodd un claf fod y profiad o fod yn yr hosbis *"fel cael cwtsh mawr cynnes."*

Ni nodwyd unrhyw risgiau uniongyrchol i ddiogelwch cleifion yn ystod yr arolygiadau hyn. Roedd y rhan fwyaf o'r canfyddiadau yn ymwneud â mân feysydd i'w gwella, gan gynnwys:

- diweddaru canllawiau i gleifion a Datganiadau o Ddiben yn barhaus
- sicrhau bod asesiadau risg yn cael eu cwblhau'n llawn a bod camau dilynol yn cael eu cofnodi'n glir
- atgyfnerthu prosesau archwilio er mwyn sicrhau bod camau gweithredu yn cael eu cwblhau a bod gwersi a ddysgwyd yn cael eu hymgorffori.

Mae'r canfyddiadau hyn yn dangos sector sy'n perfformio'n dda ar y cyfan, gyda systemau sefydledig a diwylliant o ofal cryf. Fodd bynnag, mae'n rhaid i wasanaethau barhau i ganolbwyntio ar gadw dogfennaeth gyfredol, atgyfnerthu prosesau llywodraethu, a sicrhau bod camau gwella yn cael eu cynnal.

Clinigau annibynnol

Mae amrywiaeth eang o glinigau annibynnol yng Nghymru sy'n darparu gwasanaethau arbenigol. Yn 2025-2026, gwnaethom gynnal 9 arolygiad o glinigau annibynnol, gan gynnwys clinigau cosmetig, canolfannau terfynu beichiogrwydd, a gwasanaethau adsefydlu i ddefnyddwyr cyffuriau ac alcohol.

Ar y cyfan, roedd y rhan fwyaf o'r gwasanaethau yn trin cleifion ag urddas a pharch. Roedd ymgyngoriadau yn cael eu cynnal yn breifat, ac roedd y staff yn ymddwyn mewn ffordd broffesiynol a phriodol.

Fodd bynnag, mae llawer o'r lleoliadau hyn yn fach ac yn cael eu rhedeg yn lleol. Yn aml, nid yw'r trefniadau llywodraethu mor ddatblygedig, gan ddibynnu ar nifer bach o unigolion. Mae hyn yn golygu bod gwasanaethau'n fwy bregus lle mae capasiti arweinwyr, trefniadau goruchwylio a phrosesau ffurfiol yn gyfyngedig.

Gwnaethom nodi problemau yn ymwneud â diogelwch cleifion mewn tri arolygiad (33%), sef cyfradd uwch na'r hyn a nodwyd mewn ysbytai a hosbisau, lle mae'r systemau llywodraethu fel arfer yn fwy sefydledig. Er y gall gwasanaethau llai ei chael hi'n fwy anodd bodloni'r gofynion rheoleiddio diweddaraf, mae cydymffurfiaeth yn hanfodol o hyd.

Roedd y problemau yn ymwneud â diogelwch cleifion yn cynnwys:

- darparu gwasanaethau y tu hwnt i'w hamodau cofrestru
- cofnodion meddyginiaeth anghyflawn
- cofnodion iechyd coll
- diffyg hyfforddiant Cynnal Bywyd Sylfaenol a diffibrilwyr na ellid eu cyrraedd
- glendid gwael a bylchau o ran cynnal a chadw neu galibradu cyfarpar meddygol.

Roedd meysydd cyffredin eraill i'w gwella yn cynnwys:

- dogfennaeth a chadw cofnodion
- llywodraethu a datblygu polisïau
- cynnal a chadw'r amgylchedd
- hygyrchedd a chymorth cyfathrebu.

Er bod llawer o glinigau yn darparu gofal tosturiol a pharchus, mae'r canfyddiadau hyn yn tynnu sylw at y ffaith bod yn rhaid cynnal trefniadau llywodraethu cadarn, polisïau clir, cofnodion cywir a systemau clinigol diogel er mwyn cynnig profiadau cadarnhaol i gleifion. Mae cynnal arolygiadau rheolaidd yn hanfodol o hyd, er mwyn nodi risgiau uniongyrchol a helpu i sicrhau cydymffurfiaeth a gwelliannau parhaus.

Ledled Cymru, mae'r sector gofal iechyd annibynnol yn parhau i ehangu, yn enwedig mewn meysydd fel gwasanaethau meddygon teulu preifat a thriniaethau cosmetig. Mae'r twf hwn yn cynnig mwy o ddewis i gleifion, ond mae hefyd yn gwneud y sector yn fwy cymhleth. Gall yr amrywiaeth o driniaethau sydd ar gael ei gwneud hi'n fwy anodd i bobl wybod a yw gwasanaeth wedi'i gofrestru'n briodol neu a yw ymarferwyr yn meddu ar y cymwysterau priodol.

Rydym yn annog unrhyw un sy'n chwilio am ofal iechyd annibynnol yng Nghymru i wneud y canlynol:

- sicrhau bod y darparwr wedi'i gofrestru ag AGIC
- darllen ein hadroddiadau arolygu diweddaraf
- cadarnhau bod y clinigydd y maent wedi ei ddewis yn meddu ar y cymwysterau priodol ar gyfer y driniaeth y mae'n ei chynnig.

Mae hyn yn arbennig o bwysig mewn meysydd lle mae gweithgarwch rheoleiddio yn dal i ddatblygu. Yn ogystal ag arolygu a rheoleiddio gwasanaethau, ein rôl ni yw helpu'r cyhoedd i wneud dewisiadau ar sail gwybodaeth ac i gadw'n ddiogel.

Practisau deintyddol

Mae gwasanaethau deintyddol yng Nghymru yn parhau i chwarae rôl hanfodol mewn gofal iechyd cymunedol. Mae ein harolygiadau y flwyddyn hon yn dangos bod llawer o bractisau yn darparu gofal diogel ac yn cynnig profiadau cadarnhaol i gleifion. Fodd bynnag, mae meysydd i'w gwella o hyd, yn enwedig mewn perthynas â llywodraethu, cadw cofnodion a rheoli risgiau clinigol.

Rydym yn parhau i fod yn ymrwymedig i weithredu'n gytbwys, gan gyfuno goruchwyliaeth drylwyr â chymorth ymarferol. Yn ogystal â nodi risgiau, nod ein harolygiadau yw helpu practisau i wneud gwelliannau amserol a chynaliadwy. Wrth i'r dirwedd ddeintyddol barhau i ddatblygu, mae ein rôl o ran cynnal safonau a chefnogi gwelliannau yn hanfodol o hyd.



Yn ystod 2025-2026, cynhaliodd AGIC 63 o arolygiadau o bractisau deintyddol yng Nghymru.

Arweiniad **8 archwiliad** at gyhoeddi Hysbysiadau Diffyg Cydymffurfio lle roedd risgiau sylweddol i ddiogelwch cleifion yr oedd angen cymryd camau yn eu cylch ar unwaith

Cafodd **4 practis** eu hatal ar frys yn dilyn camau gorfodi

Cafodd cofrestriad **1 practis** ei ganslo yn dilyn gweithgarwch gorfodi parhaus a oedd yn gysylltiedig ag arolygiad a gynhaliwyd yn 2024/25.

Cafodd llawer o faterion eu datrys yn ystod yr ymweliadau arolygu, gan adlewyrchu ein dull cefnogol a chydweithredol. Roedd y rhain yn cynnwys gwaredu meddyginiaethau yr oedd y dyddiad defnyddio arnynt wedi mynd heibio, mynd i'r afael â bylchau mewn prosesau rheoli stoc, rheoli risgiau amgylcheddol, a rhoi'r gorau i ddefnyddio cyfarpar anniogel.

Ar y cyfan, roedd y rhan fwyaf o'r practisau yn lân, mewn cyflwr da, ac yn cynnig amgylcheddau clinigol diogel. Dywedodd cleifion fod y staff yn gyfeillgar, yn barchus ac yn broffesiynol, a'u bod wedi cael eu trin ag urddas ac wedi cael eu cynnwys mewn penderfyniadau am eu gofal.

Gwelsom hefyd enghreifftiau o ymarfer da ac arloesi. Roedd rhai practisau yn gweithio gydag ysgolion lleol i hybu iechyd y geg, ac roedd eraill wedi cyflwyno newidiadau bach ond effeithiol i wella profiadau cleifion a'u gallu i gael gofal. Roedd y rhain yn cynnwys amseroedd apwyntiadau tawelach i gleifion niwroamrywiol, oriau agor hyblyg, offer cyfathrebu gwell, a rheoli apwyntiadau'n well drwy restrau byr rybudd. Roedd yr adborth a gafwyd gan gleifion yn tynnu sylw at effaith gadarnhaol gofal, gyda chleifion yn nodi bod eu hyder wrth fynychu apwyntiadau wedi cynyddu'n sylweddol.

Fodd bynnag, nododd ein harolygiadau nifer o feysydd sy'n peri pryder hefyd, y mae angen canolbwyntio arnynt yn barhaus.

Y prif feysydd i'w gwella

Atal a rheoli heintiau

Gwnaethom nodi risgiau mewn rhai practisau yn ymwneud â phrosesau dihalogi a thrin offer clinigol. Mae'r problemau hyn yn peri risgiau posibl i ddiogelwch cleifion ac mae angen eu rheoli'n effeithiol.

Cofnodion clinigol a phrosesau archwilio

Mae cadw cofnodion yn faes i'w wella o hyd. Fodd bynnag, gwelsom nad oedd hanes meddygol bob amser yn cael ei ddiweddaru, ac nad oedd asesiadau risg a phenderfyniadau ynghylch triniaeth bob amser yn cael eu cofnodi. Nid oedd gwybodaeth glinigol allweddol, gan gynnwys gwiriadau o iechyd y deintgig, ar gael weithiau, ac roedd safonau'n amrywio rhwng clinigwyr yn yr un practis. Mewn rhai achosion, nid oedd gan bractisau raglenni archwilio strwythuredig neu nid oeddent yn defnyddio canfyddiadau archwiliadau yn effeithiol i wella gofal. Mae cofnodion cyson a phrosesau archwilio cadarn yn hanfodol i ddarparu gofal diogel ac effeithiol.

Llywodraethu a'r gweithlu

Gwnaethom nodi anghysondebau o ran y ffordd yr oedd systemau llywodraethu yn cael eu cymhwyso. Nid oedd polisïau bob amser yn cael eu hadolygu'n rheolaidd nac yn cynnwys gwybodaeth rheoli fersiynau, ac nid oedd systemau i fonitro hyfforddiant staff a chadw cofnodion cywir bob amser ar waith. Roedd gwiriadau recriwtio, gan gynnwys geirdaon a hanes cyflogaeth, weithiau'n anghyflawn

Rhaid i bractisau sicrhau bod systemau llywodraethu yn cael eu defnyddio'n weithredol a'u hadolygu'n rheolaidd er mwyn rhoi sicrwydd clir bod risgiau'n cael eu rheoli.

Risgiau uniongyrchol a phroblemau yn ymwneud â diogelwch

Nododd rhai arolygiadau risgiau difrifol yr oedd angen eu huwchgyfeirio. Roedd y rhain yn cynnwys problemau yn ymwneud â diogelwch amgylcheddol, bylchau o ran cynnal a chadw a gwasanaethu cyfarpar, a risgiau yn gysylltiedig â chofnodion clinigol anghyflawn neu anghyson. Mae'r problemau hyn yn dangos pwysigrwydd cynnal gwiriadau rheolaidd a rheoli risgiau'n rhagweithiol.

Darpariaeth Gymraeg

Roedd darpariaeth gwasanaethau Cymraeg yn amrywio. Er bod gwybodaeth yn aml ar gael yn Gymraeg ac yn Saesneg, nid oedd bob amser yn cael ei defnyddio'n ymarferol. Roedd prosesau cofnodi dewisiadau iaith cleifion yn dameidiog, ac nid oedd gwasanaethau bob amser yn cael eu cynnig yn rhagweithiol yn Gymraeg. Hoffem weld darparwyr yn mynd ati'n fwy rhagweithiol i ddeall a diwallu anghenion cleifion o ran y Gymraeg, gan sicrhau bod pobl yn gallu cael gofal a gwybodaeth yn eu dewis iaith lle bynnag y bo'n bosibl.

Cyd-destun a ffocws ar gyfer y dyfodol

Yn ystod 2025-2026, roedd y sector deintyddol yn gweithredu yn ystod cyfnod o ansicrwydd wrth i baratoadau gael eu gwneud ar gyfer cyflwyno contract deintyddol newydd y GIG. Mae practisau wedi gweithio i ddeall y newidiadau sydd eu hangen, gan gydnabod bod hyn yn golygu newid sylweddol i'r ffordd y mae gwasanaethau'n cael eu darparu. Wrth i'r contract ddod i rym ym mis Ebrill 2026, byddwn yn parhau i fonitro ei effaith ar ofal a phrofiadau cleifion.

Cofio Ali

Hoffem dalu teyrnged i Ali, cydweithiwr uchel ei barch, ac Arweinydd Deintyddol Clinigol yn AGIC. Ers ymuno yn 2014, gwnaeth Ali gyfraniad sylweddol i ddeintyddiaeth yng Nghymru, gan arwain arolygiadau, cefnogi cymheiriaid, a helpu i lywio dulliau rheoleiddio sy'n blaenoriaethu ansawdd a diogelwch cleifion. Roedd yn adnabyddus am ei degwch, ei broffesiynoldeb a'i ymrwymiad i wella, yn ogystal â'i gynhesrwydd a'i haelioni. Cafodd effaith Ali effaith enfawr ar ei gydweithwyr a'r gymuned ddeintyddol ehangach, a bydd colled fawr ar ei ôl.

Triniaeth gan ddefnyddio laser Dosbarth 3B/4 neu ddyfais Goleuni Pwls Dwys (IPL)

Mae ein cyfrifoldebau rheoleiddio ym maes gofal iechyd annibynnol yn cynnwys rheoleiddio ac arolygu gwasanaethau sy'n cynnig triniaethau laser a Goleuni Pwls Dwys (IPL). Defnyddir y triniaethau anfeddygol hyn fel arfer at ddibenion cosmetig neu ddibenion sy'n gysylltiedig â'r croen, fel gwaredu blew neu drin acne neu bigmentiad.

Er bod llawer o ddarparwyr yn ymrwymedig i gynnig gwasanaeth da, mae ein harolygiadau yn parhau i ddangos nad yw rhai yn cydnabod yr amser, yr arbenigedd a'r systemau sydd eu hangen i gyrraedd y safonau cyfreithiol sydd eu hangen i sicrhau gofal diogel o ansawdd uchel.

Rhaid i'r gwasanaethau hyn gydymffurfio â rheoliadau penodol i leihau risgiau, yn enwedig llosgiadau ac anafiadau i'r llygaid, ac i sicrhau amgylcheddau diogel i gleifion a staff. Fel y rheoleiddiwr annibynnol, ein blaenoriaeth yw sicrhau bod gwasanaethau yn ddiogel, yn cael eu rhedeg yn dda, ac yn parchu urddas pobl.

Unwaith eto yn ystod 2025-2026, i ddarparwyr laser ac IPL y cyhoeddwyd y gyfran fwyaf o Hysbysiadau Diffyg Cydymffurfio brys yn y sector. Roedd angen cymryd camau brys i fynd i'r afael â risgiau i ddiogelwch cleifion mewn bron chwarter y gwasanaethau (9 allan o 39), ac roedd disgwyl i'r darparwyr ymateb o fewn cyfnod byr o amser.

Pryderon allweddol am ddiogelwch

Diogelwch tân

Mewn nifer o wasanaethau, nid oedd asesiadau risg tân digonol ar waith ac nid oedd y staff wedi cwblhau hyfforddiant digonol ar ddiogelwch tân i'w galluogi i ymateb yn effeithiol mewn argyfwng.

Defnydd diogel o gyfarpar

Nid oedd gan rai darparwyr brotocolau trin priodol na rheolau diogelwch lleol ar waith ac nid oeddent wedi ceisio cyngor proffesiynol i sicrhau bod triniaethau'n cael eu darparu'n ddiogel.

Hyfforddiant staff

Mewn rhai gwasanaethau, nid oedd y staff wedi cwblhau'r hyfforddiant diweddaraf mewn meysydd allweddol sy'n effeithio ar ddiogelwch cleifion, gan gynnwys cymorth cyntaf.

Gwnaethom hefyd nodi'r canlynol:

- cofnodion cleifion a chofrestrau triniaeth anghyflawn
- cyfarpar nad oedd yn cael ei wasanaethu na'i gynnal a'i gadw'n gywir
- systemau annigonol i sicrhau bod staff wedi cwblhau'r hyfforddiant diweddaraf bob amser
- tystiolaeth gyfyngedig o brosesau llywodraethu effeithiol i fonitro ansawdd a bodloni gofynion rheoleiddio.

Er bod llawer o gleifion yn cael profiadau cadarnhaol, mae'r canfyddiadau hyn yn dangos bod risgiau cynhennid yn gysylltiedig â thriniaethau laser ac IPL, ac nad oes gan bob darparwr y mesurau diogelu angenrheidiol ar waith i'w lleihau. Mae ein hadroddiadau arolygu yn rhoi gwybodaeth bwysig i helpu pobl i wneud dewisiadau gwybodus wrth ystyried y gwasanaethau hyn.

Mae AGIC yn parhau i fod yn ymrwymedig i ddwyn darparwyr i gyfrif a'u helpu i ddeall eu cyfrifoldebau, am fod pawb yng Nghymru yn haeddu cael gofal diogel o ansawdd uchel.

04

Gweithredu drwy uwchgyfeirio a gorfodi

Cipolwg ar: Ein gweithgarwch y flwyddyn hon

Mae'r tîm Uwchgyfeirio a Gorfodi yn arwain ymateb AGIC i risgiau difrifol yng ngwasanaethau'r GIG ac mewn gwasanaethau gofal iechyd annibynnol a deintyddiaeth breifat yng Nghymru. Rydym yn gweithio gyda sefydliadau'r GIG drwy brosesau uwchgyfeirio strwythuredig i geisio sicrwydd a chefnogi gwelliannau. Yn y sector gofal iechyd annibynnol, rydym yn defnyddio ein pwerau o dan Ddeddf Safonau Gofal 2000 i gymryd camau lle nad yw gwasanaethau'n cyrraedd safonau rheoliadol. Mae hyn yn cynnwys atal gwasanaethau, gosod amodau, dynodi darparwyr yn Wasanaeth sy'n Peri Pryder, canslo cofrestriadau a chychwyn ymchwiliadau troseddol lle bo'n briodol.

Mae'r broses ar gyfer gwasanaethau sy'n peri pryder yn parhau i fod yn llwybr uwchgyfeirio allweddol pan fydd risg sylweddol i ddiogelwch cleifion neu achosion parhaus o ddiffyg cydymffurfio. Mae'n berthnasol i wasanaethau gofal iechyd y GIG a gwasanaethau gofal iechyd annibynnol ac yn cynnwys cyfarfodydd strwythuredig, gwaith monitro wedi'i dargedu, a chamau cydlynol i lywio gwelliannau neu, lle bo angen, gyfyngu ar wasanaethau er mwyn diogelu'r cyhoedd. Gall sefydliadau'r GIG sy'n cael eu uwchgyfeirio drwy'r broses hon gael eu dynodi'n **Wasanaeth sydd Angen ei Wella'n Sylweddol** os nad eir i'r afael â'r risgiau.

Yn 2025–2026, ni chafodd yr un o wasanaethau'r GIG ei ddynodi'n wasanaeth sydd angen ei wella'n sylweddol. Fodd bynnag, parhaodd gwasanaethau'r GIG i gael eu rheoli'n weithredol drwy'r llwybr ar gyfer gwasanaethau sy'n peri pryder, a gwnaed defnydd cynyddol o gyfarfodydd i fonitro risg a llywio gwelliannau.

Yn ystod y flwyddyn, cynhaliodd y tîm lefel uchel o weithgarwch. Cynhaliwyd cyfanswm o 26 o gyfarfodydd ar gyfer gwasanaethau'r GIG sy'n peri pryder, ynghyd â 122 o gyfarfodydd ar gyfer gwasanaethau gofal iechyd meddwl annibynnol sy'n peri pryder, gan gynnwys deintyddiaeth breifat, iechyd meddwl, estheteg laser a lleoliadau eraill. Er mai gofal iechyd annibynnol sy'n cyfrif am y rhan fwyaf o'r gweithgarwch o hyd, arhosodd lefelau gweithgarwch uwchgyfeirio ar gyfer gwasanaethau'r GIG yn debyg i'r flwyddyn flaenorol, a gostyngodd y lefelau ar gyfer y sector annibynnol.

Mae'r dosbarthiad o weithgarwch yn ymwneud â gwasanaethau iechyd meddwl annibynnol sy'n peri pryder yn dangos crynodiad risg clir mewn sectorau penodol:

Iechyd meddwl:
46 o achosion

Deintyddiaeth breifat:
39 o achosion

Estheteg laser:
24 o achosion

Gwasanaethau eraill (gan gynnwys llawdriniaeth gosmetig, gwasanaethau acíwt a gwasanaethau ambiwlans):
13 cyfanswm o 13 o achosion

O fewn gwasanaethau'r GIG, cafodd gweithgarwch yn ymwneud â gwasanaethau sy'n peri pryder ei wasgaru ar draws byrddau iechyd, gyda'r nifer mwyaf o gyfarfodydd wedi'u cofnodi ym Mwrdd Iechyd Prifysgol Betsi Cadwaladr (7, 27%), yna Aneurin Bevan a Phowys (5 yr un, 19%), Bae Abertawe (4, 15%), Hywel Dda (3, 12%), a Chaerdydd a'r Fro (2, 8%).

Roedd monitro darparwyr anghofrestredig yn rhan sylweddol o'r gwaith gorfodi o hyd. Cynyddodd nifer y darparwyr a oedd yn cael eu monitro'n weithredol ar unrhyw adeg o 4 ym mis Mai 2025 i 13 ym mis Awst 2025, sef y nifer uchaf, cyn sefydlogi ar oddeutu 10–11 o achosion byw ar ddiwedd 2025 a dechrau 2026. Roedd y mwyafrif o'r achosion hyn yn ymwneud â gwasanaethau estheteg laser, a oedd yn aml yn cyfrif am fwy na thri chwarter yr holl weithgarwch yn ymwneud â gwasanaethau anghofrestredig.

Ar y cyfan, arhosodd lefelau gweithgarwch yn uchel drwy'r flwyddyn, gan adlewyrchu galw parhaus am brosesau uwchgyfeirio a gorfodi yn hytrach na chyfnodau byrdymor o gynnydd sydyn.

Ffigurau allweddol a gweithgarwch gorfodi

Gweithgarwch uwchgyfeirio – byrddau iechyd y GIG

26 o gyfarfodydd wedi'u cynnal ar gyfer gwasanaethau'r GIG sy'n peri pryder

Gofal iechyd annibynnol – gweithgarwch yn ymwneud â gwasanaethau sy'n peri pryder

122 o gyfarfodydd wedi'u cynnal ar gyfer gwasanaethau gofal iechyd annibynnol

Dynodiadau Gwasanaeth sy'n Peri Pryder

6 (50%) Darparwyr estheteg laser anghofrestredig

5 (41.7%) Practisau deintyddol preifat

1 (8.3%) Darparwr laser cofrestredig

Gweithgarwch gorfodi

5 gwasanaeth wedi'u hatal:
- 4 practis deintyddol preifat
- 1 darparwr estheteg laser

2 gofrestriad wedi'u canslo:
- 1 practis deintyddol (yn dilyn camau gorfodi brys)
- 1 darparwr estheteg laser (methiant i hysbysu AGIC ei fod wedi cau)

5 rhybudd Syml wedi'u cyhoeddi yn dilyn ymchwiliadau troseddol

Darparwyr anghofrestredig ac ymchwiliadau troseddol

- Cynyddodd nifer y darparwyr a oedd yn cael eu monitro o **4** ym mis Mai i **13** ym mis Awst 2025, cyn sefydlogi ar oddeutu 10–11 achos y mis
- Gwasanaethau estheteg laser sy'n cyfrif am y mwyafrif o ddarparwyr anghofrestredig **(dros 75% yn aml)**
- Rhaglen barhaus o ymchwiliadau troseddol yn gysylltiedig â gwasanaethau estheteg anghofrestredig



Themâu allweddol

Daeth nifer o themâu i'r amlwg o'r gweithgarwch uwchgyfeirio a gorfodi yn 2025-2026.

Pwysau gorfodi parhaus ym maes estheteg laser

Estheteg laser sy'n peri'r risg reoleiddiol fwyaf o hyd. Mae'n cyfrif am y rhan fwyaf o'r gweithgarwch sy'n ymwneud â darparwyr heb eu cofrestru, cyfran sylweddol o ddynodiadau Gwasanaeth sy'n Peri Pryder, a nifer mawr o ymchwiliadau troseddol a chamau gorfodi, gan gynnwys presenoldeb darparwyr anghofrestredig a bylchau o fewn y fframwaith rheoleiddio presennol.

Gofal iechyd annibynnol fel prif ffynhonnell gweithgarwch

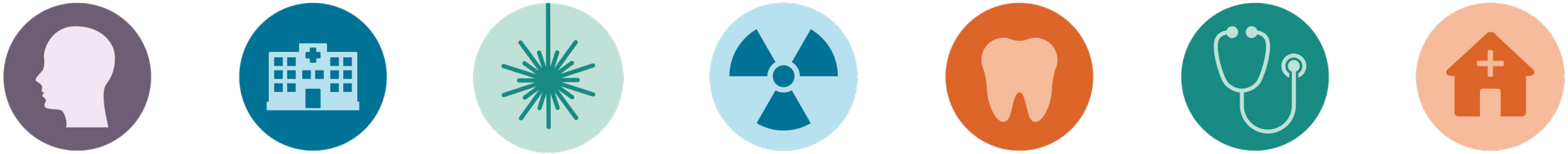
Mae gofal iechyd annibynnol yn cyfrif am lefelau llawer uwch o weithgarwch uwchgyfeirio na gwasanaethau'r GIG. O fewn hyn, gyda'i gilydd, mae iechyd meddwl a deintyddiaeth breifat yn cynrychioli 70% o'r holl wasanaethau sy'n peri pryder, sy'n dangos lle mae ffocws rheoleiddiol ac adnoddau wedi'u cyfeirio fwyaf.

Crynodiad risg mewn sectorau penodol

Mae pryderon wedi'u crynhoi mewn nifer bach o fathau o wasanaethau; iechyd meddwl, deintyddiaeth breifat, ac estheteg laser, sy'n awgrymu bod problemau mynych yn ymwneud â chydymffurfio yn y sectorau hyn yn hytrach na phryderon system gyfan.

Defnydd effeithiol o'r fframwaith ar gyfer gwasanaethau sy'n peri pryder

Ni chafodd yr un o wasanaethau'r GIG ei uwchgyfeirio'n Wasanaeth sydd Angen ei Wella'n Sylweddol yn ystod y flwyddyn er bod AGIC wedi cynnal 26 o gyfarfodydd fel rhan o'r llwybr ar gyfer gwasanaethau sy'n peri pryder. Mae hyn yn awgrymu bod risgiau'n cael eu nodi a'u rheoli'n effeithiol i raddau helaeth drwy'r broses ar gyfer gwasanaethau sy'n peri pryder, fel bod modd ymyrryd yn gynt cyn i broblemau gyrraedd y lefel uwchgyfeirio uchaf.



Her barhaus darparwyr anghofrestredig

Mae'r lefel uchel a pharhaus o weithgarwch monitro darparwyr anghofrestredig, yn enwedig ym maes estheteg laser, yn parhau i gyflwyno her reoleiddiol sylweddol, sy'n golygu bod angen cymryd camau gorfodi a goruchwylio yn barhaus.

Defnydd cynyddol o gamau gorfodi a llwybrau cyfreithiol

Gwnaed defnydd cadarn o bwerau atal a chanslo cofrestriadau, ymchwiliadau troseddol a rhybuddion yn y sector gofal iechyd annibynnol. Mae hyn yn dangos dull rhagweithiol a chynyddol bendant lle nad yw darparwyr yn cydymffurfio'n wirfoddol.

Dull rheoleiddio ymatebol ac yn seiliedig ar risg

Mae'r defnydd o arolygiadau wedi'u targedu, cyfarfodydd strwythuredig ar gyfer gwasanaethau sy'n peri pryder, a phenderfyniadau cymesur yn adlewyrchu dull rheoleiddio hyblyg a arweinir gan wybodaeth. Mae ein gwaith yn cydbwyso camau gorfodi ag ystyriaethau ymarferol fel pwysau ar y system, gan gynnal ffocws clir ar ddiogelwch cleifion ac ansawdd gofal.

Lle nad yw darparwyr yn cyrraedd y safonau gofynnol, rydym wedi defnyddio amrywiaeth o bwerau rheoleiddio, gan gynnwys atal a chanslo cofrestriadau, cychwyn ymchwiliadau troseddol a chyhoeddi rhybuddion. Mae'r camau gweithredu hyn yn dangos dull cadarn ond cymesur, gan ddiogelu cleifion a chefnogi gwelliannau lle mae darparwyr yn ymgysylltu ac yn cymryd y camau angenrheidiol i gyflawni cydymffurfiaeth.

Mae gweithgarwch y flwyddyn hon yn dangos pwysigrwydd dull sy'n seiliedig ar risg, yn enwedig mewn perthynas â darparwyr anghofrestredig a phroblemau mynych yn ymwneud â chydymffurfio mewn sectorau risg uwch. Mae cynnal gwaith goruchwylio effeithiol yn y meysydd hyn yn flaenoriaeth fawr o hyd.



Bwrw golwg manylach: Gweithgarwch gorfodi a rheoleiddio mewn gwasanaethau deintyddol

Ym mis Tachwedd 2025, cynhaliodd AGIC arolygiad o ddau bractis deintyddol cysylltiedig yn Sir Benfro. Roedd gan y ddau wasanaeth yr un Unigolyn Cyfrifol a Rheolwr Cofrestredig. Nododd yr arolygiadau achosion sylweddol o ddiffyg cydymffurfio yn y ddau leoliad, gan godi pryderon difrifol am ddiogelwch cleifion ac ansawdd gwasanaethau.

Roedd y prif broblemau yn cynnwys safonau glendid gwael, bylchau o ran hyfforddiant a chymhwysedd y staff, methiannau mewn prosesau dihalogi, a diffyg asesiadau risg sy'n ofynnol i gyrraedd safonau rheoliadol. Roedd y canfyddiadau hyn yn tynnu sylw at fethiannau ehangach o ran y trefniadau llywodraethu a goruchwylio ar y ddau safle.

Cymerodd AGIC gamau gorfodi brys, gan atal y ddau wasanaeth er mwyn atal risg bellach i gleifion. Drwy gymryd y cam pendant hwn, sicrhawyd na allai'r gwasanaethau barhau i weithredu'n anniogel a gosodwyd disgwyliadau clir ar gyfer gwella.

Ar ôl i'r ddau wasanaeth gael eu hatal, cymerodd y darparwr gamau i fynd i'r afael â'r problemau, gan gynnwys gwelliannau ym maes atal heintiau, gallu staff, a threfniadau llywodraethu. Cadarnhaodd arolygiad dilynol fod cynnydd digonol wedi'i wneud, a daethpwyd â'r cyfnod atal i ben, gan alluogi'r gwasanaethau i weithredu eto.

Roedd yr achos hwn hefyd yn dangos pwysigrwydd gwaith amlasiantaethol. Hysbysodd AGIC y Cyngor Deintyddol Cyffredinol, y Gwasanaeth Tân ac Achub, a'r bwrdd iechyd perthnasol, gan sicrhau goruchwyliaeth ehangach.

Mae'r achos yn tynnu sylw at y modd y gall camau gorfodi amserol ddiogelu cleifion a chefnogi gwelliannau. Mae'n dangos pwysigrwydd llwybrau uwchgyfeirio clir, camau dilynol cadarn, a sicrhau bod gwelliannau'n cael eu cynnal cyn codi cyfyngiadau.



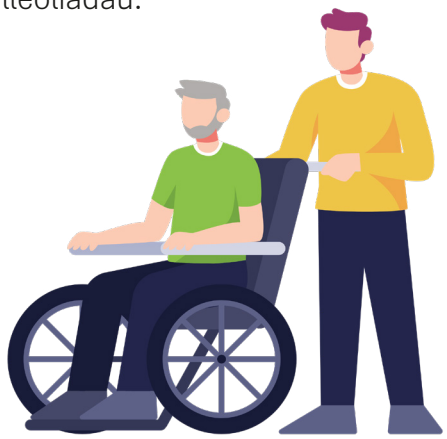
05

Asesu ansawdd a diogelwch gofal y GIG a phrofiadau ohono

Cipolwg ar: Ein gweithgarwch y flwyddyn hon

Mae'r GIG yn parhau i weithredu o dan bwysau parhaus a chymhleth, gan gynnwys galw cynyddol, heriau o ran llif cleifion a chyfyngiadau ar y gweithlu. Er gwaethaf y pwysau hyn, canfu ein gwaith arolygu a sicrwydd fod gofal tosturiol sy'n canolbwyntio ar yr unigolyn yn gryfder sylweddol o hyd, gyda chleifion yn nodi bod staff yn ofalgar, yn barchus ac yn ymrwymedig. Er ein bod yn parhau i weld effaith y pwysau ar y system ar draws gwasanaethau, rydym hefyd yn gweld cyfleoedd clir i wella ansawdd, diogelwch, profiad ac arweinyddiaeth gofal.

Yn ystod 2025-2026, fel rhan o'n gwaith sicrwydd ar gyfer y GIG, gwnaethom oruchwylio ansawdd a diogelwch gwasanaethau gofal iechyd a phrofiadau ohonynt ledled Cymru, yn annibynnol. Gwnaethom ymgymryd â rhaglen eang o weithgarwch arolygu a sicrwydd mewn practisau meddygaeth gyffredinol, gwasanaethau iechyd meddwl, gwasanaethau ysbyty cyffredinol, gwasanaethau gofal mewn argyfwng a gwasanaethau mamolaeth. Drwy'r gwaith hwn, casglwyd gwybodaeth am brofiadau cleifion ac effeithiolrwydd trefniadau llywodraethu, diogelwch ac arweinyddiaeth ar draws lleoliadau.

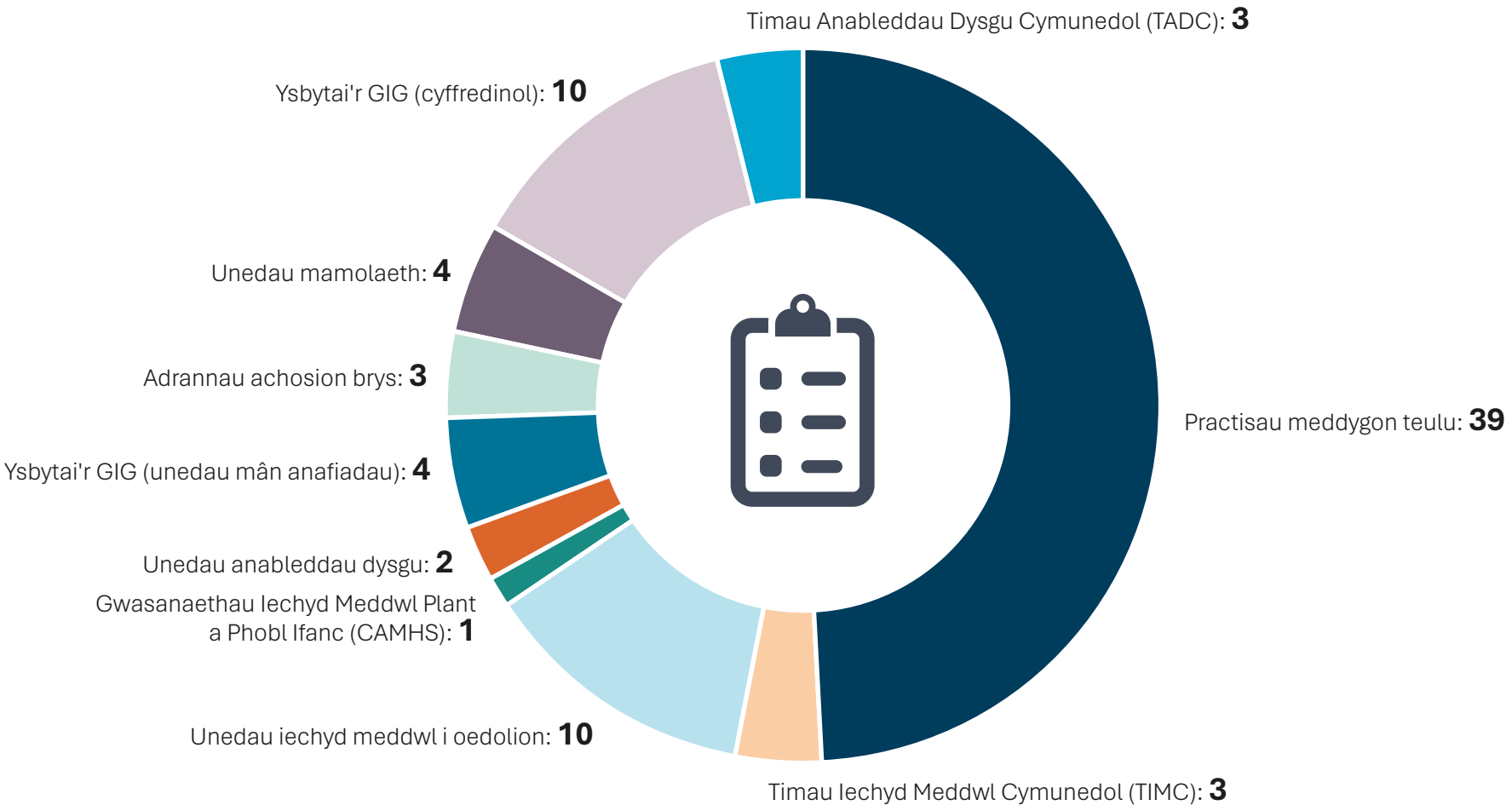


Ym mhob un o'r gwasanaethau, gwnaethom nodi pryderon mynych yn ymwneud â llywodraethu, rheoli risg a chymhwyso prosesau diogelwch craidd, gan gynnwys rheoli meddyginiaethau, cydymffurfiaeth â hyfforddiant, dogfennaeth a diogelwch amgylcheddol. Er bod camau gwella yn aml yn cael eu cymryd yn dilyn arolygiad, mae llawer o broblemau'n codi eto, sy'n dangos nad yw'r gwelliannau bob amser yn cael eu hymgorffori na'u cynnal.

Ar y cyfan, mae ein gwaith yn dangos system gofal iechyd sy'n cael ei chefnogi gan staff ymroddedig ond sy'n wynebu pwysau gweithredol sylweddol. Bydd goruchwyliaeth gryfach, prosesau rheoli risg rhagweithiol a chydweithio ar draws y system gyfan yn hanfodol i gyflawni gwelliannau cynaliadwy a sicrhau bod cleifion yn cael gofal diogel, effeithiol a theg.

Gwnaethom gynnal 79 o arolygiadau mewn lleoliadau gofal sylfaenol, cymunedol ac ysbyty, a dod â thri adolygiad cenedlaethol ac ar y cyd i ben, wrth i waith dilynol pellach fynd rhagddo.

Arolygiadau o wasanaethau'r GIG



Yr hyn a nodwyd gennym: Themâu a gwybodaeth allweddol

Iechyd meddwl: Cyfyngiadau ar ofal tosturiol o ganlyniad i bwysau ar y system

Ar draws gwasanaethau iechyd meddwl a gwasanaethau anableddau dysgu, gwelsom fod cleifion yn cael eu trin ag urddas, tosturi a pharch. Roedd ymrwymiad staff, gwaith amlddisgyblaethol ac enghreifftiau o arweinyddiaeth weladwy yn cefnogi gofal sy'n canolbwyntio ar yr unigolyn, ac yn aml yn cyd-fynd â Mesur Iechyd Meddwl (Cymru) 2010, sydd â'r nod o wella'r gallu i gael cymorth iechyd meddwl, cynllun gofal ac eiriolaeth.



Fodd bynnag, mae pwysau parhaus ar y system yn parhau i gyfyngu ar y cryfderau hyn. Roedd heriau o ran y gweithlu, gan gynnwys swyddi gwag, dibyniaeth ar staff dros dro a bylchau mewn hyfforddiant gorfodol, yn effeithio ar gysondeb ac amseroldeb gofal. Gwnaethom hefyd nodi amrywiadau o ran cynllunio gofal, asesu risg, mynediad at weithgarwch therapiwtig, a rheoli meddyginiaethau.

Roedd ansawdd yr amgylchedd gofal yn bryder sylweddol o hyd. Roedd problemau parhaus o ran cynnal a chadw ystadau, rheoli risgiau amgylcheddol ac addasrwydd cyfleusterau yn golygu nad oedd rhai lleoliadau yn cyrraedd y safonau disgwyliedig ar gyfer preifatrwydd, urddas neu atal heintiau. Mewn rhai achosion, roedd yr amgylchedd ffisegol yn effeithio'n uniongyrchol ar ddiogelwch cleifion.

Nododd gweithgarwch arolygu bryderon mynych am ddiogelwch, gan gynnwys risgiau heb eu lliniaru yn gysylltiedig â phwyntiau clymu, gwendidau mewn prosesau llywodraethu meddyginiaethau, bylchau mewn arferion atal heintiau a methiannau wrth wirio cyfarpar. Er bod camau gweithredu fel arfer yn cael eu cymryd yn dilyn arolygiad, mae natur fynych y problemau hyn yn awgrymu nad yw gwasanaethau bob amser yn rhoi prosesau diogelwch craidd ar waith yn effeithiol o ddydd i ddydd.

Roedd trefniadau llywodraethu ar waith ond yn aml nid oeddent yn ddigon trylwyr i nodi, uwchgyfeirio a datrys risgiau'n effeithiol. Nid oedd rhai gwasanaethau wedi mynd i'r afael â phroblemau hysbys yn llawn, ac roedd hyn yn cyfyngu ar eu cynnydd tuag at gyflawni gwelliannau cynaliadwy.

Mae atgyfnerthu atebolrwydd a goruchwyliaeth arweinwyr yn hanfodol i sicrhau gofal diogel a chynaliadwy.

Ceir rhagor o fanylion am ein gwaith mewn lleoliadau iechyd meddwl mewn adran benodol yn ddiweddarach yn yr adroddiad hwn.



Practisau meddygaeth gyffredinol: Gofal cadarnhaol o dan bwysau cynyddol

Gwnaethom gwblhau
39 o arolygiadau o bractisau meddygon teulu

chawsom adborth gan
1,799 o gleifion
a **399 staff**

Roedd profiadau'r cleifionyn **gadarnhaol ar y cyfan o hyd**

Roedd profiadau'r cleifion yn gadarnhaol ar y cyfan o hyd, gyda'r rhan fwyaf o gleifion yn nodi eu bod wedi cael eu trin ag urddas, parch a thosturi a'u bod yn teimlo eu bod wedi cael eu cynnwys mewn penderfyniadau am eu gofal. Roedd ymatebion y staff yn gadarnhaol hefyd, gyda'r rhan fwyaf yn nodi eu bod yn teimlo eu bod wedi'u hyfforddi'n briodol ac yn hyderus o ran y gofal a oedd yn cael ei ddarparu.

Fodd bynnag, mae ein canfyddiadau'n dangos pwysau cynyddol ar bractisau meddygon teulu. Mae'r galw yn parhau i fod yn fwy na'r capasiti sydd ar gael mewn sawl ardal, yn enwedig mewn cymunedau gwledig ac ardaloedd o amddifadedd uwch. Mae hyn yn effeithio ar y gallu i gael apwyntiadau, morâl staff a chysondeb y gwasanaethau a ddarperir.

Roedd y gallu i gael gwasanaethau yn bryder allweddol. Er bod y rhan fwyaf o'r cleifion wedi gallu cysylltu â'u practis, roedd llai ohonynt wedi gallu cael apwyntiadau brys neu apwyntiadau arferol mewn modd amserol. Nododd y cleifion heriau parhaus wrth gysylltu dros y ffôn, gydag achosion o oedi a phrosesau blaenoriaethu aneglur. Er bod rhai practisau wedi cyflwyno datrysiadau lleol, nid ydynt bob amser yn cael eu cymhwyso, sy'n arwain at amrywiadau o ran y gallu i gael apwyntiadau a phrofiadau.

Yn ystod rhai arolygiadau, gwnaethom hefyd nodi gwendidau mewn prosesau diogelwch craidd, gan gynnwys atal a rheoli heintiau, rheoli meddyginiaethau a pharatoi ar gyfer argyfyngau. Roedd y trefniadau ar gyfer cael sicrwydd ynghylch y gweithlu yn amrywio, gyda bylchau mewn gwiriadau recriwtio, cydymffurfiaeth â hyfforddiant a sesiynau goruchwylio staff.

Ar y cyfan, roedd y gofal clinigol yn dda o hyd; fodd bynnag, nodwyd amrywiadau mewn meysydd megis defnyddio hebryngwyr ac ansawdd prosesau cadw cofnodion. Nid oedd y prosesau llywodraethu yn effeithiol o ran cefnogi prosesau rheoli risg rhagweithiol neu welliannau cynaliadwy, ac roedd anghysondebau mewn dogfennaeth, prosesau archwilio a'r broses o roi polisïau ar waith yn cyfyngu ar sicrwydd bod risgiau'n cael eu nodi a'u rheoli'n rhagweithiol. Er bod y gofal yn parhau i fod yn dosturiol ac yn gadarn yn glinigol, mae'r canfyddiadau hyn yn dangos bod cysondeb a dibynadwyedd yn her o hyd.

Ysbytai cyffredinol: Pwysau ar y system yn effeithio ar lif

Mewn gwasanaethau ysbyty cyffredinol, roedd cleifion yn cael eu trin ag urddas a pharch ar y cyfan, ac roedd y staff yn cefnogi cleifion i gymryd rhan yn eu gofal a chynnal eu hannibyniaeth. Fodd bynnag, nid oedd hyn yn wir ym mhob gwasanaeth.

Un o'r prif themâu oedd pwysau ar y system yn effeithio ar lif cleifion a'r gallu i'w rhyddhau o'r ysbyty Roedd oedi wrth ryddhau cleifion, a oedd yn aml yn gysylltiedig â chapasiti cymunedol cyfyngedig, yn golygu bod cleifion yn aros yn yr ysbyty am gyfnodau hwy, a bod llai o lif drwy wasanaethau. Mewn rhai achosion, roedd oedi wrth wneud penderfyniadau clinigol a threfnu cymorth therapi yn gwaethygu'r sefyllfa.



Roedd yr amgylchedd gofal yn amrywio. Er bod rhai ardaloedd yn cael eu cynnal a'u cadw'n dda, roedd gorlenwi, y defnydd o gapasiti ychwanegol a phroblemau amgylcheddol yn effeithio ar rai eraill, gan effeithio ar breifatrwydd, urddas a diogelwch cleifion.

Roedd trefniadau atal heintiau ar waith ar y cyfan, ond roedd safonau amgylcheddol yn amrywio.

Roedd pwysau ar y gweithlu yn amlwg, gan gynnwys prinder staff, heriau o ran cymysgedd sgiliau a bylchau mewn hyfforddiant. Er bod gwaith tîm cadarnhaol ac arweinyddiaeth ar lefel y ward i'w gweld yn aml, roedd pryderon yn bodoli o hyd am forâl staff a gweledd uwch-arweinwyr.

Gwnaethom hefyd nodi amrywiadau mewn prosesau cyfathrebu, asesu risg ac uwchgyfeirio, ochr yn ochr â darpariaeth Gymraeg anghyson ac ymdrechion i hyrwyddo'r Cynnig Rhagweithiol. Er bod y rhain yn aml wedi cael eu datrys ar y pryd, mae'r ffaith eu bod wedi'u nodi eto yn dangos nad yw prosesau craidd bob amser yn cael eu cymhwyso'n rheolaidd.

Gofal mewn argyfwng: Pwysau parhaus a heriau o ran llif cleifion

Mewn adrannau achosion brys ac unedau mân anafiadau, roedd cleifion yn cael eu trin ag urddas a pharch ar y cyfan, a chafwyd adborth cadarnhaol ar ymddygiad y staff a chyfathrebu.

Canfu ein harolygiadau fod unedau mân anafiadau fel arfer yn darparu gofal amserol sy'n canolbwyntio ar y claf, wedi'i gefnogi gan waith amlddisgyblaethol effeithiol. Fodd bynnag, mae adrannau achosion brys yn parhau i wynebu pwysau gweithredol sylweddol. Mae oedi o ran llif cleifion ac amseroedd aros hir yn parhau i fod yn her, ac mae gorlenwi a'r defnydd o ofal yn y coridorau yn effeithio ar breifatrwydd ac urddas cleifion mewn rhai lleoliadau.

Roedd yr amgylchedd gofal yn lân ar y cyfan, ond roedd cyfyngiadau ar le a phwysau ar ardaloedd aros yn bodoli o hyd. Er bod systemau ar waith ar gyfer rheoli meddyginiaethau a diogelu cyfarpar, nid oeddent yn cael eu cymhwyso bob amser, a nodwyd risgiau yn ymwneud â rheoli stoc, gwirio cyfarpar a dogfennaeth.

Roedd pwysau ar y gweithlu, gan gynnwys prinder staff a blinder, yn amlwg. Roedd prosesau diogelu ar waith, ond roedd amrywiadau o ran asesu risg a goruchwylio yn bodoli o hyd.

Roedd darpariaeth Gymraeg yn cael ei chefnogi mewn rhai ardaloedd ond nid yn gyson, a nodwyd cofnodion cyfyngedig o ddewisiadau iaith ac amrywiadau o ran cymhwyso'r Cynnig Rhagweithiol.

Ar y cyfan, er bod gofal tosturiol yn gryfder o hyd, mae pwysau parhaus ar y system yn dal i effeithio ar gysondeb a dibynadwyedd y gofal a ddarperir. Rhaid i fyrddau iechyd atgyfnerthu trefniadau goruchwylio, sicrhau bod prosesau craidd yn cael eu cymhwyso'n rheolaidd, a gwella llif cleifion ym mhob rhan o'r system er mwyn sicrhau bod cleifion yn cael gofal diogel ac amserol.



Gwasanaethau mamolaeth: Gofal sy'n canolbwyntio ar yr unigolyn ond pryderon parhaus

Canfu ein gwaith mewn gwasanaethau mamolaeth fod menywod yn cael eu trin ag urddas, tosturi a pharch, a'u cefnogi gan staff ymroddedig a oedd yn darparu gofal sy'n canolbwyntio ar yr unigolyn, yn aml mewn amgylchiadau heriol.



Gwelwyd enghreifftiau cadarnhaol o arloesi, gan gynnwys offer digidol, gwybodaeth amlieithog a dulliau o wella dealltwriaeth o ddiogelwch ac uwchgyfeirio. Wrth i systemau digidol barhau i gael eu cyflwyno ledled Cymru, gwelsom enghreifftiau o drefniadau llywodraethu yn cefnogi arferion atal a rheoli heintiau effeithiol, prosesau cadw cofnodion o ansawdd da a'r defnydd o systemau digidol i atgyfnerthu'r gwaith o oruchwylio ansawdd a risg.

Fodd bynnag, roedd pwysau ar y gweithlu yn her sylweddol o hyd, yn enwedig mewn perthynas â chapasiti staff, cymysgedd sgiliau a dibyniaeth ar staff dros dro. Roedd y pwysau hyn yn effeithio ar barhad ac amseroldeb gofal ac, mewn rhai achosion, yn cyfyngu ar allu gwasanaethau i gyrraedd y safonau disgwyliedig.

Nodwyd amrywiadau mewn prosesau clinigol allweddol, gan gynnwys trefniadau brysbennu cleifion beichiog, prosesau uwchgyfeirio a chydymffurfiaeth â hyfforddiant gorfodol, er enghraifft ym maes argyfyngau obstetrig a monitro'r ffetws. Gan fod y prosesau hyn yn hanfodol i nodi risgiau'n gynnar a'u rheoli, mae anghysondeb o ran eu cymhwyso yn lleihau dibynadwyedd prosesau diogelwch mewn gwasanaethau.

Er y dywedwyd yn aml fod y gofal yn dosturiol ac yn gefnogol, nid oedd y cyfathrebu bob amser yn glir nac yn amserol, ac roedd amrywiadau'n bodoli o hyd o ran y broses o gymhwyso egwyddorion cydraddoldeb, gan gynnwys darpariaeth Gymraeg. Er bod dulliau digidol yn cefnogi gwelliannau mewn rhai meysydd, mae'r broses o'u rhoi ar waith yn dal i amrywio ac nid yw'n rhoi sicrwydd parhaus ar draws gwasanaethau.

Ar y cyfan, mae ymrwymiad proffesiynol cryf yn sail i ofal mamolaeth o hyd. Fodd bynnag, mae amrywiadau o ran gwydnwch y gweithlu, llywodraethu a chymhwyso prosesau diogelwch craidd yn bodoli o hyd, sy'n dangos nad yw gwelliannau wedi'u hymgorffori na'u cynnal eto. Bydd atgyfnerthu trefniadau goruchwylio arweinwyr a sicrhau bod prosesau hanfodol yn cael eu rhoi ar waith mewn modd dibynadwy yn hanfodol i wella canlyniadau a darparu gofal mamolaeth diogel, teg, ac o ansawdd uchel.

Bwrw golwg manylach: Gwasanaethau mamolaeth yn Ysbyty Glangwili, Bwrdd Iechyd Prifysgol Hywel Dda

Canfu arolygiad dirybudd o wasanaethau mamolaeth yn Ysbyty Cyffredinol Glangwili ym mis Mai 2025 wasanaeth wedi'i sefydlu'n dda a oedd yn darparu gofal tosturiol sy'n canolbwyntio ar yr unigolyn. Roedd hyn yn cael ei gefnogi gan weithlu amlddisgyblaethol ymrwymedig. Nododd menywod a theuluoedd brofiadau cadarnhaol, gan ddweud bod y staff yn garedig, yn broffesiynol ac yn ymatebol. Gwelodd yr arolygwyr ofal yn cael ei ddarparu mewn amgylchedd tawel, glân a chroesawgar, lle roedd urddas a phreifatrwydd yn cael eu parchu.

Dangosodd y gwasanaeth ymrwymiad cryf i ddarparu gofal sy'n canolbwyntio ar yr unigolyn. Roedd menywod a theuluoedd yn cael eu cynnwys yn weithredol mewn penderfyniadau am eu gofal ac yn cael eu cefnogi i wneud dewisiadau gwybodus yn seiliedig ar yr hyn a oedd orau ganddynt. Nododd yr arolygwyr ymarfer cadarnhaol o ran defnyddio deunyddiau hybu iechyd dwyieithog, argaeledd gwasanaethau cyfieithu, a chymorth wedi'i dargedu ar gyfer grwpiau amrywiol. Roedd hyn yn cynnwys pasbort mamolaeth i unigolion niwroamrywiol a gweithgareddau allgymorth gyda chymunedau ymylol. Roedd y ffaith bod bydwraig profiad y claf a gwasanaeth Myfyrio ar Enedigaethau ar gael yn atgyfnerthu'r ffordd roedd y gwasanaeth yn casglu ac yn ymateb i adborth.

O safbwynt diogelwch a llywodraethu, roedd systemau effeithiol ar waith i gefnogi gofal diogel a chlinigol effeithiol. Roedd y rhain yn cynnwys gweithgarwch archwilio rheolaidd, gwaith cynllunio gofal dyddiol ac adolygiadau amlddisgyblaethol o ddigwyddiadau.



Dangosodd y gwasanaeth ddiwylliant cadarnhaol a diogel yn seicolegol. Nododd y staff lefelau uchel o foddhad a chefnogaeth gref gan gydweithwyr ac arweinwyr, ac roeddent yn teimlo'n hyderus i godi pryderon. Nododd yr arolygwyr hefyd waith amlddisgyblaethol effeithiol, gan gynnwys yn y theatrau ac wrth reoli risg.

Nododd yr arolygiad hefyd feysydd lle mae angen mwy o gysondeb. Roedd y rhain yn cynnwys yr angen i roi gwybod yn gynt am ddigwyddiadau cenedlaethol yn unol â pholisi Llywodraeth Cymru, defnyddio prosesau trosglwyddo strwythuredig fel SBAR yn fwy cyson, ac atgyfnerthu'r trefniadau archwilio ymhellach i ddangos gwersi a ddysgwyd ac effaith yn glir. Roedd angen gwella cydymffurfiaeth â hyfforddiant gorfodol hefyd, yn enwedig ym maes diogelu, a sicrhau dulliau effeithiol o reoli meddyginiaethau a gwirio cyfarpar.

Lle roedd gwaith gwella eisoes wedi'i wneud, roedd cynnydd yn amlwg ers yr arolygiad blaenorol ym mis Tachwedd 2022.
Er enghraifft, roedd dogfennaeth yn ymwneud â maeth a hydradu wedi gwella, ac roedd siartiau cydbwysedd hylif bellach yn cael eu cwblhau i safon uchel. Mae hyn yn adlewyrchu gwaith â ffocws i ddatblygu dull penodol ar gyfer gwasanaethau mamolaeth, ac mae'n dangos gallu'r gwasanaeth i ymateb i ganfyddiadau a throi gwelliannau'n ymarfer.

Ar y cyfan, canfu'r arolygiad hwn wasanaeth â diwylliant cryf a systemau craidd effeithiol sy'n cynnig profiadau cadarnhaol i gleifion. Fodd bynnag, mae angen mwy o gysondeb wrth gymhwyso prosesau llywodraethu a sicrwydd. Bydd cynnal ffocws parhaus ar ymgorffori'r gwelliannau hyn yn bwysig i sicrhau bod risgiau'n cael eu nodi, eu huwchgyfeirio a'u datrys ym mhob rhan o'r gwasanaeth.



Y prif themâu a gwersi a ddysgwyd yng ngwasanaethau'r GIG

Daeth nifer o themâu i'r amlwg ar draws yr holl wasanaethau.

Mae gofal tosturiol sy'n canolbwyntio ar yr unigolyn yn gryfder amlwg o hyd, gyda chleifion yn nodi rhyngweithio cadarnhaol â staff ymroddedig a phroffesiynol.

Mae pwysau ar y system yn parhau i effeithio ar wasanaethau mewn ffyrdd gwahanol, gyda heriau o ran llif cleifion mewn ysbytai a phwysau o ran y gallu i gael apwyntiadau mewn practisau meddygon teulu.

Mae amrywiadau o ran ansawdd gofal yn broblem allweddol o hyd, ac nid yw cleifion bob amser yn cael gofal o'r un safon gan bob gwasanaeth.

Nid yw prosesau diogelwch craidd wedi'u hymgorffori, yn enwedig mewn perthynas â rheoli meddyginiaethau, hyfforddiant, dogfennaeth, asesu risg ac atal a rheoli heintiau.

Mae prosesau llywodraethu a sicrwydd yn parhau i amrywio, gan gyfyngu ar y gallu i nodi risgiau'n gynnar, dysgu a chyflawni gwelliannau cynaliadwy.

Mae problemau amgylcheddol a phroblemau yn ymwneud a seilwaith yn effeithio ar y gofal a ddarperir, gan gynnwys cyflwr yr ystâd, gorlenwi, preifatrwydd ac amgylcheddau gofal anaddas.

Mae pwysau ar y gweithlu yn parhau i effeithio ar y gwasanaethau a ddarperir ym mhob lleoliad, gan effeithio ar gysondeb, amseroldeb a chynaliadwyedd gofal.

Mae darpariaeth Gymraeg a chydraddoldeb yn parhau i amrywio ar draws gwasanaethau, gyda gwahaniaethau o ran y cymorth sydd ar gael i ddiwallu anghenion iaith a darparu'r Cynnig Rhagweithiol.

Mae cydweithio ym mhob rhan o'r system yn hanfodol, gan na ellir mynd i'r afael â heriau allweddol fel llif, mynediad a'r gweithlu yn annibynnol.



Sicrhau defnydd diogel o ymbelydredd ïoneiddio ym maes gofal iechyd

Mae ymbelydredd ïoneiddio yn chwarae rôl hanfodol mewn gofal iechyd modern. Fe'i defnyddir ar gyfer y canlynol:

- **delweddu diagnostig –** fel archwiliadau pelydr-X a sganiau CT i edrych ar strwythurau mewnol
- **radiotherapi –** i drin cyflyrau fel canser
- **meddygaeth niwclear –** sy'n defnyddio symiau bach o ddeunydd ymbelydrol i ganfod neu drin amrywiaeth o gyflyrau.

Gan fod yr archwiliadau hyn yn cynnwys cysylltiad ag ymbelydredd, rhaid iddynt gael eu rheoli'n ofalus er mwyn amddiffyn cleifion a staff. Mae hyn wedi'i nodi yn Rheoliadau Ymbelydredd Ïoneiddio (Amlygiad Meddygol) 2017 (IR(ME)R), sy'n diffinio sut y caiff ymbelydredd ei ddefnyddio'n ddiogel mewn lleoliadau meddygol, gan gynnwys rolau, cyfrifoldebau, gwybodaeth i gleifion a monitro.

AGIC sy'n gyfrifol am fonitro cydymffurfiaeth ag IR(ME)R yng Nghymru. Yn ystod 2025-2026, gwnaethom arolygu wyth lleoliad gofal iechyd annibynnol neu'r GIG sy'n defnyddio ymbelydredd ïoneiddio. Cyhoeddir arolygiadau ymlaen llaw ac maent y cynnwys hunanasesiad gan y darparwr. Mae hyn yn galluogi timau arolygu, wedi'u cefnogi gan arbenigwyr technegol o Grŵp Cysylltiadau Meddygol Asiantaeth Diogelwch Iechyd y DU (UKHSA), i ganolbwyntio ar yr amgylchedd a sut y caiff archwiliadau eu cynnal yn ymarferol.

Fel rhan o'r rhaglen hon, gwnaethom hefyd ofyn i Grŵp Cysylltiadau Meddygol UKHSA adolygu adroddiadau am gysylltiadau damweiniol neu anfwriadol arwyddocaol a gyflwynwyd rhwng 1 Ebrill 2024 a 31 Mawrth 2025.

Yr hyn a nodwyd gennym yn 2025-2026

Ar y cyfan, canfu ein harolygiadau fod gwasanaethau ledled Cymru yn darparu gofal diogel, a bod cleifion yn nodi profiadau cadarnhaol.

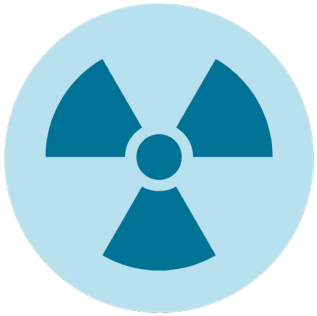
Dywedodd cleifion wrthym eu bod wedi cael eu trin ag urddas a pharch, eu bod wedi cael digon o wybodaeth, a'u bod wedi cael eu cynnwys mewn penderfyniadau am eu gofal.

Gwelsom y canlynol:

- staff brwdfrydig a phroffesiynol, a chyfathrebu cryf â chleifion
- arweinyddiaeth effeithiol mewn gwasanaethau radioleg a delweddu
- diwylliannau cadarnhaol, gyda gwasanaethau'n agored i adborth ac yn ymrwymedig i wella.

Roedd yr adborth a gafwyd i'r arolygon a sylwadau cleifion yn ategu hyn, gyda chleifion yn nodi bod gwasanaethau'n groesawgar, yn broffesiynol ac yn rhoi tawelwch meddwl.

Gwnaethom hefyd nodi enghreifftiau o arloesi. Mewn un gwasanaeth, roedd radiolegwyr yn defnyddio adnodd gwerthuso strôc sy'n defnyddio deallusrwydd artiffisial (AI) i gefnogi'r broses brysbennu gychwynnol. Roedd hyn yn fodd i nodi cleifion y gallai fod angen triniaeth frys arnynt yn gynnar, cyn i radiolegydd gynnal adolygiad clinigol llawn. Fodd bynnag, gwelsom nad oedd Gweithdrefnau'r Cyflogwr wedi cael eu diweddaru i adlewyrchu'r defnydd hwn o ddeallusrwydd artiffisial, a allai arwain at amwysedd ynghylch rolau a chyfrifoldebau.



Meysydd i'w gwella

Er bod y gofal cyffredinol yn gadarnhaol, gwnaethom nodi sawl maes lle mae angen gwneud rhagor o waith i wella cysondeb, prosesau llywodraethu a chydymffurfiaeth.

Lefelau Cyfeirio Diagnostig

Defnyddir lefelau cyfeirio diagnostig i helpu i fonitro ac optimeiddio dosau o ymbelydredd ar gyfer cleifion sy'n cael archwiliadau delweddu. Nododd un arolygiad wendid sylweddol yn y broses ar gyfer pennu ac adolygu lefelau cyfeirio diagnostig. Nid oedd unrhyw dystiolaeth glir i ddangos sut y cafodd lefelau cyfeirio diagnostig eu cymeradwyo na sut y cafodd camau gweithredu a ddeilliodd o gyngor gan Arbenigwr Ffiseg Feddygol ar waith. Rhaid i wasanaethau sicrhau bod prosesau clir ar waith i ddiffinio a monitro lefelau cyfeirio diagnostig, a gweithredu arnynt, er mwyn cynnal lefelau cysylltiad diogel.

Llywodraethu a llwybrau atgyfeirio

Gwnaethom nodi trefniadau llywodraethu anghyson lle mae gweithgareddau IR(ME)R y tu allan i adrannau radioleg craidd, yn enwedig ar draws llwybrau amlddisgyblaethol. Mae hyn yn cynnwys amrywiadau o ran cydymffurfiaeth atgyfeirwyr a phrosesau cyfathrebu. Wrth i wasanaethau ddod yn fwy cymhleth, mae angen trefniadau llywodraethu cryfach ac atebolrwydd cliriach.

Gweithdrefnau'r Cyflogwr

Roedd amrywiadau o ran deall rôl y cyflogwr mewn perthynas ag IR(ME)R a'i chymhwyso yn ymarferol. Nid oedd Gweithdrefnau'r Cyflogwr bob amser yn cael eu hadolygu'n rheolaidd nac yn cyd-fynd â'r ymarfer gwirioneddol. Rhaid i Weithdrefnau'r Cyflogwr fod yn glir, yn gyfredol a chael eu rhoi ar waith, yn enwedig yn dilyn newidiadau rheoliadol diweddar.

Archwilio a dysgu

Gwelsom amrywiadau mewn rhaglenni archwilio clinigol ac o ran y ffordd y caiff gwersi a ddysgwyd o ddigwyddiadau eu defnyddio. Mae angen i rai gwasanaethau atgyfnerthu eu trefniadau archwilio, gan gynnwys amserlenni clir, camau dilynol a dulliau casglu adborth er mwyn sicrhau gwelliannau parhaus yn hytrach na chydymffurfiaeth yn unig.

Llywodraethu clinigol a chyfarpar

Erys cyfleoedd i atgyfnerthu'r systemau ar gyfer llywodraethu cyfarpar, gan gynnwys cynnal rhestrau eiddo cywir a gwneud yn siŵr bod prosesau sicrhau ansawdd ar waith. Rhaid i wasanaethau hefyd sicrhau eu bod yn cydymffurfio'n llawn â gofynion IR(ME)R wedi'u diweddaru, gan gynnwys y rhai sy'n ymwneud â hyfforddiant a chydweithrediad cyflogwyr.

Arfer da

Gwnaethom nodi enghreifftiau o arloesi sy'n canolbwyntio ar yr unigolyn. Roedd un gwasanaeth wedi creu ardal aros sy'n addas i blant, gan gynnwys gweithgareddau rhyngweithiol a llyfr lluniau a ddatblygwyd gan y staff i esbonio archwiliadau delweddu i blant. Roedd y fenter hon, a gydnabuwyd gan Gymdeithas Meddygaeth Niwclear Prydain, wedi helpu i leihau pryder a gwella dealltwriaeth ymhlith cleifion iau.



Bwrw golwg manylach: Cydymffurfio â'r Rheoliadau Ymbelydredd Ïoneiddio (Cysylltiad Meddygol) (IR(ME)R)

Canfu arolygiad blaenorol o wasanaeth sgrinio cenedl nad oedd y gwasanaeth yn cydymffurfio'n llawn â rheoliadau IR(ME)R. Roedd pryderon am ddiffyg gweithdrefnau, protocolau a threfniadau sicrhau ansawdd clir sydd eu hangen i gefnogi ymarfer diogel.

Cyhoeddodd AGIC Hysbysiad Gwella o dan Ddeddf Iechyd a Diogelwch yn y Gwaith etc. 1974. Ers hynny, rydym wedi gweithio'n agos gyda'r gwasanaeth ar lefel strategol a gweithredol i gefnogi gwelliannau. Ymatebodd y darparwr yn gadarnhaol, gan gymryd camau i atgyfnerthu'r prosesau llywodraethu a diogelwch, a chafodd yr hysbysiad ei ddiddymu ymhen cyfnod byr o amser.

Mae'r achos hwn yn tynnu sylw at ddull rheoleiddio AGIC. Rydym yn cymryd camau pendant lle nodir risgiau, ond rydym hefyd yn cydweithio â darparwyr i gefnogi gwelliannau a chyflawni cydymffurfiaeth gynaliadwy.



Sicrhau effaith drwy adolygiadau

Rydym yn cyhoeddi amrywiaeth o adolygiadau ac adroddiadau eraill bob blwyddyn.

Mae adolygiadau cenedlaethol yn ein helpu i werthuso sut mae gwasanaethau gofal iechyd yng Nghymru yn cael eu darparu.

Yn ystod 2025-2026, aeth ein rhaglen adolygu i'r afael â rhai o'r meysydd gofal mwyaf sensitif a chymhleth, gan ganolbwyntio ar gysondeb, cydweithredu, a thosturi.



Gwaith dilynol: Cefnogi anghenion iechyd meddwl plant a phobl ifanc

Ym mis Tachwedd 2024, gwnaethom gyhoeddi ein **hadolygiad ar y cyd ag Estyn ac Arolygiaeth Gofal Cymru** yn archwilio sut mae gwasanaethau gofal iechyd, gwasanaethau addysg a gwasanaethau plant yn cefnogi anghenion iechyd meddwl plant a phobl ifanc.

Yn ystod 2025–2026, gwnaethom ymgymryd â gwaith dilynol cam un drwy adolygu cynlluniau gwella wedi'u diweddaru gan fyrddau iechyd, awdurdodau lleol a byrddau partneriaeth rhanbarthol.

Gwnaethom nodi'r canlynol:

- roedd y rhan fwyaf o'r camau gweithredu a neilltuwyd yn uniongyrchol i fyrddau iechyd wedi'u cwblhau
- roedd ychydig dros hanner y camau gweithredu lle roedd cydweithio rhwng sefydliadau wedi'u cwblhau
- roedd pob sefydliad yn dangos cynnydd mewn meysydd allweddol.

Roedd yn galonogol gweld enghreifftiau o ymarfer cryfach a ffyrdd gwell o weithio. Fodd bynnag, roedd cynnydd yn fwy amrywiol lle mae angen gweithredu ar y cyd, gan adlewyrchu her cyflawni gwelliannau cydlynol ar draws ffiniau sefydliadol.

Byddwn yn parhau i fonitro cynnydd ac rydym yn cynllunio gwaith dilynol cam dau ar gyfer hydref 2026 i asesu a yw'r gwelliannau wedi cael eu cynnal ac a ydynt yn gwneud gwahaniaeth i blant a phobl ifanc.



Gwaith dilynol: Gwasanaethau fasgwlaidd, Bwrdd Iechyd Prifysgol Betsi Cadwaladr

Fel rhan o'n gwaith sicrwydd cam dau yn dilyn **ein hadolygiad o wasanaethau fasgwlaidd yn 2023**, gwnaethom gynnal gweithgarwch dilynol pellach gyda Bwrdd Iechyd Prifysgol Betsi Cadwaladr.

Nid oedd yr ymateb cychwynnol a gafwyd gan y bwrdd iechyd yn rhoi sicrwydd digonol i ni, a gofynnwyd am eglurhad pellach a thystiolaeth. Cynhaliwyd cyfarfod Gwasanaeth sy'n Peri Pryder, fel rhan o'n proses uwchgyfeirio ffurfiol i fynd i'r afael â risgiau i ansawdd a diogelwch, ym mis Ionawr 2026, lle nododd y bwrdd iechyd ei gynnydd a'i gynlluniau gwella yn fanwl.

Yn dilyn hyn, gwelsom dystiolaeth o'r canlynol:

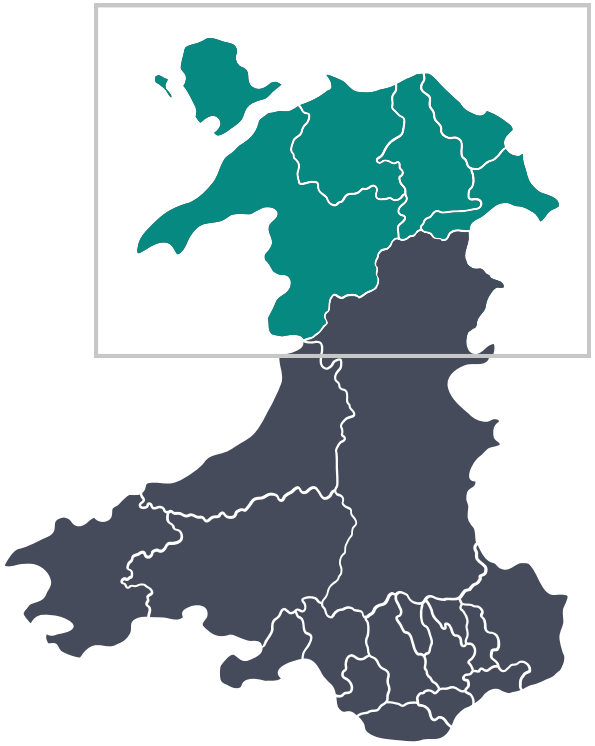
- trefniadau llywodraethu cliriach
- cyfrifoldebau arwain wedi'u diffinio
- strwythurau gwell ar gyfer archwilio clinigol, goruchwylio a dysgu.

Fodd bynnag, sicrwydd cyffredinol rhannol a gafwyd o hyd. Er bod y bwrdd iechyd wedi sefydlu cynlluniau a threfniadau monitro mwy strwythuredig, mae llawer o'r gwaith hwn yn dal i gael ei ddatblygu neu ar gam cynnar y broses o'i weithredu. Ar hyn o bryd, nid oes llawer o dystiolaeth bod y camau gweithredu hyn wedi arwain at welliannau cynaliadwy o ran canlyniadau cleifion, cysondeb gwasanaethau neu brofiadau staff.

Rhaid i'r bwrdd iechyd nawr ddangos bod y gwelliannau:

- wedi'u rhoi ar waith yn llawn ar draws yr holl wasanaethau
- wedi'u cymhwyso'n gyson yn ymarferol
- wedi'u cefnogi gan dystiolaeth glir o'r effaith ar ddiogelwch, ansawdd a chanlyniadau.

Bydd AGIC yn parhau i geisio sicrwydd drwy ymgysylltu a chraffu'n barhaus, gan gynnwys adolygu cynnydd yn erbyn camau gweithredu arfaethedig a thystiolaeth o welliannau parhaus. Ar y cyfan, mae ein gwaith dilynol y flwyddyn hon yn dangos bod cynnydd yn cael ei wneud, ond nad yw gwelliannau bob amser yn cael eu cyflawni ar raddfa fawr nac yn cael eu cynnal dros amser.



Mae ffocws parhaus, arweinyddiaeth gref a gweithio mewn partneriaeth effeithiol yn parhau i fod yn hanfodol i sicrhau bod gwelliannau'n cael eu cyflawni'n gyflym ac yn cael eu cynnal dros amser. Bydd AGIC yn parhau i ddefnyddio ei rhaglen adolygu i ddarparu her annibynnol, monitro cynnydd a chefnogi gwelliannau ym mhob rhan o'r system.

06

Gwasanaethau iechyd meddwl yng Nghymru: Ein canfyddiadau a'n heffaith

Cipolwg ar: Ein gweithgarwch y flwyddyn hon

Mae gwasanaethau iechyd meddwl ac anableddau dysgu ledled Cymru yn parhau i wynebu pwysau sylweddol a pharhaus. Mae'r pwysau hyn yn arbennig o amlwg yng ngwasanaethau'r GIG, er bod darparwyr annibynnol hefyd yn wynebu heriau o ran darparu gofal diogel, effeithiol sy'n canolbwyntio ar yr unigolyn. O safbwynt AGIC, mae hyn yn un o'r meysydd mwyaf cymhleth a risg uchel rydym yn eu harolygu a'u rheoleiddio. Mae angen arweinyddiaeth gref, amgylcheddau diogel, gweithlu medrus a ffocws parhaus ar wella ym mhob rhan o'r system.



Yr hyn a wnaethom yn 2025–2026

Yn ystod y flwyddyn, cynhaliodd AGIC

31
o arolygiadau ar y safle
o wasanaethau iechyd meddwl ac anableddau dysgu yng Nghymru,

gan gynnwys

19
o leoliadau'r GIG

a

12
o leoliadau gofal iechyd annibynnol.

Roedd ein rhaglen yn cwmpasu amrywiaeth eang o wasanaethau, gan gynnwys:

- Timau Iechyd Meddwl Cymunedol (TIMC)
- Timau Anableddau Dysgu Cymunedol (TADC), ar y cyd ag Arolygiaeth Gofal Cymru
- Gwasanaethau anableddau dysgu cleifion mewnol y GIG
- Lleoliad cleifion mewnol Gwasanaethau Iechyd Meddwl Plant a Phobl Ifanc (CAMHS)
- Rhaglen ehangach o arolygiadau o wasanaethau iechyd meddwl cleifion mewnol ar draws y GIG a darparwyr annibynnol.

Canolbwyntiodd ein harolygiadau ar ansawdd a phrofiad y claf, y gallu i ddarparu gofal diogel ac effeithiol, a chryfder yr arweinyddiaeth a'r oruchwyliaeth. Ar draws y gwasanaethau, nododd cleifion fod y staff yn ofalgar ac yn gefnogol, a gwelsom lawer o enghreifftiau o ofal tosturiol, sy'n canolbwyntio ar yr unigolyn.

Yr hyn rydym yn ei weld ledled Cymru

Ar draws y gwasanaethau a arolygwyd gennym, roedd tystiolaeth glir o staff ymroddedig, gwaith amlddisgyblaethol effeithiol a phrosesau cynllunio gofal a thriniaeth cadarn ar y cyfan, yn unol â Mesur Iechyd Meddwl (Cymru) 2010. Nododd cleifion fod y staff yn ofalgar ac yn gefnogol, a gwelsom lawer o enghreifftiau o ofal tosturiol, sy'n canolbwyntio ar yr unigolyn.

Roedd y trefniadau o ran y Ddeddf Iechyd Meddwl yn cydymffurfio i raddau helaeth, ac roedd cleifion yn cael eu cefnogi i ddeall eu hawliau a chael gwasanaethau eirioli. Roedd y systemau rheoli meddyginiaethau yn ddiogel ar y cyfan, er bod problemau'n bodoli o hyd ynghylch cysondeb a chyflawnder dogfennaeth. Mae angen i rai gwasanaethau hefyd wella'r ffordd y caiff gwybodaeth ei darparu, gan gynnwys defnyddio fformatau hygyrch.

Mewn gwasanaethau anableddau dysgu, gwelsom enghreifftiau cadarnhaol o ofal sy'n canolbwyntio ar yr unigolyn, gyda'r staff yn dangos dealltwriaeth gref o anghenion cyfathrebu ac yn defnyddio'r dulliau lleiaf cyfyngol yn effeithiol. Ar y cyfan, roedd teuluoedd a gofalwyr yn cael eu cynnwys yn dda, ac roedd y cynlluniau gofal yn adlewyrchu anghenion a dewisiadau unigol. Er bod angen gwneud rhai gwelliannau mewn meysydd fel llywodraethu, dogfennaeth ac agweddau ar yr amgylchedd gofal, roedd ansawdd y gofal uniongyrchol yn gadarnhaol ar y cyfan.

Fodd bynnag, mae'r cryfderau hyn i'w gweld mewn system sy'n wynebu pwysau parhaus. Y pryder mwyaf sylweddol o hyd yw'r amgylchedd gofal, yn enwedig yn lleoliadau'r GIG. Mae seilwaith sy'n heneiddio, problemau o ran cynnal a chadw ac oedi wrth fynd i'r afael â risgiau hysbys yn parhau i effeithio ar ddiogelwch cleifion, urddas ac ansawdd therapiwtig gwasanaethau. Mewn sawl achos, nid oedd problemau a nodwyd yn flaenorol wedi cael eu datrys, sy'n dangos nad yw gwelliannau bob amser yn cael eu cyflawni'n ddigon cyflym.

Mae'r pwysau ar y gweithlu yn amlwg o hyd yng ngwasanaethau'r GIG ac mewn gwasanaethau annibynnol. Mae'r rhain yn cynnwys heriau o ran cynnal cydymffurfiaeth â hyfforddiant, mynediad at rolau arbenigol a chyflawni'r cymysgedd sgiliau cywir. Yn lleoliadau'r GIG, mae dibyniaeth ar staff dros dro a phwysau ehangach ar y system yn parhau i effeithio ar barhad gofal a mynediad at weithgarwch therapiwtig. Ar y cyfan, roedd gwasanaethau annibynnol yn dangos modelau gweithlu mwy sefydlog, amgylcheddau mewn cyflwr da a mynediad at weithgarwch therapiwtig strwythuredig. Fodd bynnag, roedd rhai gwasanaethau yn parhau i wynebu pwysau o ran cynnal lefelau staffio ac ymateb i anghenion cynyddol gymhleth.

Ar y cyfan, roedd trefniadau llywodraethu ar waith mewn gwasanaethau. Fodd bynnag, roedd gwendidau yn ymwneud â dogfennaeth, goruchwylio, cadw cofnodion a defnyddio gwersi a ddysgwyd o ddigwyddiadau yn lleihau sicrwydd bod risgiau bob amser yn cael eu nodi a'u lliniaru'n effeithiol.

Ar y cyfan, mae'r dystiolaeth yn dangos bod gofal uniongyrchol yn gryfder o hyd, a gefnogir gan staff ymroddedig a thosturiol. Fodd bynnag, mae cyfyngiadau amgylcheddol, pwysau ar y gweithlu ac oedi wrth ddatrys problemau hysbys yn parhau i effeithio ar ddibynadwyedd a chynaliadwyedd gofal ledled Cymru.

Monitro'r Ddeddf Iechyd Meddwl

Mae Deddf Iechyd Meddwl 1983 yn darparu'r fframwaith cyfreithiol ar gyfer cadw a thrin unigolion â chyflyrau iechyd meddwl difrifol pan fo hyn yn angenrheidiol i'w cadw nhw, neu eraill, yn ddiogel. Fel rhan o'n rôl reoleiddio, mae AGIC yn parhau i fonitro'r ffordd y mae gwasanaethau'n cymhwyso'r Ddeddf yn ymarferol.

Yn 2025-2026, canfu ein gwaith sicrwydd fod y trefniadau o ran y Ddeddf Iechyd Meddwl yn cydymffurfio i raddau helaeth, a bod cleifion, ar y cyfan, yn cael eu cefnogi i ddeall eu hawliau a chael gwasanaethau eirioli. Ym mhob un o'r gwasanaethau a arolygwyd, roedd tystiolaeth bod mesurau diogelu cyfreithiol fel arfer yn cael eu cymhwyso'n briodol.

Fodd bynnag, fel y gwelwyd mewn blynyddoedd blaenorol, mae angen gwella rhai meysydd o hyd. Yn benodol, mae angen i wasanaethau sicrhau bod dogfennaeth yn gyflawn, bod gwybodaeth yn hygyrch i gleifion, a bod y trefniadau llywodraethu yn darparu goruchwyliaeth gref o'r ffordd y mae'r Ddeddf yn cael ei chymhwyso yn ymarferol o ddydd i ddydd.

Mae'r canfyddiadau hyn yn atgyfnerthu pwysigrwydd systemau clir, dogfennaeth dda a goruchwyliaeth barhaus i ddiogelu hawliau cleifion a sicrhau gofal cyfreithlon a pharchus.



Y Gwasanaeth Meddygon a Benodwyd i Roi Ail Farn



Mae'r gwasanaeth Meddygon a Benodwyd i Roi Ail Farn (SOAD) yn ffordd hollbwysig o ddiogelu cleifion sy'n cael eu cadw o dan y Ddeddf Iechyd Meddwl na allant gydsynio i driniaethau penodol neu sy'n gwrthod gwneud hynny. Seiciatryddion ymgynghorol annibynnol yw meddygon a benodwyd i roi ail farn, sy'n adolygu cynlluniau triniaeth arfaethedig i sicrhau eu bod yn briodol yn glinigol, yn gyfreithlon ac er lles pennaf y claf. Mae hyn yn cynnig haen bwysig o her a diogelwch allanol i gleifion.

Mae AGIC yn parhau i reoli'r gwasanaeth Meddygon a Benodwyd i Roi Ail Farn yng Nghymru, gan sicrhau bod trefniadau cadarn ar waith i helpu i gynnig ail farn annibynnol mewn modd amserol ac effeithiol. Mae hyn yn cynnwys goruchwylio prosesau gweithredol, hyrwyddo cysondeb wrth wneud penderfyniadau, a sicrhau bod gwersi a ddysgwyd o arolygiadau a gweithgarwch sicrwydd ehangach yn llywio'r gwasanaeth.

Gweithgarwch sicrwydd a chyflawni

Rhwng 1 Ebrill 2025 a 31 Mawrth 2026, gwnaed 873 o geisiadau i'r gwasanaeth Meddygon a Benodwyd i Roi Ail Farn. O blith y rhain:

- roedd 808 yn ymwneud â chleifion a oedd yn cael eu cadw mewn ysbytai (achosion SOAD 1)
- roedd 65 yn ymwneud â chleifion a oedd yn cael eu Gorchymyn Triniaeth Cymundeol (achosion SOAD 2).

Mae hyn yn cynrychioli cynnydd o gymharu â'r blynyddoedd diwethaf, ond yn cyd-fynd yn fras â'r gweithgarwch a welwyd dros y pum mlynedd diwethaf.

Mae'r gwasanaeth yn parhau i weithredu drwy fodel cyflawni hybrid, gan gyfuno asesiadau ar y safle ac asesiadau o bell, wedi'u cefnogi gan garfan o tua 14 o feddygon a benodwyd i roi ail farn gweithredol ledled Cymru. Er bod ardystio o bell yn parhau i fod yn rhan bwysig o hyblygrwydd a phrydlondeb y gwasanaeth, ystyrir mai asesiadau ar y safle yw'r arfer gorau

o hyd lle bynnag y bo modd, a hynny oherwydd y gwerth ychwanegol y maent y ei gynnig o ran ymgysylltu â chleifion a rhoi sicrwydd.

Mae gwaith hefyd wedi parhau i atgyfnerthu'r systemau digidol sy'n cefnogi'r gwasanaeth. Mae mesurau diogelwch gwell ar gyfer y model gweithredu digidol yn cael eu profi a'u rhoi ar waith er mwyn gwella gwydnwch, prosesau llywodraethu gwybodaeth ac effeithlonrwydd.

Datblygu a gwella gwasanaethau

Yn ystod y flwyddyn, cymerwyd sawl cam i wella cysondeb ac ansawdd ymarfer meddygon a benodwyd i roi ail farn. Roedd hyn yn cynnwys cyflwyno pecyn cymorth diwygiedig i feddygon a benodwyd i roi ail farn, gyda chanllawiau wedi'u diweddaru ac adnoddau ymarferol i gefnogi meddygon a benodwyd i roi ail farn wrth gyflawni eu rôl statudol.

Cyflwynwyd y rhaglen hyfforddiant flynyddol hefyd, gyda ffocws penodol ar adolygiadau gan gymheiriaid, ymarfer myfyriol, a sesiynau thematig ar ddefnyddio Therapi Electrogynhyrfol (ECT), triniaeth a ddefnyddir i drin rhai cyflyrau iechyd meddwl difrifol lle mae ysgogiad trydanol rheoledig yn cael ei roi o dan anesthetig i wella symptomau. Nodwyd y rhain yn feysydd â blaenoriaeth i gefnogi cysondeb wrth wneud penderfyniadau ac atgyfnerthu arfer da.

Yn ogystal â hyn, cynhaliodd AGIC archwiliad cynhwysfawr o ardystiadau meddygon a benodwyd i roi ail farn o'r cyfnod adrodd blaenorol. Rhannwyd y canfyddiadau â'r garfan o feddygon a benodwyd i roi ail farn er mwyn hyrwyddo dysgu a gwella parhaus, yn enwedig mewn perthynas â safonau dogfennaeth a chysondeb rhesymeg wrth wneud penderfyniadau ardystio.

Parhaodd AGIC hefyd i gyflawni ei chyfrifoldebau o dan Adran 61 o Ddeddf Iechyd Meddwl 1983, gan adolygu'r driniaeth a roddir i gleifion sy'n cael eu cadw o dan y Ddeddf. Ar y cyfan, canfu'r adolygiadau hyn lefelau uchel o gydymffurfiaeth â gofynion statudol. Lle y nodwyd problemau, mân wallau gweinyddol oedd y rhain yn bennaf, a chymerwyd camau dilynol yn eu cylch i sicrhau bod darparwyr wedi cymryd camau unioni priodol.

Heriau ac edrych i'r dyfodol

Mae recriwtio a chadw meddygon a benodwyd i roi ail farn yn parhau i fod yn her sylweddol i'r gwasanaeth. Er gwaethaf ymdrechion parhaus, nid yw'r garfan bresennol wedi cael ei hehangu, sy'n parhau i roi pwysau ar gapasiti a gwydnwch y gwasanaeth. Mae'n debygol y daw'r her hon yn fwy byth yn sgil Diwygio'r Ddeddf Iechyd Meddwl (2025), y disgwylir iddi gynyddu'r galw am wasanaethau Meddygon a Benodwyd i Roi Ail Farn.

Gan edrych ymlaen at 2026-2027, y ffocws fydd atgyfnerthu capasiti a gwydnwch, bwrw ymlaen â chamau gweithredu i fynd i'r afael â heriau recriwtio, a sicrhau bod y gwasanaeth yn barod ar gyfer unrhyw gynnydd yn y galw. Bydd gwaith pellach hefyd yn parhau i wella'r model cyflawni digidol, integreiddio gwersi a ddysgwyd o archwiliadau a hyfforddiant mewn ymarfer, a hyrwyddo cysondeb ac ansawdd ar draws prosesau gwneud penderfyniadau meddygon a benodwyd i roi ail farn.

Ar y cyfan, mae'r gwasanaeth Meddygon a Benodwyd i Roi Ail Farn yn parhau i gynnig mesur diogelu hanfodol yn y system iechyd meddwl yng Nghymru, gan helpu i ddiogelu hawliau cleifion a sicrhau y creffir yn annibynnol ar benderfyniadau pwysig am driniaeth.



07

Pryderon, Ymchwiliadau a Hysbysiadau

Pryderon: Ein gweithgarwch y flwyddyn hon

Rydym yn ymrwymedig i reoli pryderon yn deg, yn effeithlon ac yn effeithiol. Mae pryderon a rennir â ni am ansawdd a diogelwch gwasanaethau gofal iechyd a phrofiadau ohonynt yn ffynhonnell wybodaeth hollbwysig sy'n ein helpu i nodi risgiau, tynnu sylw at arferion da, ac ysgogi gwelliannau mewn gwasanaethau gofal iechyd yng Nghymru.



Pam mae pryderon yn bwysig

Mae llawer o'n gwaith wrth ymateb i bryderon yn digwydd y tu ôl i'r llenni. Er bod y gweithgaredd hwn yn llai gweladwy nag arolygiadau neu adroddiadau cyhoeddedig, mae'n rhan hanfodol o'r ffordd rydym yn dwyn sefydliadau i gyfrif.

Drwy bryderon, gallwn nodi arwyddion rhybudd cynnar risg, ceisio sicrwydd gan ddarparwyr a, lle bo angen, uwchgyfeirio materion i ddiogelu cleifion.

Mae'r wybodaeth hon yn llywio ein rhaglen arolygu, ein gwaith sicrwydd a'n penderfyniadau rheoleiddio ehangach yn uniongyrchol.

Rydym hefyd yn parhau i weld pryderon mwy cymhleth yn cael eu codi. Mae llawer ohonynt yn ymwneud â nifer o wasanaethau a lefelau risg uwch, ac yn gofyn am gamau dilynol mwy uniongyrchol. Yn 2025–2026, gwnaethom geisio sicrwydd pellach gan wasanaethau mewn perthynas â thua 30% o'r pryderon a godwyd, gan adlewyrchu difrifoldeb y problemau a nodwyd.

Sut rydym yn ymateb

Rydym yn gweithredu'n gyflym i fynd i'r afael â phryderon risg uchel, gan geisio sicrwydd ar unwaith gan ddarparwyr gofal iechyd a chymryd camau pellach lle bo angen.

Caiff pob pryder yn ymwneud ag ansawdd a diogelwch gwasanaethau gofal iechyd neu brofiadau ohonynt eu dosbarthu yn ôl risg, gydag amseroedd targed clir ar gyfer ymateb i'r unigolyn a gododd y pryder:

- mae angen i AGIC weithredu ar unwaith i fynd i'r afael â **phryderon risg uchel**, gan ymateb iddynt o fewn dau ddiwrnod gwaith
- mae angen i AGIC ymateb i **bryderon risg ganolig** o fewn pum diwrnod gwaith, ac mae'n bosibl y bydd yn ymgysylltu'n uniongyrchol â'r darparwr
- fel arfer, caiff **pryderon risg isel** eu cyfeirio at brosesau cwynion lleol, a bydd AGIC yn ymateb iddynt o fewn saith diwrnod gwaith.

Lle bydd pryderon yn dangos bod risgiau posibl i ddiogelwch cleifion neu ansawdd gofal, mae'n bosibl y byddwn yn ceisio sicrwydd yn uniongyrchol gan y darparwr. Mae'n bosibl y bydd angen sicrwydd ar unwaith ynghylch pryderon risg uchel, ac fel arfer, bydd disgwyl i'r darparwr ymateb i bryderon risg ganolig o fewn 5 diwrnod gwaith.

Cipolwg ar bryderon

Yn 2025–2026, cawsom 783 o bryderon, sef cynnydd o 40 o gymharu â'r flwyddyn flaenorol, gan barhau â thuedd gref ar i fyny dros amser.

Pryderon a gafwyd dros y chwe blynedd diwethaf:

- 2020–2021: 434
- 2021–2022: 514
- 2022–2023: 659
- 2023–2024: 614
- 2024–2025: 743
- **2025–2026: 783**

Mae'r cynnydd parhaus hwn yn adlewyrchu ymwybyddiaeth gynyddol ymysg y cyhoedd, hyder i godi pryderon, a phwysau parhaus ar wasanaethau gofal iechyd.

783
o bryderon

Natur y pryderon

115 Bwrdd Iechyd Prifysgol Betsi Cadwaladr	52 Deintyddol
110 Bwrdd Iechyd Prifysgol Bae Abertawe	20 Bwrdd Iechyd Addysgu Powys
110 Gofal iechyd annibynnol	17 Arall
96 Bwrdd Iechyd Prifysgol Aneurin Bevan	5 Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru
87 Bwrdd Iechyd Prifysgol Hywel Dda	2 Iechyd Cyhoeddus Cymru
85 Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg	2 Ymddiriedolaeth GIG Prifysgol Felindre
80 Bwrdd Iechyd Prifysgol Caerdydd a'r Fro	2 GIG Cymru

Nodyn: Mae'r ffigurau a ddangosir yn cynrychioli nifer y pryderon a dderbyniwyd gan AGIC yn ystod 2025–2026. Mae byrddau iechyd yn gwasanaethu poblogaethau o wahanol feintiau ac yn darparu gwasanaethau ar draws gwahanol ardaloedd daearyddol. O ganlyniad, ni ddylid defnyddio'r ffigurau hyn i gymharu sefydliadau'n uniongyrchol nac i'w dehongli fel mesur o berfformiad.

Yr hyn a ddywedodd pobl wrthym

Roedd y themâu mwyaf cyffredin a nodwyd mewn pryderon yn ystod y flwyddyn yn cynnwys:

- Amseroedd aros hir a phwysau ar adrannau achosion brys
- Cydymffurfio â'r Ddeddf Iechyd Meddwl a'r Mesur Iechyd Meddwl
- Y gallu i gael apwyntiadau i weld meddyg teulu a gwasanaethau gofal sylfaenol
- Y gallu i gael triniaeth ddeintyddol y GIG a phreifat
- Safonau gofal mewn lleoliadau cleifion mewnol
- Darpariaeth gofal a chymorth iechyd meddwl mewn lleoliadau cymunedol a chleifion mewnol

Mae'r themâu hyn yn adlewyrchu pwysau ehangach ar y system ac yn tynnu sylw at y meysydd lle mae cleifion yn ei chael hi fwyaf anodd cael gofal amserol, diogel ac effeithiol.

Chwythu'r chwiban: Codi llais dros ddiogelwch

Mae chwythu'r chwiban yn chwarae rôl hollbwysig wrth ddiogelu cleifion a gwella gwasanaethau gofal iechyd. Mae'n galluogi staff i godi pryderon am ymarfer anniogel, gofal o ansawdd gwael, neu ddiwylliant sefydliadol lle nad ydynt o bosibl yn teimlo y gallant wneud hynny'n fewnol.

Fel corff rhagnodedig, mae gan AGIC rôl allweddol i'w chwarae wrth gael y pryderon hyn a gweithredu arnynt. Mae staff yn cysylltu â ni, nid yn unig i roi gwybod am risgiau uniongyrchol, ond hefyd i dynnu sylw at broblemau dyfnach yn ymwneud â llywodraethu, arweinyddiaeth a diwylliant.

Yn ystod 2025-2026, cawsom 117 o bryderon chwythu'r chwiban, sef ychydig yn llai na'r nifer a gafwyd yn ystod y flwyddyn flaenorol sef 120.

Roedd y pryderon hyn yn ymwneud yn bennaf â'r canlynol:

- lefelau staffio, trosiant a chymysgedd sgiliau
- ymddygiad staff ac ymarfer clinigol
- yr amgylchedd a phrosesau atal a rheoli heintiau
- diwylliant, gan gynnwys bwlio a gwahaniaethu
- safonau gofal a thriniaeth
- arweinyddiaeth, cymorth a threfniadau llywodraethu
- diffyg camau gweithredu ar ôl i bryderon gael eu codi.

Rydym yn ystyried pob pryder chwythu'r chwiban o ddifrif ac mae'n bosibl y byddwn yn ceisio sicrwydd neu'n rhannu gwybodaeth â chyrff rheoleiddio eraill lle y bo'n briodol.



Hysbysiadau rheoleiddio: Rhoi'r wybodaeth ddiweddaraf i ni

Yn ôl y gyfraith, mae'n ofynnol i ddarparwyr gofal iechyd annibynnol a gwasanaethau deintyddol preifat roi gwybod i ni am ddigwyddiadau penodol Rydym hefyd yn cael hysbysiadau yn ymwneud ag ymbelydredd ïoneiddio o dan reoliadau IR(ME)R.

Yn ystod 2025-2026, cawsom 2,385 o hysbysiadau statudol, sef cynnydd o 154 (7%) o gymharu â'r flwyddyn flaenorol. Y prif reswm dros y cynnydd hwn oedd hysbysiadau Rheoliad 30/31.

Dadansoddiad o'r hysbysiadau a gafwyd:

2,250 Rheoliad 30/31

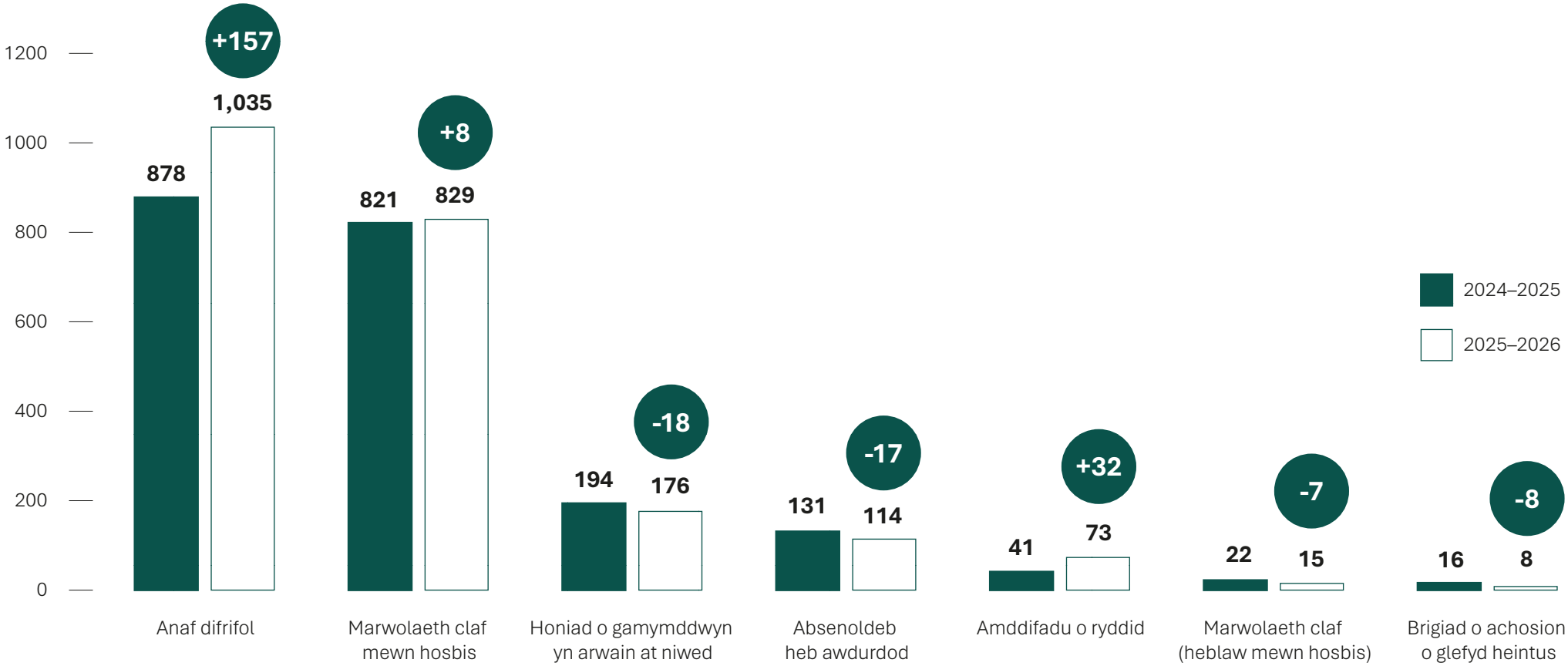
130 IR(ME)R

5 Deintyddiaeth breifat

Caiff yr hysbysiadau hyn eu hadolygu a'u hasesu er mwyn pennu lefel y risg a ph'un a oes angen cymryd camau pellach. Maent hefyd yn rhoi gwybodaeth werthfawr am dueddiadau sy'n dod i'r amlwg ac yn helpu i lywio ein gweithgarwch arolygu a rheoleiddio.

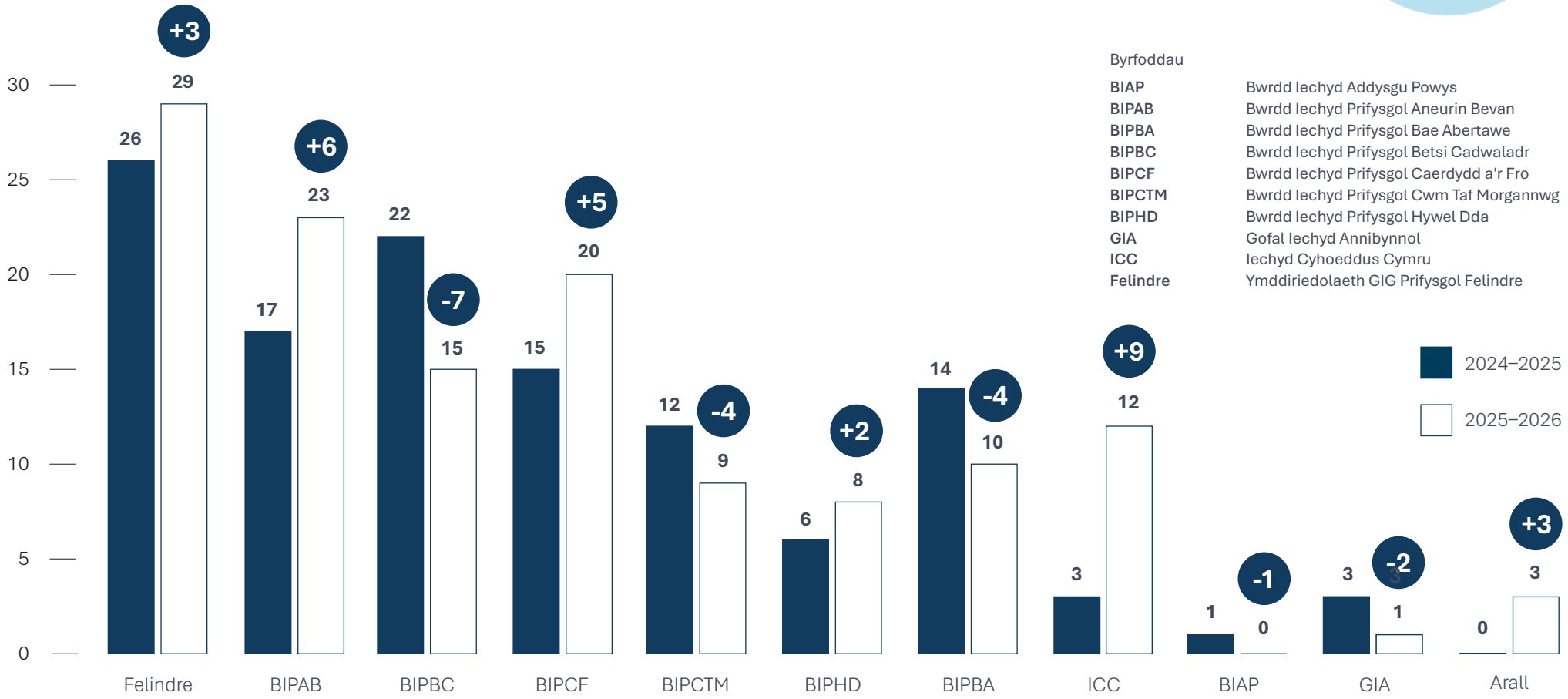
Hysbysiadau rheoliad 30/31

Bu cynnydd yn nifer yr hysbysiadau rheoliad 30/31 yn ystod 2025–2026, yn bennaf oherwydd cynnydd yn nifer yr hysbysiadau am anafiadau difrifol, a gynyddodd o 878 i 1,035. Bu cynnydd hefyd yn nifer yr hysbysiadau yn ymwneud ag amddifadu o ryddid, a lleihad yn nifer yr adroddiadau am honiadau o gamymddwyn yn arwain at niwed, absenoldebau heb awdurdod, brigiadau o achosion o glefydau heintus a marwolaethau y tu allan i hosbisau. Cafwyd yr un nifer yn fras o hysbysiadau am farwolaethau gan hosbisau o gymharu â'r flwyddyn flaenorol.



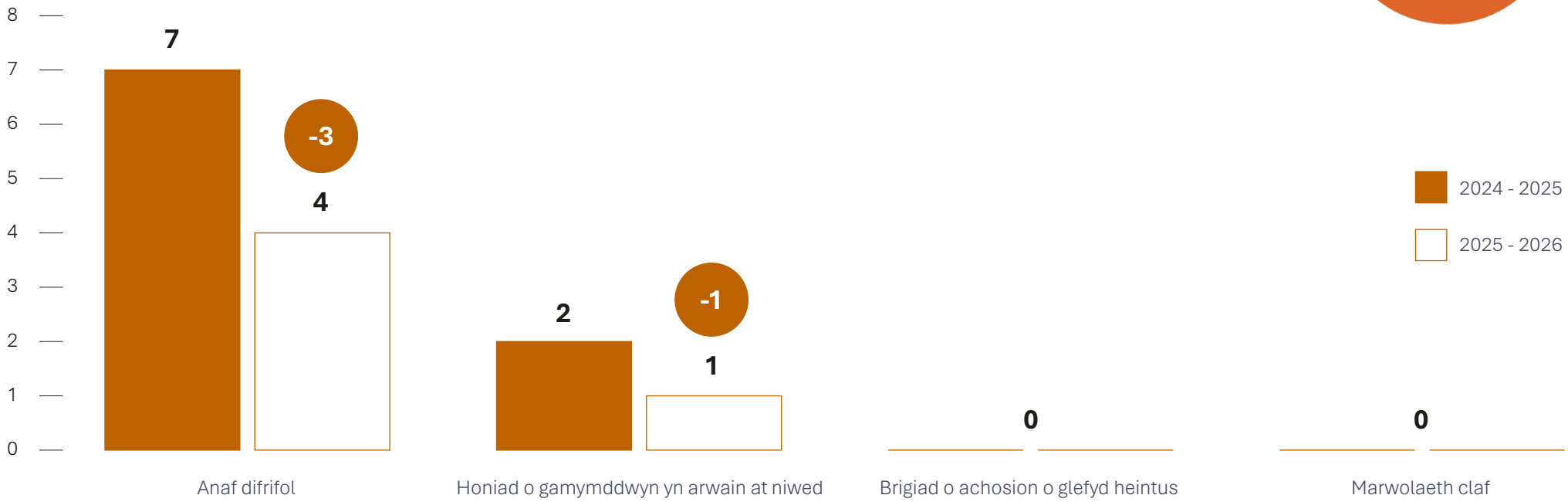
Hysbysiadau IR(ME)R yn ôl lleoliad

Ar y cyfan, cafwyd mwy o bryderon a hysbysiadau statudol yn ystod 2025-2026 o gymharu â'r flwyddyn flaenorol. Mae'r wybodaeth hon yn parhau i fod yn ganolog i'n rôl, gan ein galluogi i nodi risgiau yn gynnar, targedu ein gweithgarwch rheoleiddio a helpu i wella ansawdd a diogelwch gofal ledled Cymru.



Hysbysiadau gan wasanaethau deintyddol preifat

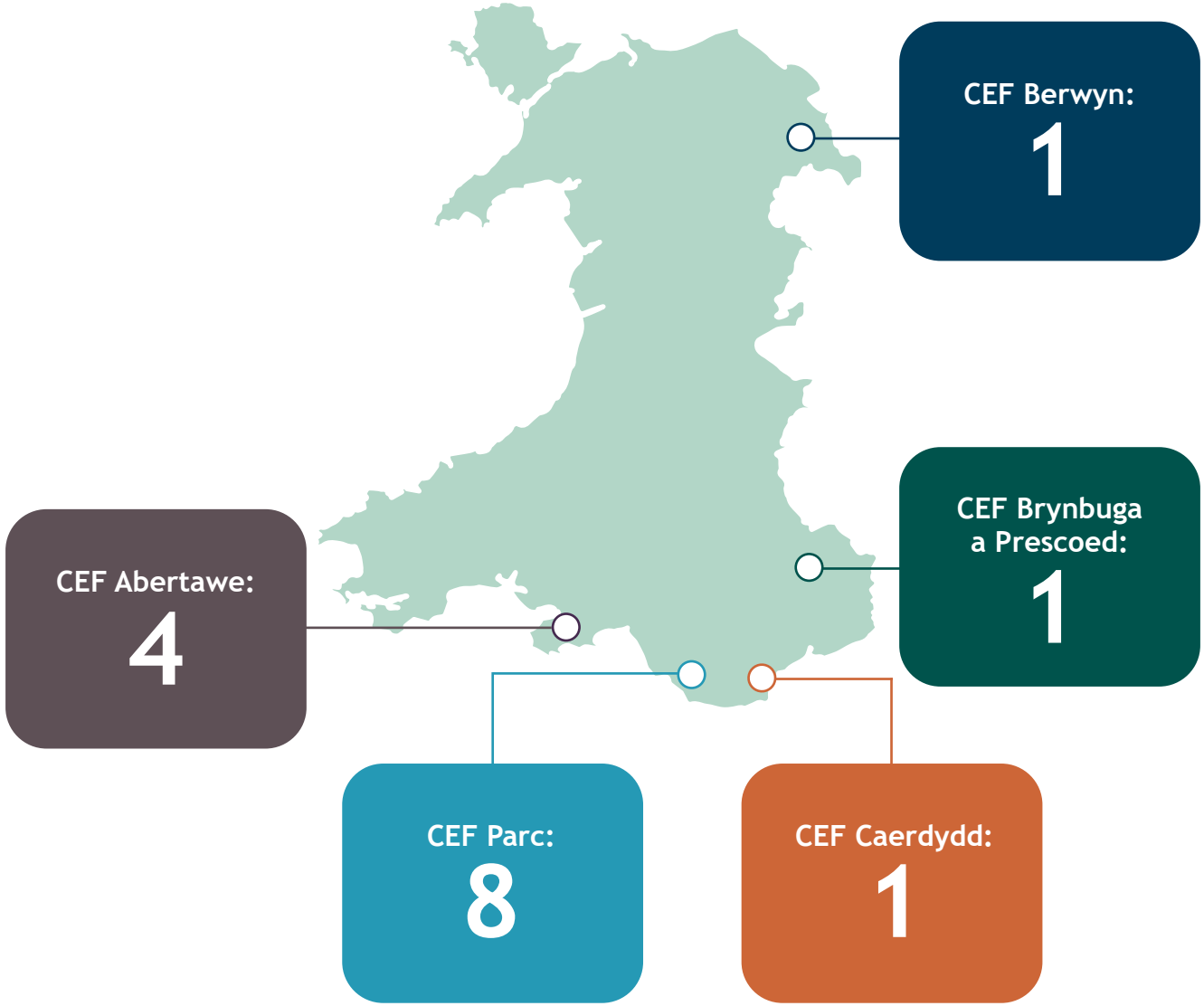
Parhaodd nifer yr hysbysiadau gan wasanaethau deintyddol preifat yn isel yn ystod 2025–2026. Lleihaodd nifer yr hysbysiadau am anafiadau difrifol o saith i bedwar, a lleihaodd nifer yr hysbysiadau am honiadau o gamymddwyn o ddau i un. Ni chafwyd hysbysiad yn ymwneud â brigiadau o achosion o glefydau heintus na marwolaethau cleifion.



Marwolaethau yn y ddalfa

Yng Nghymru, mae pob marwolaeth yn y ddalfa yn destun ymchwiliad gan yr Ombwdsmon Carchardai a Phrofiannaeth. Fel rhan o'r broses genedlaethol hon, mae AGIC yn cynnal adolygiadau clinigol i asesu a oedd y gofal iechyd a ddarparwyd yn gyfystyr â'r hyn sydd ar gael yn y gymuned. Mae'r adolygiadau hyn yn canolbwyntio ar amseroldeb, priodoldeb a pharhad gofal.

Rhwng 1 Ebrill 2024 a 31 Mawrth 2025, comisiynwyd AGIC i gynnal 16 o adolygiadau clinigol mewn carchardai yng Nghymru, y cafodd 11 ohonynt eu cwblhau erbyn diwedd y flwyddyn. Roedd y rhain wedi'u gwasgaru ar draws yr ystâd carchardai fel a ganlyn.



CEF Parc: Anghenion cymhleth a heriau systemig

Fel y gwelwyd mewn blynyddoedd blaenorol, cynhaliwyd y rhan fwyaf o'r adolygiadau yn CEF Parc. Mae ein canfyddiadau'n tynnu sylw at heriau parhaus wrth reoli unigolion ag anghenion iechyd cymhleth a lluosog, gan gynnwys cyflyrau corfforol cronig, problemau iechyd meddwl, camddefnyddio sylweddau ac eiddilwch.

Nododd sawl adolygiad bryderon ar gamau cynnar y cyfnod yn y ddalfa, gan gynnwys oedi neu hepgoriadau mewn asesiadau iechyd ail gam, a bylchau mewn arsylwadau sylfaenol ac asesiadau risg. Mewn sawl achos, roedd cyfleoedd wedi'u colli i ymateb i ddangosyddion clinigol sy'n dirywio, fel canlyniadau profion annormal neu achosion o golli llawer o bwysau.

Mae'r canfyddiadau hyn yn adlewyrchu materion tebyg i'r rhai a nodwyd y llynedd, sy'n dangos bod heriau parhaus o ran sicrhau ymyrraeth gynnar a rheoli risg glinigol yn effeithiol.

Roedd problemau parhaus hefyd o ran rheoli cyflyrau hirdymor, yn enwedig clefydau anadlol a chardiofasgwlaidd, ac o ran gofalu am unigolion bregus. Roedd diffyg cydgysylltu rhwng gwasanaethau gofal iechyd sylfaenol a gwasanaethau camddefnyddio sylweddau yn cyfyngu ar y gallu i rannu gwybodaeth yn effeithiol a pharhad gofal. Roedd oedi wrth gael gafael ar wybodaeth glinigol a diffyg integreiddio rhwng gwasanaethau yn cyfrannu at fylchau mewn gofal.

Roedd y defnydd o ddarpariaeth meddygon teulu o bell, yn enwedig y tu allan i oriau ac ar benwythnosau, hefyd yn arwain at oedi wrth wneud penderfyniadau clinigol ac, mewn rhai achosion, llai o gywirdeb diagnostig. Mae hyn yn dangos yr effaith y gall modelau gwasanaeth ei chael ar ansawdd ac amseroldeb gofal.

Gwendidau systemig

Mewn carchardai eraill, nododd ein hadolygiadau batrwm o broblemau ym mhob rhan o'r system, y mae llawer ohonynt yn adlewyrchu'r rhai a welwyd mewn blynyddoedd blaenorol. Yn aml, roedd nifer o ffactorau a oedd yn gwneud unigolion yn agored i niwed, gan gynnwys anghenion iechyd meddwl, camddefnyddio sylweddau, a chyflyrau iechyd corfforol cymhleth. Fodd bynnag, nid oedd y gofal bob amser yn gydlynol nac yn rhagweithiol.

Roedd ansawdd a chyflawnder dogfennaeth glinigol yn bryder allweddol. Mewn sawl achos, nid oedd gwybodaeth bwysig am statws iechyd, risgiau a hanes clinigol wedi'i chofnodi'n llawn. Roedd hyn yn cyfyngu ar allu clinigwyr i wneud penderfyniadau gwybodus ac yn cyfrannu at ofal tameidiog.

Gwnaethom hefyd nodi amrywiadau o ran y defnydd o brosesau asesu risg. Mewn rhai achosion:

- nid oedd asesiadau risg wedi cael eu cwblhau na'u diweddaru
- nid oedd penderfyniadau clinigol, gan gynnwys penderfyniadau yn ymwneud â meddyginiaeth neu gadw cleifion ar wahân, wedi'u hategu gan asesiad llawn
- nid oedd adolygiadau wyneb yn wyneb bob amser wedi'u cynnal lle roedd angen gwneud hynny'n glinigol.

Mae hyn yn adlewyrchu anghysondeb parhaus wrth gymhwyso prosesau diogelu, gan gynnwys defnyddio gweithdrefnau Asesu, Gofal yn y Ddalfa a Gwaith Tîm (ACCT) ac adnoddau rheoli risg eraill.

Roedd lefelau goruchwylio unigolion a oedd yn cael eu cadw ar wahân neu o dan gyfyngiadau hefyd yn amrywio. Gwnaethom nodi bylchau yn y meysydd canlynol:

- cynnal adolygiadau clinigol rheolaidd
- dogfennu gwiriadau lles
- cynnwys gweithwyr gofal iechyd wrth wneud penderfyniadau.

Mae'r bylchau hyn yn arbennig o arwyddocaol o ystyried pa mor agored i niwed yw'r grŵp hwn, ac maent yn adlewyrchu pryderon a nodwyd mewn blynyddoedd blaenorol.

Ar draws gwasanaethau, gwelsom hefyd nad oedd unigolion â chyflyrau cymhleth neu sy'n dirywio yn cael eu rheoli'n ddigon rhagweithiol, gan gynnwys y rhai eiddil, y rhai a oedd yn hunanesgeuluso, neu'r rhai â sawl cydafiachedd. Nid oedd cynlluniau gofal bob amser wedi'u haddasu i adlewyrchu newid mewn anghenion, ac roedd prosesau uwchgyfeirio yn anghyson, gan arwain at golli cyfleoedd i ymyrryd yn gynt.

Roedd bylchau hefyd mewn camau dilynol ar ôl digwyddiadau clinigol, gan gynnwys cwympiadau, anafiadau i'r pen a phryderon iechyd y rhoddwyd gwybod amdanynt. Mewn rhai achosion, nid oedd tystiolaeth glir o waith monitro ac adolygu priodol, yn enwedig lle roedd cyfyngiadau staffio neu gyfyngiadau ar fynediad yn berthnasol. At hynny, roedd lefelau ymwneud â gwasanaethau iechyd meddwl arbenigol a gwasanaethau mewngymorth yn amrywio ar gyfer risgiau allweddol.



Canfyddiadau allweddol a'r camau nesaf

Gyda'i gilydd, mae ein canfyddiadau yn tynnu sylw at wendidau parhaus yn y meysydd canlynol:

- integreiddio rhwng gwasanaethau gofal iechyd a gwasanaethau carchar
- cysondeb asesiadau clinigol a phenderfyniadau
- nodi a rheoli risg yn rhagweithiol
- goruchwylio unigolion agored i niwed, yn enwedig mewn lleoliadau cyfyngedig.

Er bod strwythurau llywodraethu a phrosesau clinigol ar waith yn gyffredinol, roedd eu heffeithiolrwydd yn gymysg yn yr achosion a adolygwyd gennym, ac mae problemau allweddol a nodwyd yn 2024-2025 yn parhau. Mae hyn yn dangos cynnydd cyfyngedig o ran mynd i'r afael â heriau sylfaenol yn y system.

Mae angen clir i atgyfnerthu'r canlynol:

- prosesau rhannu gwybodaeth a chydlyniant rhwng gwasanaethau
- cysondeb asesiadau clinigol, gwaith monitro a chamau dilynol
- dulliau amlddisgyblaethol o reoli anghenion cymhleth
- prosesau ar gyfer goruchwylio a diogelu'r rhai sy'n wynebu'r risg fwyaf.

Mae'r canfyddiadau hyn yn pwysleisio'r angen am ddull system gyfan o ddarparu gofal iechyd, lle mae gwasanaethau clinigol, carchar a chymorth yn cydweithio i sicrhau bod risgiau'n cael eu nodi'n gynnar a'u rheoli'n effeithiol. Bydd AGIC yn parhau i graffu a herio'n annibynnol er mwyn helpu i wella ansawdd a diogelwch gofal i unigolion yn y ddalfa.

08

Ymgysylltu a phartneriaethau



Partneriaethau

Yn ystod y flwyddyn, parhaodd AGIC i atgyfnerthu ei rôl fel sefydliad sy'n cysylltu'r system, gan sicrhau bod modd rhannu a thriongli gwybodaeth a nodi risgiau sy'n dod i'r amlwg.

Drwy gydweithio'n agos â phartneriaid yn y sector gofal iechyd, rheoleiddio a llywodraeth, rydym wedi helpu i oruchwylio a gwella ansawdd a diogelwch gofal ledled Cymru ar y cyd. Drwy gytundebau ffurfiol ac ymgysylltu strwythuredig, rydym wedi cefnogi'r broses o rannu a thriongli gwybodaeth, gan helpu partneriaid i nodi risgiau sy'n dod i'r amlwg a meithrin dealltwriaeth ar y cyd o heriau ym mhob rhan o'r system.



Cytundebau ffurfiol a rhannu gwybodaeth

Mae AGIC yn cynnal cydberthnasau gwaith agos ag amrywiaeth eang o sefydliadau. Mae **Memoranda Cyd-ddealltwriaeth** yn sail i'r gwaith hwn, ac yn nodi'r ffordd rydym yn rhannu gwybodaeth, yn rheoli risgiau, ac yn cydlynu gweithgarwch.

Mae'r cytundebau hyn yn cefnogi prosesau rhannu gwybodaeth amserol, llwybrau clir ar gyfer uwchgyfeirio, dulliau ar y cyd o ymdrin â risgiau sy'n dod i'r amlwg a phwysau ar y system, a mwy o gysondeb rhwng gweithgarwch rheoleiddio a gwella. Gyda'i gilydd, maent yn rhoi fframwaith ar gyfer rhannu gwybodaeth, uwchgyfeirio pryderon a chefnogi ymatebion cydlynol i risgiau sy'n effeithio ar ansawdd a diogelwch gofal.

Rydym yn adolygu'r trefniadau hyn yn rheolaidd er mwyn sicrhau eu bod yn parhau i fod yn effeithiol ac yn gyfredol. Rhwng mis Mawrth 2025 a mis Ebrill 2026, sefydlodd neu diweddarodd AGIC Femoranda Cyd-ddealltwriaeth â Gwasanaeth Dyfarnu Cwynion y Sector Annibynnol (Mehefin 2025), y Sefydliad Cenedlaethol dros Ragoriaeth mewn Iechyd a Gofal (Mehefin 2025), a Choleg Brenhinol y Bydwragedd (Medi 2025).

Yn ogystal â hynny, aeth AGIC atii atgyfnerthu gwaith partneriaeth drwy nifer o gytundebau ehangach, gan gynnwys cytundeb strategol ag Archwilio Cymru, Arolygiaeth Gofal Cymru ac Estyn (Ionawr 2026), cytundeb a Perfformiad a Gwella GIG Cymru(Chwefror 2026), a threfniant ar y cyd â Gweinidogion Cymru, Arolygiaeth Gofal Cymru ac Arolygiaeth Gofal Iechyd Cymru (Mawrth 2026).

Mae'r trefniadau hyn yn cynyddu ein gallu i gael darlun cydlynol o ansawdd a diogelwch ym mhob rhan o'r system.

Ymgysylltu â GIG Cymru

Yn ystod 2025-26, cyflwynodd AGIC broses newydd ar gyfer ymgysylltu â GIG Cymru i atgyfnerthu'r ffordd rydym yn ymgysylltu â byrddau iechyd ac ymddiriedolaethau'r GIG ledled Cymru.

Mae'r broses yn galluogi AGIC i ymgysylltu â sefydliadau'r GIG mewn modd strwythuredig, gan gefnogi trafodaethau rheolaidd ag uwch-arweinwyr a gwella cyfleoedd i rannu gwybodaeth, archwilio materion sy'n dod i'r amlwg a cheisio sicrwydd. Mae'n ategu ein gweithgarwch arolygu, adolygu a rheoleiddio

drwy ein helpu i feithrin dealltwriaeth ehangach o'r heriau a'r risgiau sy'n effeithio ar wasanaethau gofal iechyd ledled Cymru.

Drwy'r dull hwn, ymgysylltodd AGIC ag amrywiaeth o uwch-arweinwyr, gan gynnwys Cyfarwyddwyr Gweithredol Nyrsio, Cyfarwyddwyr Meddygol a Chyfarwyddwyr Therapïau a Gwyddor Iechyd. Roedd y trafodaethau'n ymwneud â phroblemau allweddol fel pwysau ar y gweithlu, gwydnwch gwasanaethau, llif cleifion, llywodraethu, risgiau i ansawdd a diogelwch, atal a rheoli heintiau, a phwysau ehangach ar y system sy'n effeithio ar ofal brys a gofal mewn argyfwng.

Mae'r ymgysylltu hwn yn gwella gallu AGIC i gasglu gwybodaeth mewn modd amserol, cymhwyso her adeiladol a meithrin dealltwriaeth well o'r ffordd y mae sefydliadau'n ymateb i risgiau, pwysau a blaenoriaethau o ran adfer. Mae hefyd yn ein helpu i weithio mewn ffordd sy'n fwy seiliedig ar wybodaeth, tystiolaeth a risg.

Uwchgynadleddau Gofal Iechyd Cenedlaethol

Ym mis Mai a mis Tachwedd 2025, gwnaeth AGIC gynnull Uwchgynadleddau Gofal Iechyd cenedlaethol, gan ddod â sefydliadau ym maes archwilio, arolygu, rheoleiddio a gwella ynghyd i rannu gwybodaeth am ansawdd a diogelwch gwasanaethau gofal iechyd yng Nghymru.

Mae'r Uwchgynadleddau yn ffordd allweddol o driongli gwybodaeth o bob rhan o GIG Cymru, gan alluogi partneriaid i feithrin cyd-ddealltwriaeth o berfformiad, risgiau sy'n dod i'r amlwg, a meysydd y mae angen eu gwella. Maent yn cynnig fforwm strwythuredig i driongli gwybodaeth o bob rhan o'r system, gan helpu partneriaid i feithrin cyd-ddealltwriaeth o berfformiad, risgiau sy'n dod i'r amlwg, a meysydd y mae angen eu gwella. Mae'r wybodaeth a geir drwy'r uwchgynadleddau yn llywio rhaglenni gwaith sefydliadol, yn helpu i sicrhau cydlyniant rhwng partneriaid, ac yn golygu bod modd ymateb i bwysau ar y system mewn modd cydlynol.

Yn ystod y ddwy uwchgynhadledd, nododd partneriaid gyfres o heriau ym mhob rhan o'r system:

Y gallu i gael gofal a llif cleifion

Bu rhywfaint o gynnydd o ran gwella'r gallu i gael gofal iechyd, gan gynnwys defnyddio apwyntiadau rhithwir a gwasanaethau meddygon teulu mwy targededig. Fodd bynnag, mae amseroedd aros hir am ofal wedi'i gynllunio yn peri pryder mawr o hyd, ac mae oedi wrth roi diagnosis a thriniaeth yn parhau i effeithio ar ddiogelwch cleifion.

Er bod rhai byrddau iechyd wedi gwella perfformiad o ran gofal mewn argyfwng, mae pwysau sylweddol yn bodoli o hyd. Mae adrannau brys yn parhau wedi'u gorlenwi, mae oedi wrth drosglwyddo cleifion o ambiwlansys yn parhau, ac mae anawsterau wrth ryddhau cleifion o'r ysbyty yn golygu nad oes gwelyau ar gael bob amser pan fo angen. Mae'r problemau hyn yn parhau i effeithio ar llif cleifion drwy'r system.

Iechyd meddwl a grwpiau agored i niwed

Mae enghreifftiau o waith lleol cadarnhaol i wella gwasanaethau iechyd meddwl, gan gynnwys y gallu i gael cymorth yn gynt mewn rhai ardaloedd. Fodd bynnag, mae pryderon difrifol yn bodoli o hyd.



Tynnodd partneriaid sylw at broblemau o ran cael cymorth mewn argyfwng, ansawdd gofal cleifion mewnol, trefniadau diogelu, a chymorth ar ôl rhyddhau. Roedd pryderon hefyd ynghylch y ffordd y caiff risgiau eu rheoli, gan gynnwys bylchau mewn gweithgarwch arsylwi, prosesau cynllunio anghyson ar gyfer rhyddhau cleifion, a gwendidau yn y ffordd y mae gwasanaethau'n cadw pobl yn ddiogel.

Ansawdd, diogelwch a llywodraethu

Nododd yr uwchgynadleddau bryderon parhaus am y ffordd y mae sefydliadau'n rheoli digwyddiadau, yn ymateb i gwynion, ac yn dysgu o'r hyn sy'n mynd o'i le.

Mae oedi wrth ymchwilio i ddigwyddiadau a chymryd camau gweithredu yn parhau i fod yn her, ac mewn rhai achosion ni chaiff gwersi a ddysgwyd eu rhoi ar waith yn effeithiol. Mae heriau o ran ansawdd data, a defnydd anghyson o'r ddyletswydd gonestrwydd, yn ei gwneud hi'n fwy anodd deall risgiau'n glir a sicrhau bod gwelliannau'n cael eu gwneud.

Y gweithlu, arweinyddiaeth a diwylliant

Mae pwysau o ran staffio yn parhau i effeithio ar wasanaethau ledled Cymru. Mae'r rhain yn cynnwys anawsterau wrth recriwtio staff, lefelau uchel o absenoldeb oherwydd salwch, a dibyniaeth barhaus ar staff dros dro.

Mewn rhai gwasanaethau, mae pryderon am gydymffurfiaeth â hyfforddiant a dibyniaeth ar nifer bach o unigolion allweddol, sy'n creu risgiau os nad yw'r staff hynny ar gael. Mae problemau diwylliannol sylweddol yn bodoli o hyd mewn rhai meysydd hefyd, gan gynnwys pryderon am fwlio, diffyg ymgysylltu â staff, a staff yn teimlo na allant godi eu llais.

Cynaliadwyedd y system a phwysau strategol

Mae pryderon cynyddol am gynaliadwyedd hirdymor rhai gwasanaethau. Mae pwysau ariannol yn cynyddu a nodwyd bod hyn yn risg gynyddol i ansawdd gofal a'r ffordd y caiff ei ddarparu.

Un o'r problemau allweddol a godwyd oedd y ffocws parhaus ar gamau gweithredu byrdymor i reoli pwysau uniongyrchol, yn hytrach na gwaith cynllunio tymor hwy i fynd i'r afael â heriau sylfaenol a chefnogi gwelliannau cynaliadwy ym mhob rhan o'r system.



Gwybodaeth glinigol

Dros y flwyddyn ddiwethaf, mae Tîm Clinigol AGIC wedi parhau i chwarae rôl hollbwysig wrth ymgorffori arbenigedd clinigol yn ein gwaith arolygu, sicrwydd a rheoleiddio. Mae ei gyfraniad wedi atgyfnerthu'r ffordd rydym yn asesu pryderon, yn cynllunio arolygiadau ac yn dehongli canfyddiadau, gan sicrhau bod ein gwaith yn adlewyrchu ymarfer clinigol cyfredol ac yn parhau i ganolbwyntio ar ansawdd, diogelwch a phrofiad cleifion.



Defnyddio Adolygwyr Cymheiriaid

Mae AGIC yn parhau i ddefnyddio adolygwyr cymheiriaid clinigol i gyfrannu gwybodaeth rheng flaen ac arbenigol at ein gwaith sicrwydd. Mae'r gweithwyr proffesiynol hyn, sy'n parhau i chwarae rhan weithredol mewn ymarfer clinigol, yn cynnig safbwynt annibynnol ac ymarferol ar y ffordd y caiff gofal ei ddarparu.

Yn ystod y flwyddyn, gwnaethom atgyfnerthu'r dull hwn ymhellach drwy nodi a neilltuo'r arbenigedd cywir i feysydd penodol o weithgarwch arolygu. Mae adolygwyr cymheiriaid wedi cefnogi amrywiaeth eang o waith sicrwydd, wedi darparu her allanol ac wedi helpu i sicrhau bod ein canfyddiadau yn gredadwy yn glinigol, yn seiliedig ar dystiolaeth ac yn berthnasol i'r gwasanaethau rydym yn eu hadolygu.

Mae eu cyfranogiad hefyd yn ein helpu i gadw mewn cysylltiad â realiti darparu gwasanaethau ac yn cefnogi diwylliant o ddysgu a gwella ar y cyd ym mhob rhan o'r system gofal iechyd.

Rhoi cyngor arbenigol

Darparodd y Tîm Clinigol gyngor arbenigol a her ar draws amrywiaeth eang o weithgarwch arolygu ac adolygu. Mae hyn yn cynnwys cefnogi gwaith cynllunio arolygiadau, nodi meysydd lle ceir risg glinigol, ac adolygu canfyddiadau uniongyrchol mewn perthynas â sicrwydd a diffyg cydymffurfio er mwyn sicrhau cywirdeb clinigol.

Drwy gydol y flwyddyn, gwerthusodd y tîm p'un a oedd ymatebion sefydliadol a chynlluniau gweithredu a luniwyd gan wasanaethau gofal iechyd yn dilyn ein harolygiadau yn rhoi digon o sicrwydd, gan helpu i sicrhau bod ein casgliadau'n gadarn ac yn canolbwyntio ar y materion sydd bwysicaf i gleifion a gwasanaethau.

Drwy gydol y flwyddyn, ymatebodd y tîm i amrywiaeth eang o faterion clinigol a gweithredol, gan gynnwys pryderon am ddiogelwch cleifion, atal a rheoli heintiau, diogelu, materion llywodraethu a digwyddiadau sy'n dod i'r amlwg. Roedd hyn yn cynnwys darparu mewnbwn clinigol gwybodus ar faterion cymhleth ac sy'n datblygu, fel rheoli brigiadau o achosion a sefyllfaoedd lle mae angen barn broffesiynol fanwl.

Drwy'r gwaith hwn, bu modd i AGIC ymateb mewn modd amserol a gwybodus, gan sicrhau bod penderfyniadau'n cael eu cefnogi gan arbenigedd clinigol cadarn a dealltwriaeth glir o'r cyd-destun gofal iechyd ehangach.

Ymgysylltu – Gwrando a dysgu

Mae gwrando ar y bobl sy'n defnyddio gwasanaethau gofal iechyd ac yn gweithio ynddynt wrth wraidd ein gwaith o hyd. Mae eu profiadau yn ein helpu i ddeall sut mae gofal yn cael ei ddarparu ledled Cymru a'r meysydd lle mae angen newid fwyaf.

Rydym yn meithrin y ddealltwriaeth hon drwy bob rhan o'n gwaith. Yn ystod arolygiadau ac adolygiadau, rydym yn siarad yn uniongyrchol â staff, cleifion a gofalwyr, gan ddefnyddio sgyrsiau ac arolygon i gasglu profiadau bywyd go iawn. Y tu hwnt i arolygiadau, rydym yn parhau i ehangu'r ffordd rydym yn ymgysylltu gan ddefnyddio llwyfannau digidol, ymgyrchoedd, a chyfleoedd wyneb yn wyneb er mwyn cyrraedd mwy o bobl a chlywed mwy o leisiau.



Y flwyddyn hon:

cynhaliwyd
216
o arolygiadau ar y safle

cwblhawyd
1,628
o arolygon staff

cafodd
4,407
o arolygon cleifion, gofalwyr a chyhoeddus
eu dychwelyd

cafwyd
2,353
o ymatebion
i'r ymgynghoriad
ar ein Strategaeth

Mae'r wybodaeth hon yn atgyfnerthu ein canfyddiadau, yn herio tybiaethau ac yn ysgogi gwelliannau. Rydym yn gwneud mwy na dim ond gwrando ar leisiau pobl; maent yn llunio ein gwaith yn weithredol ac yn dylanwadu ar newid mewn gwasanaethau gofal iechyd.

Codi ymwybyddiaeth ac ennyn hyder y cyhoedd

Yn ystod 2025-2026, gwnaethom barhau i gyhoeddi adroddiadau arolygu a chanfyddiadau allweddol, a chafodd llawer ohonynt sylw yn y cyfryngau rhanbarthol a chenedlaethol ar draws y prif allfeydd. Roedd hyn yn cynnwys cyfweliadau byw ac wedi'u recordio, gan helpu i godi ymwybyddiaeth o rôl AGIC ac atgyfnerthu hyder y cyhoedd mewn gweithgarwch craffu annibynnol.

Rydym hefyd wedi cynyddu ein presenoldeb a'n cyrhaeddiad digidol, gan sicrhau bod mwy o bobl yn deall pwy ydym a'r ffordd rydym yn gweithio.

Mae ein data diweddaraf ar ymgysylltu yn dangos y canlynol:

mae
50%
o'r cyhoedd bellach yn adnabod AGIC, i fyny o 47% yn 2024

daeth
19%
o bobl yn ymwybodol o AGIC drwy ffynonellau ar-lein neu wefannau

23%
drwy'r radio

20%
drwy'r cyfryngau cymdeithasol

Mae'r gweledegdd cynyddol hwn yn bwysig gan ei fod yn cefnogi tryloywder, yn tawelu meddyliau'r cyhoedd bod gwasanaethau'n cael eu monitro'n annibynnol, ac yn annog darparwyr i gynnal safonau gofal uchel.

Ymgysylltu hygyrch, cynhwysol ac effeithiol

Rydym yn parhau i ddatblygu dull ymgysylltu sy'n hygyrch, yn gynhwysol ac yn adlewyrchu amrywiaeth cymunedau ledled Cymru.

Yn ystod 2025–2026, rydym wedi gwneud y canlynol:

- atgyfnerthu ein harlwy digidol, gan gynnwys ehangu'r defnydd o fideos, animeiddiadau a llwyfannau newydd igyrraedd cynulleidfaoedd ehangach
- parhau i wella hygyrchedd ar draws ein gwefan a'n cyhoeddiadau, gan gynnal ffocws parhaus ar iaith glir a fformatau cynhwysol, gan gynnwys rhai Hawdd eu Deall
- defnyddio mwy o gynnwys ar y we yn lle ffeiliau PDF i'w gwneud yn haws cael gafael ar wybodaeth a'i diweddaru
- datblygu canllawiau ac adnoddau mewnol i gefnogi'r staff i greu cynnwys hygyrch a chynhwysol.

Rydym hefyd yn ystyried ffyrdd newydd o ymgysylltu, gan brofi sianeli, fformatau a dulliau gwahanol er mwyn sicrhau ein bod yn cyrraedd pobl mewn ffyrdd sy'n gweithio iddynt.

Dysgu a dealltwriaeth sy'n ysgogi gwelliannau

Rydym yn parhau i atgyfnerthu'r ffordd rydym yn rhannu gwersi a ddysgwyd o'n gwaith er mwyn cefnogi gwelliannau ym mhob rhan o'r system gofal iechyd.

- Mae ein **Bwletinau Arsylwi** yn parhau i gyrraedd cynulleidfa gynyddol, gan rannu canfyddiadau allweddol, risgiau ac enghreifftiau o ymarfer da
- Mae lefelau ymgysylltu â'n Bwletinau Newyddion ac Arsylwi wedi cynyddu, gan ddangos diddordeb cryf yn ein gwaith a'n canfyddiadau.
- Rydym wedi ehangu ein cynnwys digidol ac wedi gwella'r ffordd rydym yn cyflwyno gwybodaeth ar-lein, gan ei gwneud yn gliriach ac yn haws ei defnyddio.

Drwy sicrhau bod ein gwybodaeth yn fwy hygyrch, rydym yn helpu darparwyr, llunwyr polisïau, a'r cyhoedd i ddeall sut beth yw gofal da a'r meysydd y mae angen eu gwella.

Bod yn weladwy, ennyn ymddiriedaeth

Rydym yn fwy gweladwy nag erioed, ac yn cymryd rhan mewn mwy o ddigwyddiadau cenedlaethol, fforymau rhanddeiliaid a chyfleoedd i ymgysylltu â'r cyhoedd.

Y flwyddyn hon, gwnaethom y canlynol:

- mynychu digwyddiadau cenedlaethol mawr fel y Sioe Iechyd Meddwl a Llesiant, a chynadleddau proffesiynol
- ymgysylltu'n uniongyrchol â gweithwyr gofal iechyd proffesiynol, rhanddeiliaid a'r cyhoedd
- hyrwyddo ein gwaith a chynyddu ymwybyddiaeth o gyfleoedd i gymryd rhan, gan gynnwys rolau adolygwyr cymheiriaid.

Gwnaethom hefyd ailwampio ein deunyddiau arddangos er mwyn sicrhau eu bod yn ddiddorol, yn gynhwysol ac yn amgylcheddol gynaliadwy, gan adlewyrchu ein gwerthoedd o ran dylunio a chyflawni.

Uchafbwyntiau ymgysylltu

8.1% yn fwy o ddilynwyr newydd ar y cyfryngau cymdeithasol

Ein fideos wedi'u gwylio 29k o weithiau ar draws llwyfannau (cynnydd o 437% o 5.4k y flwyddyn ddiwethaf)

1.6k o bostiadau wedi'u cyhoeddi ar y cyfryngau cymdeithasol (cynnydd o 14.3% o 1.4k y flwyddyn ddiwethaf)

ein cynnwys wedi'i weld 833k o weithiau ar y cyfryngau cymdeithasol (cynnydd o 24.4% o 670k y flwyddyn ddiwethaf)

556k o ymweliadau â'n gwefan (cynnydd o 8.8% o 511k y flwyddyn ddiwethaf)

180 o adroddiadau arolygu a 38 o eitemau newyddion wedi'u cyhoeddi

13 o hysbysiadau i'r wasg wedi'u cyhoeddi

9k+ o danysgrifwyr i'n cylchlythyr

48 rhifyn o'n cylchlythyr mewnol, 'Connect', wedi'u rhannu â'r staff

Hyrwyddo Cydraddoldeb, Amrywiaeth a Chynhwysiant

Rydym yn parhau i fod yn ymrwymedig i sicrhau bod ein gwaith yn adlewyrchu amrywiaeth y cymunedau rydym yn eu gwasanaethu. Mae ein **Strategaeth Cydraddoldeb, Amrywiaeth a Chynhwysiant ar y Cyd (2024-2028)** gydag **Arolygiaeth Gofal Cymru (AGC)** yn parhau i arwain y gwaith hwn, gan gysoni â blaenoriaethau Llywodraeth Cymru a chryfhau'r cydweithio ar draws arolygiaethau.

Pam mae cydraddoldeb, amrywiaeth a chynhwysiant yn bwysig

Caiff profiadau pobl o ofal iechyd eu llywio gan eu hunaniaeth, eu cefndir a'u hamgylchiadau. Drwy gydnabod hyn, gallwn asesu'n well a yw gwasanaethau'n hygyrch, yn barchus ac yn ymatebol.



Yr hyn a gyflawnwyd gennym y flwyddyn hon

- **Ymgorffori cydraddoldeb, amrywiaeth a chynhwysiant mewn arolygiadau:** Mae ystyriaethau yn ymwneud â chydraddoldeb a chynhwysiant bellach wedi'u hymgorffori mewn prosesau arolygu, gan gynnwys hygyrchedd, iaith, anabledd ac allgáu digidol
- **Gwella'r ffordd rydym yn defnyddio data a gwybodaeth:** Rydym yn atgyfnerthu'r ffordd rydym yn casglu ac yn dadansoddi data ar gydraddoldeb er mwyn nodi tueddiadau a risgiau ym mhob rhan o'r system.
- **Atgyfnerthu gweithgarwch ymgysylltu â chymunedau amrywiol:** Rydym wedi ymgysylltu mwy â sefydliadau sy'n cynrychioli grwpiau heb gynrychiolaeth ddigonol er mwyn deall profiadau bywyd yn well.
- **Datblygu ein gweithlu:** Mae'r staff wedi cymryd rhan mewn sesiynau dysgu a datblygu ar gydraddoldeb, amrywiaeth a chynhwysiant, ochr yn ochr â sesiynau pwrpasol sy'n canolbwyntio ar brofiadau bywyd
- **Grŵp Hyrwyddwyr Cydraddoldeb, Amrywiaeth a Chynhwysiant Mewnol:** Mae'n parhau i ddarparu arweinyddiaeth, her a goruchwyliaeth, gan sicrhau bod cydraddoldeb, amrywiaeth a chynhwysiant ym mhob rhan o'n gwaith.

Mae hyn yn ein helpu i ddatblygu sefydliad mwy cynhwysol a gwella'r ffordd rydym yn ymgysylltu â phobl, darparwyr a phartneriaid.

Gweithio gyda'n Grŵp Cynghori Rhanddeiliaid

Mae ein **Grŵp Cynghori Rhanddeiliaid** yn parhau i chwarae rôl hollbwysig wrth lywio ein gwaith.

Mae'r grŵp yn dod â sefydliadau sy'n cynrychioli amrywiaeth eang o gymunedau ledled Cymru ynghyd, gan ein helpu i feithrin dealltwriaeth well o'r anghenion, y profiadau a'r rhwystrau a wynebir gan grwpiau amrywiol. Mae hyn yn sicrhau bod ein gwaith yn adlewyrchu'r materion sydd bwysicaf i bobl a chymunedau.

Y flwyddyn hon, mae'r grŵp wedi gwneud y canlynol:

- ehangu ei aelodaeth, gan gynyddu cynrychiolaeth o gymunedau amrywiol
- cyfrannu at yr ymgynghoriad ar ein Strategaeth ar gyfer 2026-2030 a gweithgarwch ymgysylltu ehangach
- darparu gwybodaeth am hygyrchedd, cyfathrebu cynhwysol a phrofiadau bywyd.

Sut mae'r grŵp yn llywio ein gwaith

Mae'r grŵp yn chwarae rôl weithredol wrth ddylanwadu ar y ffordd rydym yn cynllunio, yn cyflawni ac yn gwella ein gwaith. Mae ei fewnbwn wedi ein helpu i wneud y canlynol:

dylunio a gwella ein dulliau ymgysylltu, gan sicrhau eu bod yn hygyrch ac yn cyrraedd amrywiaeth ehangach o bobl

atgyfnerthu'r ffordd rydym yn casglu ac yn dehongli profiadau bywyd, yn enwedig o ran grwpiau heb gynrychiolaeth ddigonol

llunio ein blaenoriaethau a'n meysydd ffocws, gan gynnwys y meysydd lle rydym yn cyfeirio ein gweithgarwch sicrwydd a gwella

gwella'r ffordd rydym yn cyfathrebu, gan wneud ein cynnwys yn gliriach, yn fwy cynhwysol ac yn haws ei ddeall

nodi anghydraddoldebau a rhwystrau posibl, gan ein helpu i herio lle nad yw gwasanaethau o bosibl yn diwallu anghenion pobl.

Mae ei wybodaeth yn ein helpu i ddeall yn well y meysydd lle mae gwasanaethau gofal iechyd yn gweithio'n dda, a'r meysydd lle mae angen gwelliannau, yn enwedig i'r rhai sy'n wynebu'r risg fwyaf o gael profiadau neu ganlyniadau gwaeth. Mae ei fewnbwn yn helpu i sicrhau bod ein gwaith yn cael ei lywio gan brofiadau go iawn a bod ein dull gweithredu yn parhau i fod yn gynhwysol, yn berthnasol ac i ganolbwyntio ar wella gofal iechyd i bawb ledled Cymru.

Y Gymraeg – Y Cynnig Rhagweithiol

Rydym yn ymrwymedig i sicrhau bod y Gymraeg yn rhan naturiol, gweladwy ac annatod o'r ffordd y mae pobl yn cael gofal iechyd yng Nghymru. I lawer o bobl yng Nghymru, yn enwedig plant, pobl hŷn, pobl â dementia, y rhai ag anableddau dysgu a phobl â salwch meddwl, mae gallu cyfathrebu yn Gymraeg yn fwy na mater o ddewis. Gall fod yn hanfodol i sicrhau urddas, dealltwriaeth, cyfranogiad mewn gofal a lles.



Atgyfnerthu'r ffordd rydym yn asesu ac yn dylanwadu ar ddarpariaeth Gymraeg

Y flwyddyn hon, rydym wedi mabwysiadu dull mwy strwythuredig o asesu darpariaeth Gymraeg drwy ein gwaith arolygu. Mae hyn yn cynnwys:

- cynnal adolygiadau rheolaidd o'r ffordd y mae gwasanaethau'n darparu'r Cynnig Rhagweithiol, gan gynnwys cyfathrebu, arwyddion, gwybodaeth i gleifion a gweledded y staff
- gwirio a yw gwasanaethau'n gofyn beth yw dewis iaith cleifion ac yn ei gofnodi, sy'n faes i'w wella o hyd
- cynnwys ystyriaethau o ran y Gymraeg wrth lunio cwestiynau a chanfyddiadau arolygiadau, gan sicrhau eu bod yn llywio ein hargymhellion a'n gwaith dilynol.

Rydym hefyd yn cefnogi cynnydd cenedlaethol drwy rannu tystiolaeth glir o arolygiadau ynghylch y ffordd y mae gwasanaethau'n galluogi pobl i gael gofal yn eu dewis iaith.

Yr hyn rydym yn ei weld

Mae canfyddiadau ein harolygiadau yn dangos darlun cymysg:

- Mae ymarfer cryf mewn rhai gwasanaethau, lle mae'r Gymraeg yn cael ei defnyddio'n hyderus, mae gwybodaeth ddwyieithog yn weladwy, ac mae cleifion yn cael eu cefnogi'n weithredol i siarad Cymraeg.
- Er ein bod yn parhau i weld enghreifftiau cadarnhaol o'r Cynnig Rhagweithiol ar waith, mae ein canfyddiadau'n dangos bod y gallu i gael gwasanaethau Cymraeg yn amrywio o hyd. Yn rhy aml, mae'r ddarpariaeth yn dibynnu ar aelodau unigol o staff yn hytrach na chael ei hymgorffori'n effeithiol mewn systemau sefydliadol, prosesau cynllunio'r gweithlu a'r gwasanaethau a ddarperir.

Drwy ein gweithgarwch ymgysylltu ehangach ar ymgynghoriad ar ein strategaeth, clywsom hefyd y canlynol:

- nid yw mynediad at ofal cyfrwng Cymraeg bob amser yn ddibynadwy yn ymarferol
- nid yw'r Cynnig Rhagweithiol yn cael ei ddarparu'n gyson
- mae rhwystrau'n cynnwys gallu'r gweithlu, hyder a hyfforddiant.

Drwy ein harolygiadau a'n gwaith ymgysylltu, mae pobl yn parhau i ddweud wrthym fod p'un a ydynt yn cael gofal yn eu dewis iaith ai peidio yn effeithio ar eu gallu i ddeall gwybodaeth, mynegi pryderon, cymryd rhan mewn penderfyniadau a chynnal eu hurddas. Gall hyn fod yn arbennig o bwysig pan fydd pobl ar eu mwyaf agored i niwed.

Ysgogi gwelliannau ym mhob rhan o'r system

Rydym yn defnyddio'r wybodaeth hon i atgyfnerthu disgwyliadau ac ysgogi gwelliannau. Rydym yn:

- tynnu sylw at yr angen i wasanaethau ymgorffori'r Cynnig Rhagweithiol yn gyson, nid yn unig mewn egwyddor ond yn ymarferol o ddydd i ddydd
- atgyfnerthu pwysigrwydd cofnodi dewisiadau iaith pan fydd claf yn dechrau cael gofal
- cefnogi ffocws cryfach ar gynllunio gweithlu Cymraeg, gan sicrhau bod gan wasanaethau'r sgiliau sydd eu hangen i ddiwallu anghenion cleifion.

Rydym yn parhau i weld enghreifftiau cadarnhaol a'u rhannu, gan gynnwys:

- staff yn cynnig gwasanaethau yn rhagweithiol yn Gymraeg
- defnydd clir o ddeunyddiau dwyieithog
- staff sy'n siarad Cymraeg yn fwy gweladwy.

Ar yr un pryd, rydym yn glir ynghylch y meysydd lle mae angen gwelliannau, yn enwedig lle mae'r ddarpariaeth Gymraeg yn amrywio, lle nad yw'n weladwy, neu lle nad yw wedi'i hintegreiddio'n llawn mewn systemau a phrosesau.



Ein hymrwymiad

Byddwn yn parhau i atgyfnerthu'r ffordd rydym yn asesu ac yn adrodd ar y ddarpariaeth Gymraeg ac yn cymryd camau dilynol yn ei chylch. Mae hyn yn cynnwys bod yn fwy gweladwy, yn fwy cyson ac yn fwy rhagweithiol wrth nodi lle mae angen newid. Ni ddylai pobl orfod dibynnu ar siawns i gael gwasanaethau gofal iechyd yn Gymraeg. Dylai'r Cynnig Rhagweithiol fod yn un o nodweddion arferol gofal ledled Cymru, yn hytrach na rhywbeth sy'n ddibynnol ar aelodau unigol o staff, brwdfrydedd lleol neu lwc dda. Er bod cynnydd yn cael ei wneud, mae ein gwaith yn dangos bod llawer i'w wneud o hyd cyn y bydd darpariaeth Gymraeg wedi'i hymgorffori'n llawn ym mhob rhan o'r system gofal iechyd.

Drwy wneud hyn, ein nod yw sicrhau nad yw'r Gymraeg yn rhywbeth ychwanegol, ond ei bod yn rhan graidd o ofal diogel, o ansawdd uchel sy'n canolbwyntio ar yr unigol ledled Cymru.

At hynny, rydym yn parhau i fod yn gwbl ddwyieithog wrth gyfathrebu â'r cyhoedd, ac rydym wedi atgyfnerthu'r ffordd y mae'r Gymraeg yn cael ei hymgorffori ym mhob rhan o'n gwaith ymgysylltu â'r cyhoedd.

Rydym hefyd yn cyhoeddi deunydd cyfathrebu allweddol yn ddwyieithog ac yn cefnogi'r staff i feithrin hyder a dealltwriaeth drwy fentrau fel Cornel Cymraeg yn ein cylchlythyr staff mewnol.

09

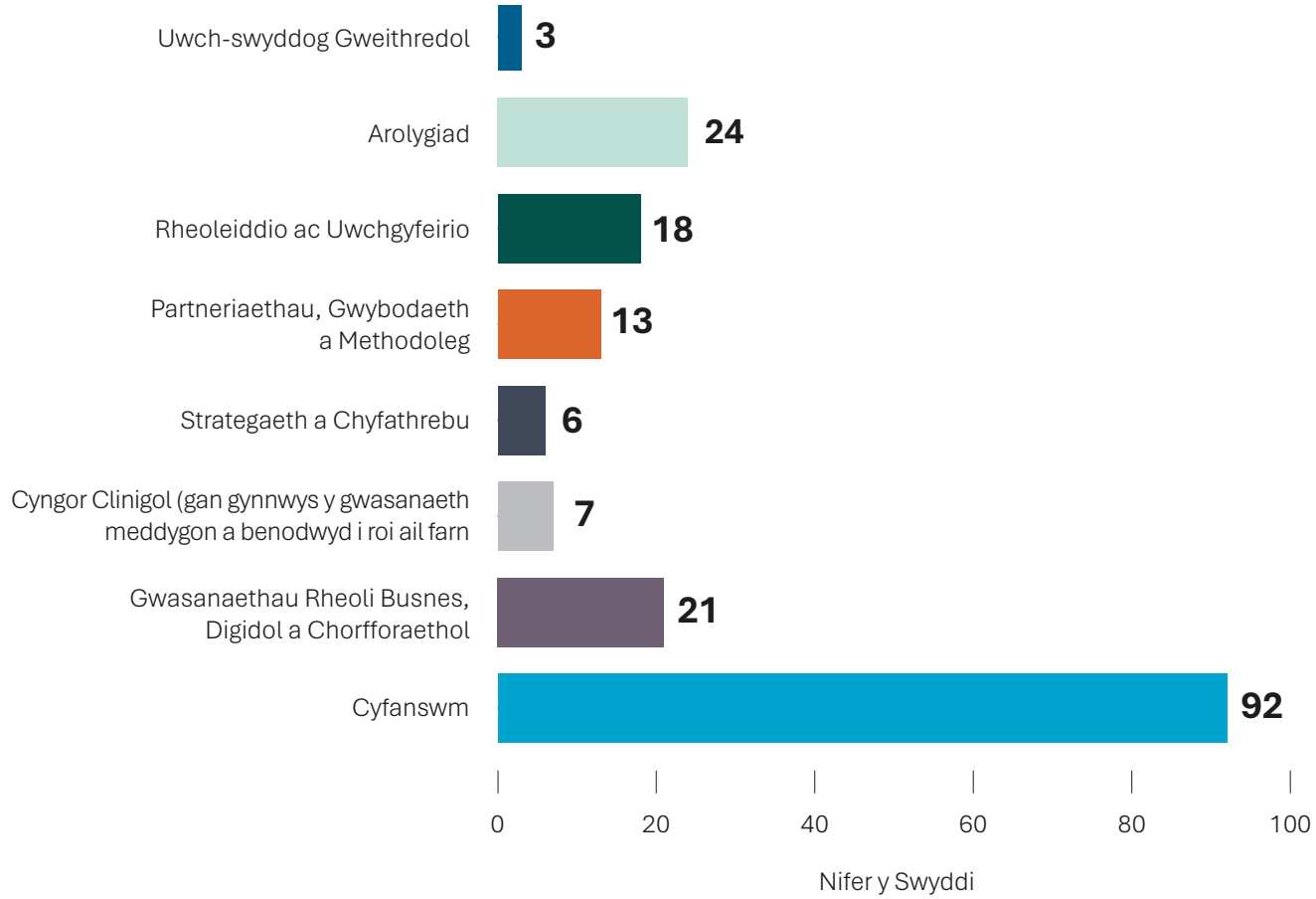
Ein hadnoddau

Ein pobl yw ein hadnodd pwysicaf o hyd. Yn 2025-26, gwnaethom barhau i fuddsoddi mewn rhaglen gynhwysfawr o gyfleoedd dysgu a datblygu, wedi'u llywio'n uniongyrchol gan adborth staff. Cafodd hyn ei ategu gan gyfres o ymarferion Gwersi a Ddysgwyd, a oedd yn ein galluogi i fyfyrio ar ein gwaith a gwella'n barhaus.

Cafodd ein Fforwm Pobl mewnol ei adolygu a'i atgyfnerthu. Mae'n parhau i fod yn ffynhonnell adborth werthfawr a chredadwy, sy'n rhoi cipolwg i uwch-reolwyr AGIC ar brofiadau staff ac yn cefnogi gwaith datblygu sefydliadol.

Rydym yn cael ein cefnogi gan nifer mawr o arbenigwyr. Mae hyn yn cynnwys dros 150 o Adolygwyr Cymheiriaid â chefndir clinigol, ochr yn ochr ag arbenigwyr ym maes Gweinyddu'r Ddeddf Iechyd Meddwl a phanel o seiciatryddion sy'n darparu ein gwasanaeth Meddygon a Benodwyd i Roi Ail Farn (SOAD). Yn ogystal â hyn, mae ein 44 o Adolygwyr Profiad y Claf ac Arbenigwyr drwy Brofiad yn chwarae rôl hanfodol wrth asesu gofal drwy ymgysylltu'n uniongyrchol â chleifion.

Cafodd meddalwedd ein system Rheoli Cydberthnasau â Chwsmeriaid (CRM) ei huwchraddio ar ddechrau 2026 ac mae'n parhau i ddarparu data gwerthfawr sy'n cefnogi gwaith timau AGIC.



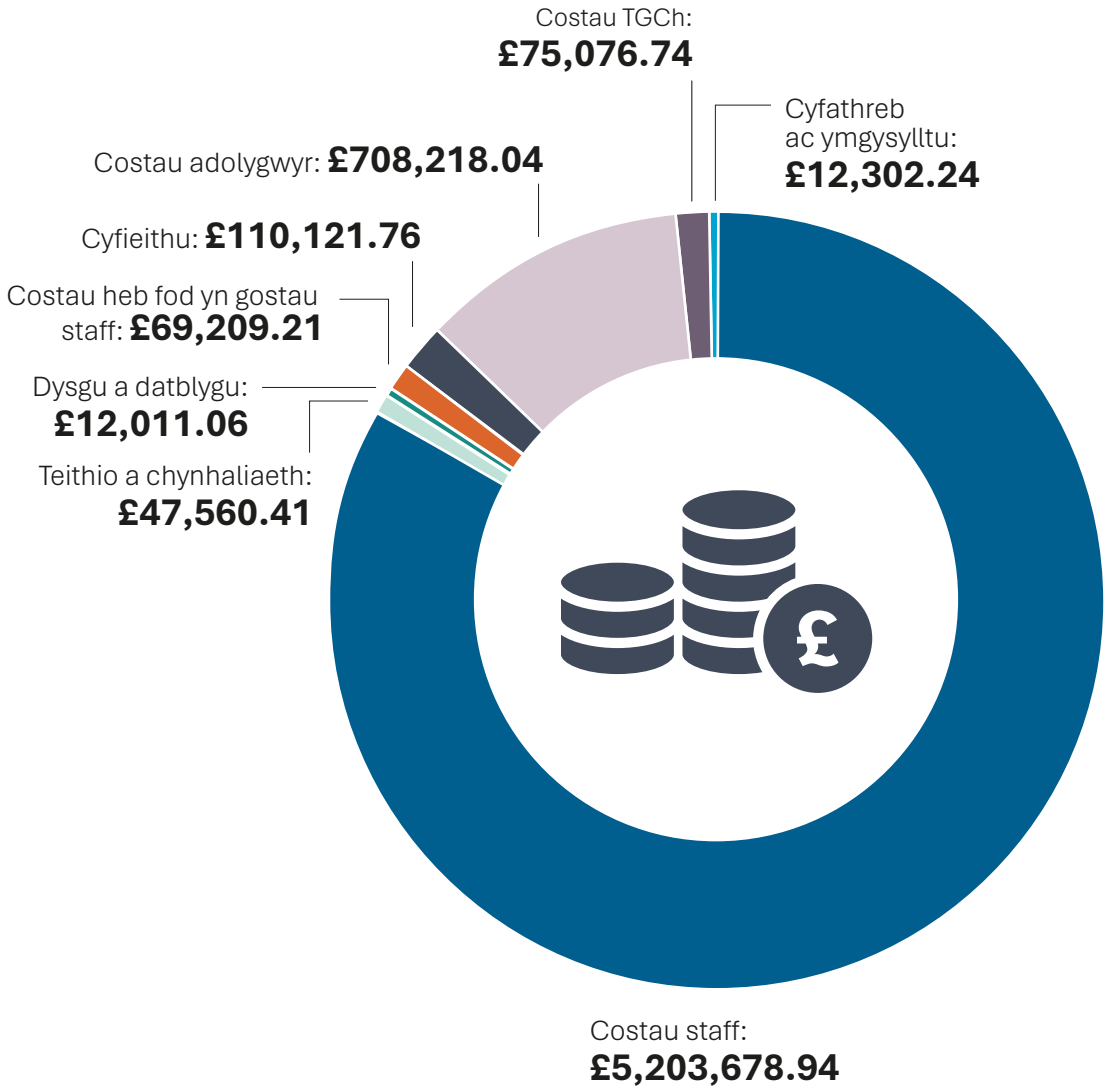
Cyllid

Ar gyfer 2025-2026, roedd gennym gyllideb o oddeutu £6.2m, sy'n cynnwys incwm ffioedd o'n rôl reoleiddio yn y sector annibynnol. Mae'r tabl isod yn dangos sut y gwnaethom ddefnyddio'r adnoddau ariannol a oedd ar gael i ni yn ystod y flwyddyn ariannol ddiwethaf i gyflawni ein gwaith yn ystod 2025-2026.

Cyfanswm y gwariant (a)
£6,238,178

Incwm o ofal iechyd annibynnol (b)
£580,350

Cyfanswm y gwariant net (a – b)
£5,657,827



Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Cysylltu â ni

Gellir darparu'r cyhoeddiad hwn a gwybodaeth arall gan AGIC mewn fformatau neu ieithoedd amgen ar gais.

Bydd oedi byr wrth i ieithoedd a fformatau amgen gael eu cynhyrchu pan ofynnir amdanynt i ddiwallu anghenion unigol. Cysylltwch â ni am gymorth.

Bydd copi o bob adroddiad, pan gaiff ei gyhoeddi, ar gael ar ein gwefan neu drwy gysylltu â ni:

Yn ysgrifenedig:
Arolygiaeth Gofal Iechyd Cymru
Llywodraeth Cymru
Parc Busnes Rhyd-y-car
Merthyr Tudful
CF48 1UZ

Ffôn: 0300 062 8163

Ebost: agic@llyw.cymru

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Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Annual Report

2025-2026

Enter



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About us

We are the independent regulator of healthcare and the inspectorate for NHS services in Wales. Our role is to check that healthcare is safe, effective, and meets the needs of people and communities.

Our purpose

We check the safety and quality of healthcare across Wales.

Our Vision

A future where healthcare in Wales is safe, effective, and high-quality for everyone.

Our values

Our values shape our work every day and ensure people remain at the heart of everything we do.

We are:

- **Independent:** we are impartial, deciding what work we do and where we do it.
- **Objective:** we are reasoned, fair and evidence driven.
- **Decisive:** we make clear judgements and take action to improve poor standards and highlight the good practice we find.
- **Inclusive:** we value and encourage equality and diversity through our work.
- **Proportionate:** we are agile and we carry out our work where it matters most.



Our four strategic priorities set out how we will work towards our vision of a future where healthcare in Wales is safe, effective, and high-quality for everyone.

1. Putting People First

We will focus on the biggest risks facing people and communities as they access healthcare services now and in the future.

2. Learning and Working Together

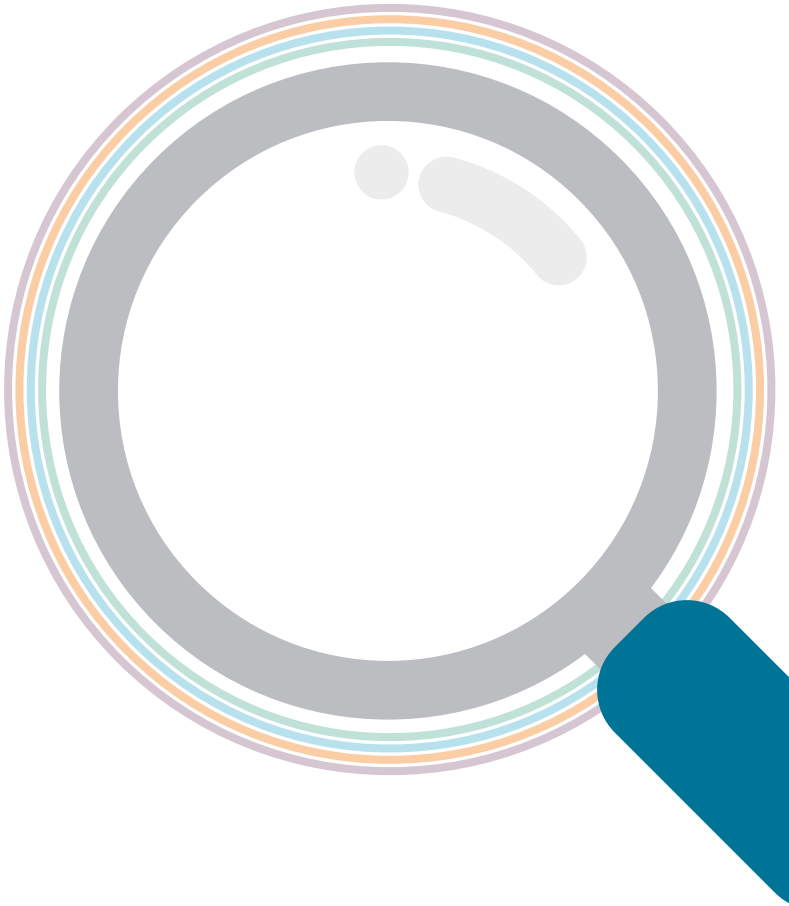
We will collaborate with partners to share learning and drive lasting improvements.

3. Investing in Our People

We will ensure our people feel supported, valued, and empowered.

4. Taking Action That Matters

We will take action to improve the quality and safety of healthcare for the future of Wales.



This report reflects activity delivered against the priorities and objectives set out in **HIW's Strategic Plan 2022–2025**, which governed the period covered by this report.

What we do

Register, regulate and inspect independent healthcare services, taking enforcement action where standards are not met.

Monitor concerns and safeguarding referrals, acting swiftly where risks are identified.

Inspect NHS services across Wales to ensure quality, safety, and effectiveness.

Recommend improvements, both immediate and long-term, to strengthen care across independent and NHS sectors.

Undertake reviews to explore key issues in depth and drive improvement.

Take regulatory enforcement action to ensure independent healthcare providers meet legislative requirements.

01

Foreword



Alun Jones
Chief Executive

Welcome to our Annual Report for 2025 to 2026.

> **"There is much to recognise in the commitment of the workforce and the delivery of compassionate care. At the same time, there are persistent challenges that affect the quality, safety and experience of services. These challenges are not new. They are recurring themes from our inspections, concerns we receive, and wider system insight."**

Healthcare in Wales is changing. Demand is growing, services are evolving, and people rightly expect safe, high-quality care wherever they access it. Against this backdrop, Healthcare Inspectorate Wales (HIW) provides independent assurance on the quality, safety and experience of healthcare across Wales.

Over the past year, our work has included 216 onsite inspections and direct engagement with thousands of people across Wales, including 4,407 survey responses from patients, families and carers, and 1,628 responses from healthcare staff. These insights provide an important, real-world understanding of how care is delivered and experienced.

We have seen a continued rise in reported concerns, with 783 received this year alone. This reflects growing awareness and confidence in people speaking up about their experiences and provides important insight and intelligence into the pressures facing healthcare services.

This report is not only a summary of our work. It provides a clear and evidence-based view of how healthcare services are working, where improvement is being made, and where further action is required. It is intended to support those delivering healthcare, those responsible for oversight, and those shaping policy, by setting out the current position and the issues that require focused attention.

A clear picture of sustained pressure

NHS healthcare services across Wales continue to operate under sustained pressure. Demand remains high, and patients are experiencing varying levels of access to care across Wales. Sub-optimal patient flow through the system continues to reduce available capacity within urgent, emergency and planned care settings. Workforce challenges remain evident across services, affecting both resilience and the sustainability of care delivery.

Meanwhile, difficulties in accessing primary care contribute to increased demand elsewhere in the system, and workforce constraints impact on the consistency and reliability of care across different settings.

The concerns raised with us reflect this wider picture. We continue to see increasing complexity, with many concerns involving

multiple parts of the system. Themes such as access to care, delays in treatment, mental health provision, and workforce pressures are recurring.

These same issues have been identified through wider system insight. They are well understood. What remains a significant concern is the slow pace at which improvement is being delivered and the extent to which improvements are sustained over time. As Wales enters a new period of government, there is a clear expectation that change is delivered more quickly and that improvements translate into lasting benefits for patients.

The strength of the workforce

Across our work, we continue to see high standards of compassion and professionalism from healthcare staff. Patients are often treated with dignity and respect, and we regularly see staff going above and beyond to improve and support patient care. This remains a significant strength within the system.

However, the quality of care cannot depend on commitment alone. Workforce challenges, reliance on temporary staffing, and pressures on training and development, are affecting the stability and sustainability of services.

Over time, this creates risk for both patients and staff. Supporting the workforce and creating the conditions for sustainable care delivery must remain a central focus.

Taking action where standards are not met

We have continued to take a responsive and proportionate approach, focusing on areas of greatest risk and responding to emerging issues as they arise. This year has seen increased levels of escalation activity across NHS services and enforcement activity within the independent healthcare sector. Where standards have not been met in independent healthcare services, we have taken action to protect patients, including restricting or suspending services where necessary.

Within NHS services, structured escalation arrangements are being used more actively to manage risk and support improvement, helping to ensure that issues are identified early and addressed. Whilst services often respond positively to our findings, the recurrence of issues remains a concern. Improvement is not always embedded or maintained, and this must be addressed if meaningful progress is to be achieved.

Independent healthcare: New risks and challenges

The independent healthcare sector in Wales continues to expand and change.

There has been growth across a wide range of services, including private primary care, aesthetic treatments and other health and wellbeing services. This brings increased choice for patients. However, our work highlights ongoing risks, particularly where new providers enter the market without a full understanding of the standards required to deliver safe care.



Alongside this, we have seen a significant increase in registration activity, with 705 cases received compared to 528 last year, while the total number of registered services increased from 746 to 771. Between April 2023 and March 2026, over half of all net growth in registered services came from independent clinics and medical agencies. These services increased from 42 to 78 over the period, a rise of almost 86%. This reflects a significant shift in the nature of independent healthcare provision in Wales, with increasing numbers of services delivering private medical consultations, diagnostics, weight management, wellbeing and aesthetic treatments.

This growth brings both opportunities and challenges. As the sector expands, so too does the need for effective regulation to ensure patients receive safe, high-quality care wherever they choose to access healthcare. The registration and regulation of services play a key role in making sure providers are safe to operate, and that there is ongoing oversight of the care people receive.

The increasing use of services such as weight management, wellbeing and aesthetic treatments is creating new regulatory challenges and exposing limitations in a framework designed for a very different healthcare market.

We continue to identify issues relating to unregistered services and unsafe practice, particularly in areas such as aesthetic treatments, where there is increasing use of higher-risk treatments.

The pace of change in the sector is increasingly exposing the limitations of the current regulatory framework. As healthcare delivery evolves, regulation has not always kept pace.



We welcome developments in other parts of the UK to strengthen safeguards in areas such as non-surgical cosmetic procedures and aesthetic treatments, recognising the need for regulation to keep pace with changing models of care. As the independent healthcare sector continues to evolve, it is important that the regulatory framework in Wales is fit for purpose, provides effective safeguards for patients and maintains public confidence in healthcare services. We have raised our ongoing concerns with government officials and look forward to engaging positively on a way forward.

Mental health: A national priority

Mental health estates remain one of the most persistent concerns identified through our work. Across both NHS and independent services, we continue to see dedicated staff providing compassionate care to some of the most vulnerable people in society. However, the most significant and longstanding concerns relating to the care environment are found within parts of the NHS mental health estate.

The condition and suitability of some NHS mental health facilities continue to raise concerns about safety, privacy, dignity and the ability to provide truly therapeutic care. Patients experiencing severe mental ill health are often at their most vulnerable. They deserve care in environments that promote recovery, preserve dignity and support their wellbeing.

While many independent mental health services generally operate from more modern and well-maintained environments, some challenges remain across all sectors. However, too many NHS services continue to operate from buildings that were not designed for modern models of care and which, in today's healthcare system, would be difficult to regard as acceptable.



The need for investment and improvement is well understood. The challenge now is delivering change at the pace required. Without sustained action, there is a risk that patients and staff will continue to be let down by environments that do not reflect the standards of care that Wales should aspire to provide.

The opportunities ahead

As Wales enters a new period of government, there is an opportunity to address some of the long-standing challenges facing healthcare services. The evidence set out in this report provides a strong and independent assessment of the current position, highlighting where focused action is required and where the pace of improvement needs to accelerate.

This report reflects the final year of delivery under **our previous strategy**. **Our Strategy for 2026-2030** sets out a bold vision for how we will strengthen our role as an independent and influential voice, with a continued focus on quality, safety and improvement across healthcare services for the people of Wales.

Next year, we will take forward a major programme of work to transform how we gain assurance and inspect maternity and neonatal services in Wales. This will introduce a more joined-up approach, with a stronger focus on whole care pathways, supporting more consistent oversight of quality and safety across services. This work will also help to shape how we inspect complex, high-risk NHS services in the future, ensuring our approach continues to reflect the realities of modern healthcare delivery.

The state of healthcare in Wales

This report provides a clear message about the state of healthcare in Wales.

There is much to recognise in the commitment of the workforce and the delivery of compassionate care. At the same time, there are persistent challenges that affect the quality, safety and experience of services. These challenges are not new. They are recurring themes from our inspections, concerns we receive, and wider system insight.

Sustained effort, clear accountability and coordinated action will be required across the system in order to address these challenges. Against this background, HIW will continue to provide independent assurance, highlight both good practice and areas of concern, and use its voice to drive improvement.

A thank you

I would like to thank the people of Wales who continue to share their experiences with us. These voices are central to our work and ensure that attention is focused where it matters most.

I would also like to thank the team at HIW. Their professionalism, dedication and commitment underpin the impact of our work and our ability to improve healthcare for the people of Wales.

If you have any comments on this report or our work, please do get in touch.

Alun Jones

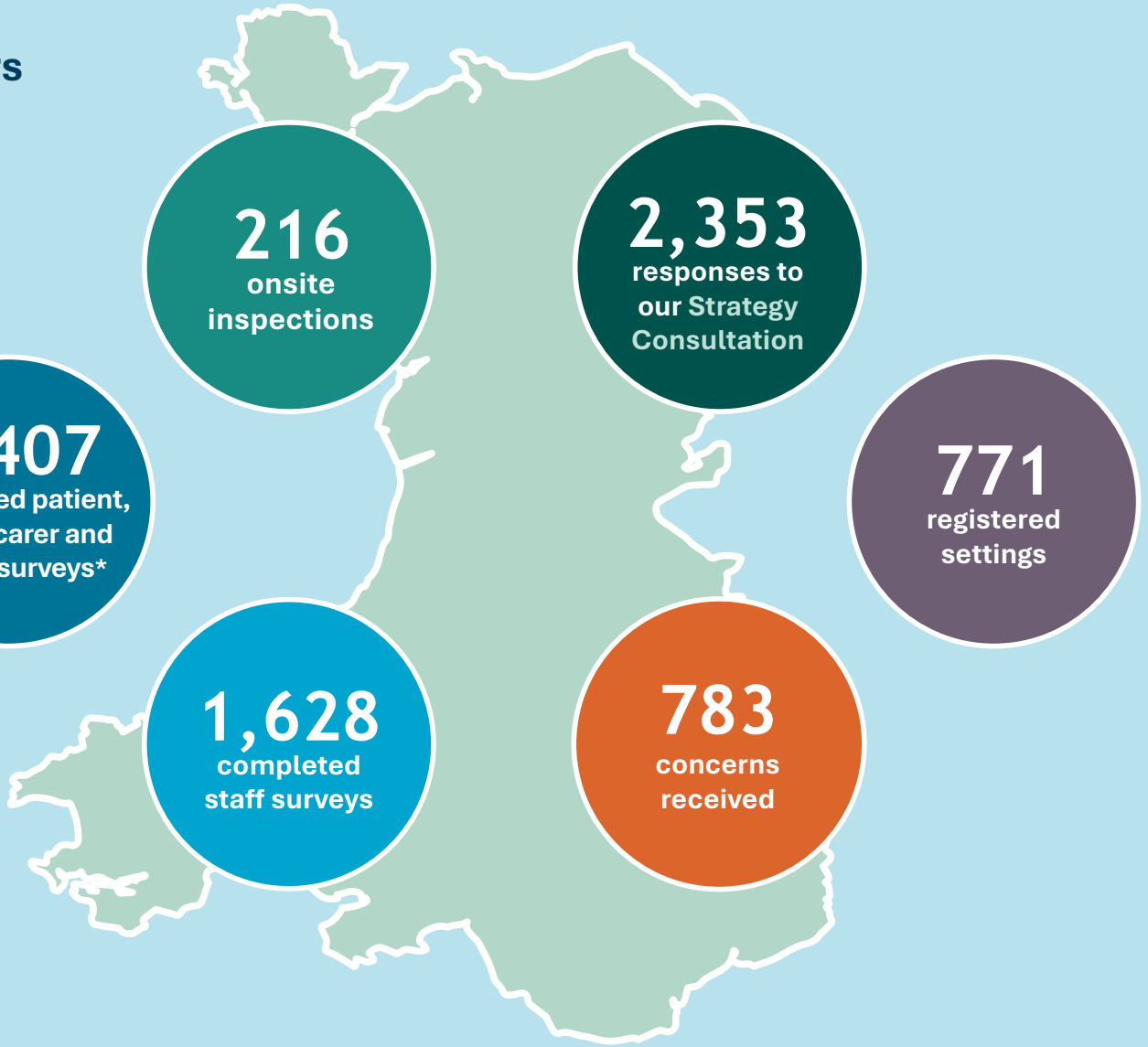
Chief Executive
Healthcare Inspectorate Wales



02

HIW in numbers

2025–2026 in Numbers



30% increase in overall patient responses.
The highest number of responses originates from GP and dental inspections.

A timeline of our activity

2025

April

11 inspections undertaken

May

17 inspections undertaken

- Improvements noted at Ysbyty Cwm Cynon's Dementia Care Unit
- Position Statement on Corridor Care
- We've published our Operational Plan 2025–2026
- Maternity Services at Neath Port Talbot Hospital Birth Centre praised but areas for further improvement
- Caution issued to provider using unregistered laser services

June

16 inspections undertaken

- Inspection Identifies Strengths but Improvements Required at Ysbyty Gwynedd's Maternity Unit
- Promoting Mental Health and Wellbeing at the 2025 Show
- Caution Issued to Provider Using Unregistered Laser Services
- Joint inspection identifies Pembrokeshire's child protection strengths and challenges amid rising demand

July

22 inspections undertaken

- Care praised but further improvements require attention at a specialist mental health unit in Cardiff
- Emergency Care Under Pressure: Staff praised despite ongoing challenges at Ysbyty Gwynedd
- Registration Cancelled for Private Dental Practice in Anglesey

August

13 inspections undertaken

- Position Statement on the Swansea Bay Maternity Support Group Family-Led Review of Maternity Services
- Caution issued to provider using unregistered laser services
- Positive Culture and Inclusive Maternity Care Praised at Glangwili, with Areas for Improvement
- Insights from Our Inspections: Key Themes in GP Practices

September

17 inspections undertaken

- Help Shape HIW's Strategy 2026–2030 – Consultation Now Open
- Birth Centre praised for individualised care and strong leadership, with areas for improvement identified

October

14 inspections undertaken

- Healthcare Inspectorate Wales calls for safe, dignified, and effective health care
- Insights from Our Inspections: Key Themes in Dental Practices
- Insight Bulletin – October 2025 issued

November

18 inspections undertaken

- Inspection of Royal Glamorgan Hospital's Emergency Department Reveals Progress and Ongoing Challenges
- Mental Health Services in Wales: Ongoing Challenges and Opportunities for Improvement
- Healthcare Inspectorate Wales and Care Inspectorate Wales conclude assurance check of Torfaen learning disability services

December

12 inspections undertaken

- Thank you for having your say on our Strategy for 2026–2030!
- HIW Inspection Highlights Compassionate Care at Bridgend Maternity Unit Alongside Areas for Improvement
- Bronglais Hospital Emergency Department Staff Praised for Compassionate Care Despite Significant Operational

2026

January

28 inspections undertaken

- Inspection identifies strong patient centred care alongside areas for improvement at a Mental Health Unit in Abergavenny
- Inspection Highlights Some Positive Changes but Ongoing Challenges in Ysbyty Gwynedd's Mental Health Unit
- Healthcare Inspectorate Wales and Care Inspectorate Wales conclude assurance check of Carmarthenshire learning disability services
- Inspection finds dedicated staff at Swansea mental health wards amid ongoing safety and dignity issues

February

18 inspections undertaken

- Inspection Identifies Positive Practice But Clear Areas for Improvement at Carmarthen Mental Health Wards
- Position Statement on National Assurance Assessment of Maternity & Neonatal Services
- Listening to Wales: What You Told Us in Our Strategy Consultation

March

30 inspections undertaken

- Annual Report: Deprivation of Liberty Safeguards (DoLS) in Wales 2024–2025

03

Regulating independent healthcare



At a glance: Our activity this year

We are responsible for registering and regulating independent healthcare services to ensure they are safe, effective, and person-centred.
We carried out 137 inspections across a wide and growing range of services, from private dental practices and cosmetic laser clinics to independent hospitals and mental health units.



Regulation provides assurance that services meet clear standards for safety, quality and governance. It also ensures that when care falls short, action can be taken to protect people and drive improvement.

A diverse and evolving sector

Many independent services operate alongside NHS care. For example, some independent hospitals provide treatment for NHS-funded patients with complex needs, and many dental practices offer a mix of NHS and private care. We have seen growth in services offering elective treatments such as laser procedures, weight management, and menopause support. As this sector grows, it can become more difficult for people to understand which services are regulated and what safeguards are in place. This makes clear, visible regulation increasingly important.

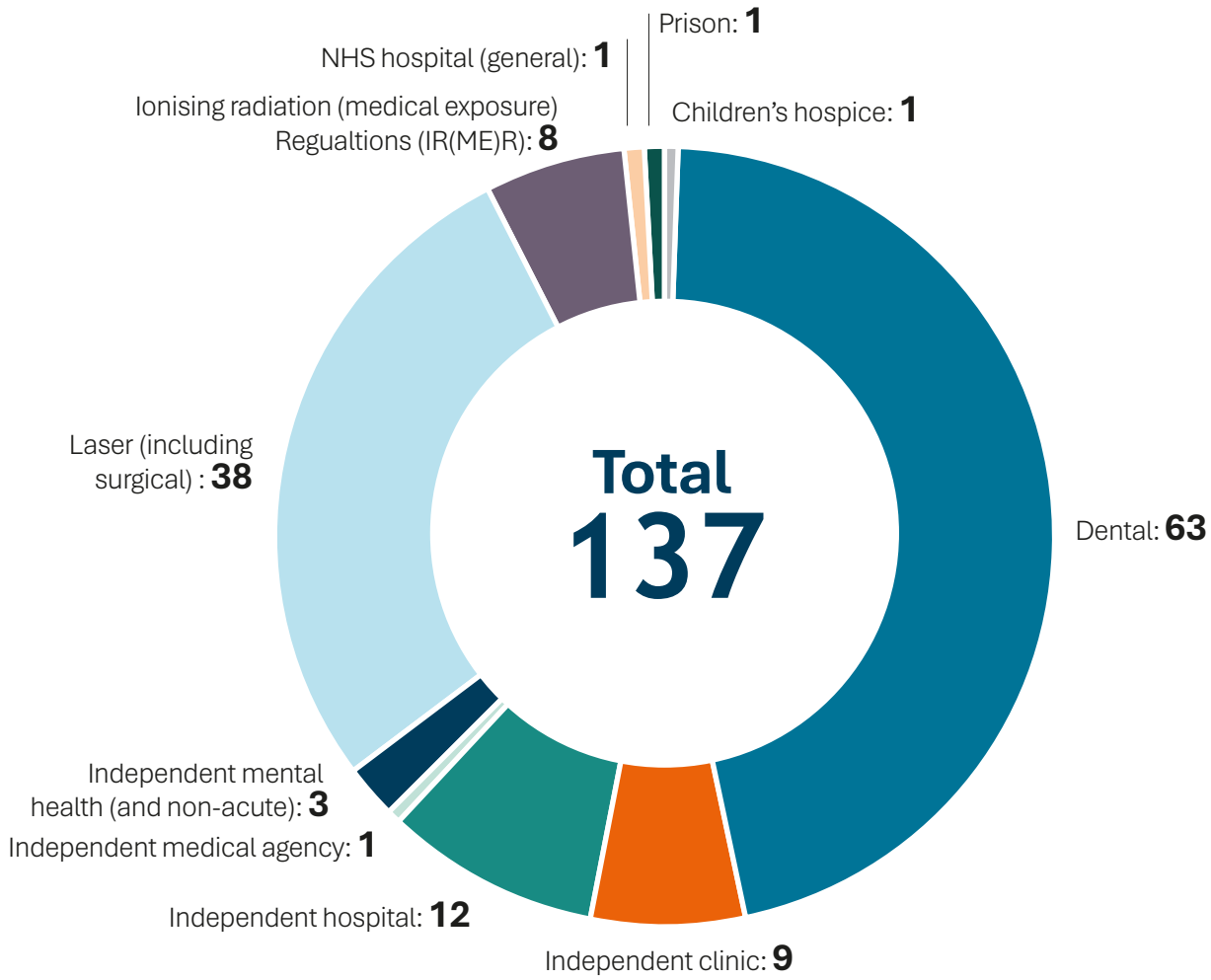


Balancing innovation and safety

From HIW's perspective, this sector brings both opportunities and challenges. Independent providers often bring flexibility and innovation, which can benefit patients, but only when supported by strong governance, clear accountability, and a commitment to continuous quality, safety and improvement. Innovation can improve choice and access, but it must not come at the expense of safety. Regulation plays a key role in maintaining this balance and ensuring that standards are routinely applied.



Independent healthcare (IHC) inspections



Our role as the regulator

Our inspections are designed not just to identify risks, but to help providers improve. We regulate services to ensure they meet the standards required by law and deliver care that is safe, respectful, and responsive to people's needs.

This includes assessing whether services are safe to operate before they are registered, monitoring them over time, and taking action where standards and legislative requirements are not met.

As the sector continues to grow and diversify, HIW remains committed to making sure that everyone in Wales, regardless of where they receive care, can expect high-quality, dignified, and safe healthcare.

Registration highlights

This year, our registration activity increased significantly, reflecting continued growth and change across the independent healthcare sector in Wales.

705 **registration cases received**
(up from 528 last year)

285 **applications granted**

75 **not granted**
(35 returned, 40 withdrawn)

Total registered services
increased from
746 to **771**

57 **services deregistered**
during the year

There has been significant growth in the independent healthcare sector. Applications in this area have increased substantially, with new independent healthcare services accounting for around 75% of all applications received

Between April 2023 and March 2026, over half of all net growth in registered services came from independent clinics and medical agencies alone. These services increased from 42 to 78 over the period, a rise of almost 86%.

This reflects a significant shift in the nature of independent healthcare provision in Wales, with increasing numbers of services delivering private medical consultations, diagnostics, weight management, wellbeing and aesthetic treatments. These shifts can increase choice for people accessing care, but they also create new challenges where services are not captured by the scope of existing regulatory frameworks which were designed for a very different healthcare market.

Independent clinics and medical agencies increased from

58 to 78

a one-third rise in the year and almost double since April 2024.

Applications for independent clinics have tripled since 2023/24.

Within dental services, the shift towards private provision continues:

Private-only services increased from

21% to 26%

The proportion of practices offering NHS services has fallen from

86% to 74%

over two years.

This increase in activity has driven a rise in operational demand:

Over 40%

more on-site registration visits

35%

increase in registered manager interviews.

We received 271

registration enquiries, continuing an upward trend.

These enquiries often come from new providers entering the market.

There were mixed trends across service types:

Dental practices decreased slightly from

513 to 510

Laser/IPL services increased from 121 to 125 although growth has slowed

Independent hospitals increased from

28 to 31

For people using these services, registration is an important safeguard. It shows that a provider has been assessed against required standards, and that there is ongoing oversight of the care being delivered.

This work highlights an ongoing gap in legislation. Some services, particularly those led by non-medical professionals such as nurses or pharmacists, do not currently require registration, even when undertaking similar activities to regulated providers.

Independent hospitals, hospices and clinics

We inspect and regulate independent healthcare services in Wales to ensure they meet the legal requirements set out in the Care Standards Act 2000, the Independent Health Care (Wales) Regulations 2011, and the National Minimum Standards for Independent Health Care Services in Wales. Inspections are a key part of our role in protecting patients and promoting high-quality care across a growing and diverse sector.



We aim to inspect independent hospitals every two years and clinics every three years. Hospices are also regularly reviewed, though we may visit any service more often if concerns are raised or there are significant changes.

Independent hospitals and hospices

In 2025-2026, we completed two inspections of independent hospitals and two inspections of adult hospices.

Overall, our assurance and inspection work indicated that services were providing safe and effective care, with positive feedback from patients, carers and staff. Patients told us they felt well supported, and we observed staff interacting with patients in a kind, respectful and dignified way.

We saw strong multidisciplinary working, with staff teams committed to delivering compassionate, safe and effective care.

Feedback reflected this positive experience, with one patient describing the hospice as *"like being surrounded by a big warm hug."*

We did not identify any immediate risks to patient safety during these inspections. Most findings related to minor areas for improvement, including:

- keeping patient guides and Statements of Purpose up to date
- ensuring risk assessments are fully completed and follow-up actions clearly recorded
- strengthening audit processes to ensure actions are completed and learning is embedded.

These findings show a sector that is generally performing well, with established systems and a strong culture of care. However, services must continue to focus on maintaining up-to-date documentation, strengthening governance processes, and ensuring that improvement actions are sustained.

Independent clinics

There are a wide range of independent clinics in Wales providing specialist services. In 2025-2026, we carried out 9 inspections of independent clinics, including cosmetic clinics, termination of pregnancy centres, and drug and alcohol rehabilitation services.

Overall, most services treated patients with dignity and respect. Consultations were carried out in private, and staff demonstrated professional and appropriate behaviour.

However, many of these settings are small and locally run. Governance arrangements are often less developed and can rely on a small number of individuals. This makes services more vulnerable where leadership capacity, oversight or formal processes are limited.

We identified patient safety issues in three inspections (33%), a higher rate than in hospitals and hospices, which generally have more established governance systems. While smaller services may find it more difficult to keep pace with regulatory requirements, compliance remains essential.

Patient safety issues included:

- providing services outside of their conditions of registration
- incomplete medication records
- lost health records
- lack of Basic Life Support training and inaccessible defibrillators
- poor cleanliness and gaps in maintenance or calibration of medical equipment.

Other common areas for improvement included:

- documentation and record keeping
- governance and policy development
- environmental maintenance
- accessibility and communication support.

These findings highlight that, while many clinics provide compassionate and respectful care, positive patient experience must be supported by robust governance, clear policies, accurate records and safe clinical systems. Regular inspection remains essential, both to identify immediate risks and to support compliance and continuous improvement.

Across Wales, the independent healthcare sector continues to expand, particularly in areas such as private GP services and cosmetic treatments. This growth provides greater choice for patients but also increases the complexity of the sector. The range of treatments available can make it harder for people to understand whether a service is properly registered or whether practitioners are appropriately qualified.

We encourage anyone seeking independent healthcare in Wales to:

- check that the provider is registered with HIW
- read our most recent inspection reports
- confirm that their chosen clinician holds the appropriate qualifications for the treatment they are offering.

This is especially important in areas where regulation continues to evolve. Our role is not only to inspect and regulate services, but also to help the public make informed choices and stay safe.

Dental practices

Dental services in Wales continue to play a vital role in community healthcare. Our inspections this year show that many practices are providing safe care and positive patient experiences. However, there are still areas where improvement is needed, particularly around governance, record keeping, and managing clinical risk.

We remain committed to a balanced approach that combines robust oversight with practical support. Our inspections are designed not only to identify risks, but also to help practices make timely and sustainable improvements. As the dental landscape continues to evolve, our role in maintaining standards and supporting improvement remains essential.



Over the course of 2025–2026, HIW carried out 63 inspections of dental practices across Wales.

8 inspections resulted in Non-Compliance Notices, issued where there were significant risks to patient safety requiring immediate action.

4 practices were urgently suspended following enforcement action.

1 practice had its registration cancelled following continued enforcement activity linked to a 2024/25 inspection.

Many issues were resolved during inspection visits, reflecting a supportive and collaborative approach. These included removing expired medicines, addressing gaps in stock control, managing environmental risks, and taking unsafe equipment out of use.

Overall, most practices were clean, well maintained, and provided safe clinical environments. Patients described staff as friendly, respectful and professional, and reported being treated with dignity and involved in decisions about their care.

We also saw examples of good practice and innovation. Some practices worked with local schools to promote oral health, while others introduced small but impactful changes to improve patient experience and access. These included quieter appointment times for neurodivergent patients, flexible opening hours, improved communication tools, and better appointment management through short notice lists. Patient feedback highlighted the positive impact of care, with patients reporting a significant improvement in their confidence when attending appointments.

However, our inspections also identified areas of concern that require continued focus.

Key areas for improvement

Infection prevention and control

We identified risks in some practices relating to decontamination processes and the handling of clinical instruments. These issues pose potential risks to patient safety and require effective controls.

Clinical records and audit

Record keeping remains an area where improvement is needed. We found that medical histories were not always updated, and examinations, risk assessments and treatment decisions were not always recorded. Key clinical information, including checks on gum health, was sometimes missing, and standards varied between clinicians within the same practice. In some cases, practices did not have structured audit programmes or were not using audit findings effectively to improve care. Consistent records and robust audit processes are essential for safe and effective care.

Governance and workforce

We found inconsistencies in how governance systems were applied. Policies were not always regularly reviewed or version controlled, and systems to monitor staff training and maintain accurate records were not always in place. Recruitment checks, including references and employment history, were sometimes incomplete.

Practices must ensure governance systems are actively used and routinely reviewed to provide clear assurance that risks are being managed.

Immediate risks and safety issues

Some inspections identified serious risks that required escalation. These included environmental safety issues, gaps in equipment maintenance and servicing, and risks linked to incomplete or inconsistent clinical records. These issues highlight the importance of regular checks and proactive risk management.

Welsh language provision

The provision of Welsh language services was variable. While information was often available in both English and Welsh, it was not always actively used in practice. The recording of patient language preferences was fragmented, and services were not always offered proactively in Welsh. We would like to see providers take a more proactive approach to understanding and meeting patients' Welsh language needs, ensuring people can access care and information in their preferred language wherever possible.

Context and future focus

During 2025–2026, the dental sector operated in a period of uncertainty as preparations were made for the introduction of the new NHS dental contract. Practices have worked to understand the changes required, recognising that this represents a significant shift in how services are delivered. As the contract comes into force in April 2026, we will continue to monitor its impact on care delivery and patient experience.

Remembering Ali

We pay tribute to Ali, a highly respected colleague and Clinical Dental Lead at HIW. Since joining in 2014, Ali made a significant contribution to dentistry in Wales, leading inspections, supporting peers, and helping shape regulatory approaches that prioritise patient safety and quality. He was known for his fairness, professionalism and commitment to improvement, as well as his warmth and generosity. Ali's impact on colleagues and the wider dental community was profound, and he will be greatly missed.

Treatment using a Class 3B/4 laser or Intense Pulsed Light (IPL)

Our regulatory responsibilities in independent healthcare include the registration and inspection of services offering laser and Intense Pulsed Light (IPL) treatments. These non-surgical procedures are typically used for cosmetic or skin-related purposes, such as hair removal or treating acne or pigmentation.

While many providers are committed to delivering a good service, our inspections continue to show that some underestimate the time, expertise and systems required to meet the legal standards needed to ensure safe, high-quality care.

These services must comply with specific regulations to minimise risks, particularly burns and eye injury, and to ensure safe environments for both patients and staff. As the independent regulator, our priority is to ensure services are safe, well-run and respectful of people's dignity.

During 2025–2026, laser and IPL providers continued to have the highest proportion of urgent Non-Compliance Notices across the sector. Nearly a quarter of services (9 out of 39) required urgent action to address risks to patient safety, with providers expected to respond within a short timeframe.

Key safety concerns

Fire safety

Several services lacked adequate fire risk assessments and staff training to respond effectively in an emergency.

Safe use of equipment

Some providers did not have appropriate treatment protocols or local safety rules in place and had not engaged professional advice to ensure treatments were delivered safely.

Staff training

In some services, staff did not have up-to-date training in key areas affecting patient safety, including first aid.

We also commonly found:

- Incomplete patient records and treatment registers
- Equipment not being serviced or maintained correctly
- Insufficient systems to ensure staff training remained up to date
- Limited evidence of effective governance to monitor quality and meet regulatory requirements.

These findings highlight that, while many patients have positive experiences, laser and IPL treatments carry inherent risks, and not all providers have the necessary safeguards in place to minimise them. Our inspection reports provide important information to help people make informed choices when considering these services.

HIW remains committed to holding providers to account and supporting them to understand their responsibilities, because everyone in Wales deserves safe, high-quality care.



04

Taking action through escalation and enforcement

At a glance: Our activity this year

The Escalation and Enforcement Team leads HIW's response to serious risks across NHS services, independent healthcare and private dentistry in Wales. We work with NHS organisations through structured escalation processes to seek assurance and support improvement. In the independent healthcare sector, we use our powers under the Care Standards Act 2000 to take action where services fall short of regulatory standards. This includes suspending services, imposing conditions, designating providers as Services of Concern (SoC), cancelling registrations and pursuing criminal investigations where appropriate.

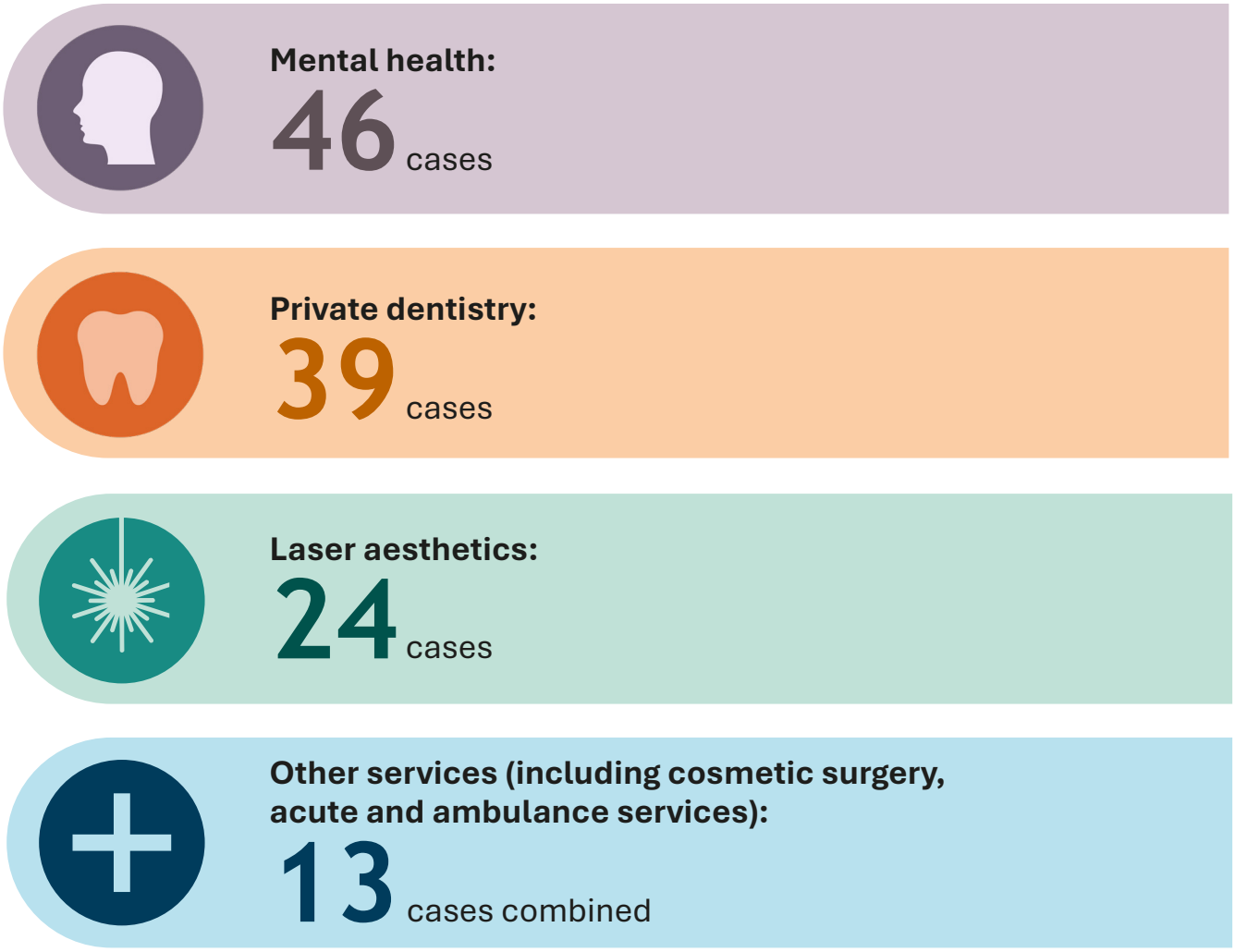
The SoC process remains a key escalation pathway when there is a significant risk to patient safety or persistent non-compliance. It applies across both NHS and independent healthcare services and involves structured meetings, targeted monitoring, and coordinated action to drive improvement or, where required, restrict services to protect the public. For NHS organisations, escalation through this process can lead to a **Service Requiring Significant Improvement (SRSI)** designation where risks are not addressed.

In 2025–2026, no NHS services were escalated to SRSI. However, NHS services continued to be actively managed through the SoC pathway, with increasing use of meetings to monitor risk and drive improvement.

Across the year, the team maintained a high level of activity. A total of 26 NHS SoC meetings were held, alongside 122 SoC meetings in independent healthcare, covering private dentistry, mental health, laser aesthetics and other settings. While independent healthcare continues to account for the majority of activity, NHS escalation activity remained at similar levels to the previous year, while independent sector meetings declined.



The distribution of independent healthcare SoC activity shows a clear concentration of risk in specific sectors:



Within NHS services, SoC activity was spread across health boards, with the highest number of meetings recorded in Betsi Cadwaladr University Health Board (7, 27%), followed by Aneurin Bevan and Powys (5 each, 19%), Swansea Bay (4, 15%), Hywel Dda (3, 12%), and Cardiff and Vale (2, 8%).

Monitoring of unregistered providers remained a significant part of enforcement work. The number of providers actively being monitored at any one time increased from 4 in May 2025 to a peak of 13 in August 2025, before stabilising at around 10–11 live cases during late 2025 and early 2026. The majority of these cases related to laser aesthetics services, often accounting for more than three quarters of all unregistered activity.

Overall, activity levels remained high throughout the year, reflecting sustained demand on escalation and enforcement processes rather than short-term spikes.

Key figures and enforcement activity

Escalation Activity — NHS Health Boards

26 SoC Pathway meetings held across NHS services

Independent healthcare — SoC activity

122 SoC meetings held across independent healthcare

Service of Concern designations

6 (50%) Unregistered laser aesthetic providers

5 (41.7%) Private Dentistry meetings

1 (8.3%) Laser Aesthetics meetings

Enforcement Activity

5 services suspended:
- 4 private dental practices
- 1 laser aesthetics provider

2 registrations cancelled:
- 1 dental practice (following urgent enforcement action)
- 1 laser aesthetics provider (failure to notify HIW of closure)

5 simple cautions issued following urgent enforcement action

Unregistered Providers and Criminal Investigations

- The number of unregistered providers being monitored increased from **4** in May 2025 to **13** in August 2025, before stabilising at around **10-11** cases per month
- Laser aesthetics services account for the majority of unregistered providers **(often over 75%)**
- Ongoing programme of criminal investigations linked to unregistered aesthetic services



Key themes

Several themes emerged from escalation and enforcement activity in 2025-2026.

Sustained enforcement pressure in laser aesthetics

Laser aesthetics continues to present the highest regulatory risk. It accounts for the majority of unregistered provider activity, a significant proportion of SoC designations, and a high volume of criminal investigations and enforcement action. This reflects the challenges associated with a rapidly evolving sector, including the presence of unregistered providers and gaps within the current regulatory framework.

Independent healthcare as the primary source of activity

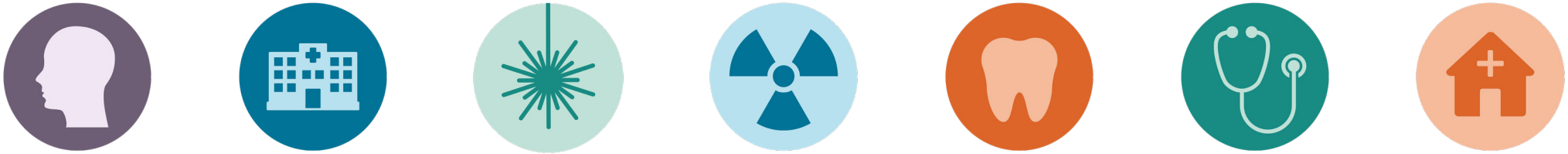
Independent healthcare accounts for significantly higher volumes of escalation activity than NHS services. Within this, mental health and private dentistry together represent 70% of all SoC cases, highlighting where regulatory focus and resource have been most heavily directed.

Concentration of risk in specific sectors

Concerns are concentrated within a small number of service types; mental health, private dentistry, and laser aesthetics, indicating recurring compliance issues within these sectors rather than system-wide concerns.

Effective use of the SoC framework

No NHS services were escalated to SRSI during the year despite HIW holding 26 SoC pathway meetings. This suggests that risks are largely being identified and managed effectively through the SoC process, enabling earlier intervention before issues reach the highest level of escalation.



Ongoing challenge of unregistered providers

The high and sustained level of unregistered provider monitoring, particularly in laser aesthetics, continues to present a significant regulatory challenge, requiring ongoing enforcement and oversight.

Increased use of enforcement and legal routes

There has been robust use of suspensions, cancellations, criminal investigations, and cautions within the independent healthcare sector. This demonstrates a proactive and increasingly assertive approach where providers fail to achieve compliance voluntarily.

Responsive and risk-based regulation

The use of targeted inspections, structured SoC meetings and proportionate decision-making reflects a flexible and intelligence-led regulatory approach.
Our work balances enforcement with practical considerations such as system pressures, while maintaining a clear focus on patient safety and quality of care.

Where providers fail to meet required standards, we have used a range of regulatory powers, including suspensions, cancellations, criminal investigations and cautions. These actions demonstrate a firm but proportionate approach, protecting patients while supporting improvement where providers engage and take the necessary steps to achieve compliance.

This year's activity highlights the importance of a risk-based approach, particularly in relation to unregistered providers and recurring compliance issues within higher-risk sectors. Maintaining effective oversight in these areas remains a significant priority.



A closer look: Enforcement and regulatory action in dental services

In November 2025, HIW inspected two associated dental practices in Pembrokeshire. Both services shared the same Responsible Individual and Registered Manager. Inspections identified significant non-compliance across both locations, raising serious concerns about patient safety and service quality.

Key issues included poor cleanliness standards, gaps in staff training and competence, failures in decontamination processes, and missing risk assessments required to meet regulatory standards. These findings pointed to wider governance and oversight failures across both sites.

HIW took urgent enforcement action, suspending both services to prevent further risk to patients. This decisive step ensured that services could not continue operating while unsafe and set clear expectations for improvement.

Following the suspension, the provider took action to address the issues, including improvements in infection prevention, staff capability, and governance arrangements.

Subsequent reinspection confirmed sufficient progress, and the suspensions were lifted, allowing services to resume.

This case also demonstrated the importance of multi-agency working. HIW informed the General Dental Council, Fire and Rescue Service, and the relevant health board, ensuring wider system oversight.

The case highlights how timely enforcement can protect patients while also supporting improvement. It shows the importance of clear escalation pathways, robust follow-up, and ensuring that improvements are sustained before restrictions are lifted.



05

Assessing the quality, safety and experience of NHS care

At a glance: Our activity this year

The NHS continues to operate under sustained and complex pressures, including rising demand, patient flow challenges and workforce constraints. Despite these pressures, our inspection and assurance work found that compassionate, person-centred care remains a significant strength, with patients describing staff as caring, respectful and committed. While we continue to see the impact of system pressures across services, we also identify clear opportunities for improvement in the quality, safety, experience and leadership of care.

In 2025–2026, our NHS Assurance work continued to provide independent oversight of the quality, safety and experience of healthcare services across Wales. We undertook a broad programme of inspection and assurance activity across general practice, mental health, general hospital services, emergency care and maternity services. This work provided insight into both patient experience and the effectiveness of governance, safety and leadership arrangements across settings.

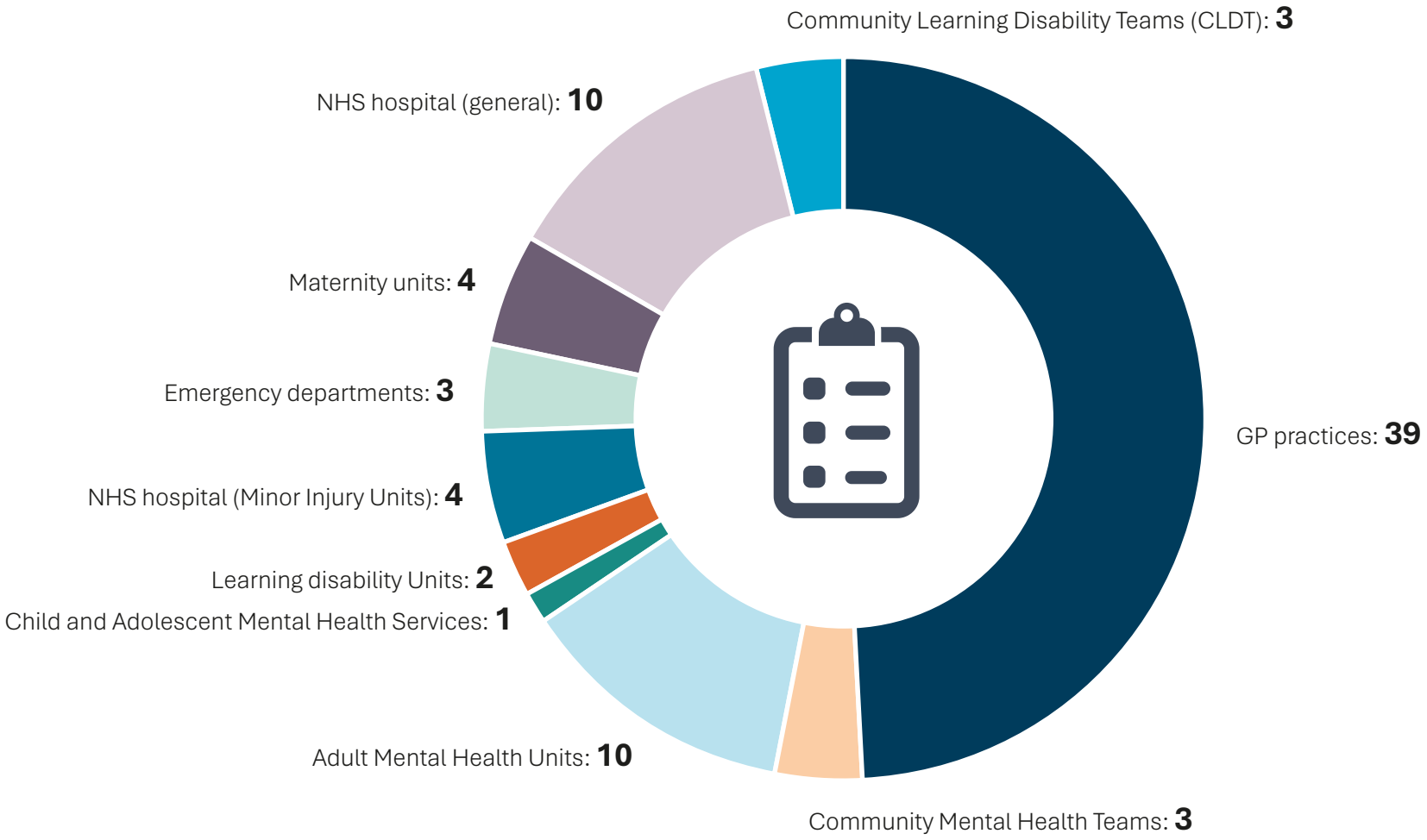


Across all services, we identified recurring concerns relating to governance, risk management and the application of core safety processes, including medicines management, training compliance, documentation and environmental safety. While improvement action is often taken following inspection, many issues continue to recur, indicating that improvements are not always embedded or sustained.

Overall, our work highlights a healthcare system supported by dedicated staff but facing significant operational pressures. Stronger oversight, proactive risk management and whole-system working will be essential to delivering sustainable improvement and ensuring patients receive safe, effective and equitable care.

We carried out 79 inspections across primary care, community, and hospital settings, and concluded three national and joint reviews, with further follow-up work underway.

NHS Inspections



What we found: Key themes and insights

Mental health: Compassionate care constrained by system pressures

Across mental health and learning disability services, we found that patients were treated with dignity, compassion and respect. Staff commitment, multidisciplinary working and examples of visible leadership supported person-centred care, often aligned with the Mental Health (Wales) Measure 2010, which aims to improve access to mental health support, care planning and advocacy.



However, these strengths continue to be constrained by persistent system pressures. Workforce challenges, including vacancies, reliance on temporary staff and gaps in mandatory training, affected the consistency and timeliness of care. We also identified variation in care planning, risk assessment, access to therapeutic activity and medicines management.

The quality of the care environment remained a significant concern. Ongoing issues with estate maintenance, environmental risk management and the suitability of facilities meant some settings did not meet expected standards for privacy, dignity or infection prevention. In some cases, the physical environment directly affected patient safety.

Inspection activity identified recurring safety concerns, including unmitigated ligature risks, weaknesses in medicines governance, gaps in infection prevention and failures in equipment checks. While action was usually taken following an inspection, the repeated nature of these issues indicates that core safety processes are not always effectively implemented in day-to-day practice.

Governance arrangements were in place but often lacked the rigour needed to identify, escalate and resolve risks effectively. In some services, known issues had not been fully addressed, indicating limited progress in delivering sustainable improvement.

Strengthening leadership accountability and oversight is essential to ensure safe and sustainable care.

Further details about our work in mental health settings are included in a dedicated section later in this report.



General practice: Positive care under increasing pressure

We completed **39 GP inspections**

received feedback from **1,799 patients** and **399 staff**

Patient experience remained **broadly positive**

Most patients reported that they were treated with dignity, respect and compassion and felt involved in decisions about their care. Staff responses were also positive, with most reporting that they felt appropriately trained and confident in the care being delivered.

However, our findings highlight increasing pressure across general practice. Demand continues to exceed capacity in many areas, particularly in rural communities and areas of higher deprivation. This is affecting access, staff morale and the consistency of service delivery.

Access to services was a key concern. While most patients were able to contact their practice, fewer were able to secure timely urgent or routine appointments. Patients reported ongoing challenges with telephone access, delays and unclear triage processes. Although some practices have introduced local solutions, these are not always applied, resulting in variation in access and experience.

During some inspections, we also identified weaknesses in core safety processes, including infection prevention and control, medicines management and emergency preparedness. Workforce assurance arrangements were variable, with gaps in recruitment checks, training compliance and staff oversight.

Clinical care remained generally good; however, variation was identified in areas such as the use of chaperones and the quality of record keeping. Governance processes were not effective in supporting proactive risk management or sustained improvement, with inconsistencies in documentation, audit processes and policy implementation limiting assurance that risks were being identified and managed proactively. These findings indicate that, while care remains compassionate and clinically sound, consistency and reliability remain a challenge.

General hospitals: System pressures affecting flow

Across general hospital services, patients were generally treated with dignity and respect, with staff supporting involvement in care and maintaining patient independence. However, this was not the case across all services.



System pressures affecting patient flow and discharge were a key theme. Delayed discharges, often linked to limited community capacity, contributed to longer stays and reduced flow through services. In some cases, this was compounded by delays in clinical decision-making and therapy input.

The care environment varied. While some areas were well maintained, others were affected by overcrowding, use of surge capacity and environmental issues that impacted patient privacy, dignity and safety.

Infection prevention arrangements were generally in place, but environmental standards were variable.

Workforce pressures were evident, including staffing shortages, skill mix challenges and gaps in training. While positive team working and ward-level leadership were often observed, concerns remained about staff morale and the visibility of senior leadership.

We also identified variation in communication, risk assessment and escalation processes, alongside inconsistent Welsh language provision and promotion of the Active Offer. Although these were often addressed at the time, their recurrence indicates that core processes are not always routinely applied.

Emergency care: Sustained pressure and patient flow challenges

Across emergency departments and minor injury units, patients were generally treated with dignity and respect, with positive feedback on staff behaviour and communication.

Our inspections found that minor injury units generally provided timely, patient-centred care, supported by effective multidisciplinary working. However, emergency departments continue to face significant operational pressures. Delays in patient flow and extended waiting times remain a challenge, with overcrowding and the use of corridor care affecting patient privacy and dignity in some settings.

The care environment was generally clean, but space constraints and waiting area pressures remained. While systems for medicines management and equipment safety were in place, they were not always applied, with risks identified in stock control, equipment checks and documentation.

Workforce pressures, including staffing shortages and fatigue, were evident. Safeguarding processes were in place, but variation in risk assessment and oversight remained.

Welsh language provision was supported in some areas but not consistently, with limited recording of language preferences and variable application of the Active Offer.

Overall, while compassionate care remains a strength, sustained system pressures continue to impact the consistency and reliability of care delivery. Health boards must strengthen oversight, ensure core processes are routinely applied, and take a whole-system approach to improving patient flow to ensure patients receive safe and timely care.



Maternity services: Person-centred care but ongoing concerns

Our work across maternity services found that women were treated with dignity, compassion and respect, supported by committed staff delivering person-centred care, often in challenging circumstances.



There were positive examples of innovation, including digital tools, multilingual information and approaches to improving understanding of safety and escalation. As digital systems continue to be introduced across Wales, we saw examples of governance arrangements supporting effective infection prevention and control, good quality record keeping and the use of digital systems to strengthen oversight of quality and risk.

However, workforce pressures remained a significant challenge, particularly in relation to staffing capacity, skill mix and reliance on temporary staff. These pressures affected the continuity and timeliness of care, and in some cases, limited the ability of services to meet the expected standards.

Variation was identified in key clinical processes, including maternity triage arrangements, escalation processes and compliance with mandatory training, such as obstetric emergencies and foetal monitoring. As these processes are critical to the early identification and management of risk, inconsistency in their application reduces reliability of safety processes across services.

While care was frequently described as compassionate and supportive, communication was not always clear or timely, and variation remained in the application of equality principles, including the Welsh language provision. Although digital approaches are supporting improvement in some areas, implementation remains variable and is not yet providing sustained assurance across services.

Overall, strong professional commitment continues to underpin maternity care. However, variation in workforce resilience, governance and the application of core safety processes persists, indicating that improvements are not yet embedded or sustained. Strengthening leadership oversight and ensuring the reliable implementation of critical processes will be essential to improving outcomes and delivering safe, high-quality and equitable maternity care.

A closer look: Maternity services at Glangwili General Hospital, Hywel Dda University Health Board

An unannounced inspection of maternity services at Glangwili General Hospital in May 2025 found a well established service delivering compassionate, person centred care. This was supported by a committed multidisciplinary workforce. Women and families reported positive experiences, describing staff as kind, professional and responsive. Inspectors observed care being provided in a calm, clean and welcoming environment, where dignity and privacy were respected.

The service demonstrated a strong approach to individualised and inclusive care. Women and families were actively involved in decisions about their care and supported to make informed choices based on their preferences. Inspectors identified positive practice in the use of bilingual health promotion materials, access to translation services, and targeted support for diverse groups. This included a maternity passport for neurodiverse individuals and outreach activity with marginalised communities. Access to a patient experience midwife and a Birth Reflections service strengthened how the service gathered and responded to feedback.

From a safety and governance perspective, effective systems were in place to support safe and clinically effective care. These included regular audit activity, daily care planning and multidisciplinary review of incidents.



The service showed a positive and psychologically safe culture. Staff reported high levels of satisfaction, felt confident to raise concerns and described strong support from colleagues and leaders. Inspectors also noted effective multidisciplinary working, including within theatre settings and in the management of risk.

The inspection also identified areas where greater consistency is required. These included the need for earlier reporting of national incidents in line with Welsh Government policy, more consistent use of structured handover processes such as Situation, Background, Assessment and Recommendation (SBAR), and further strengthening of audit arrangements to clearly demonstrate learning and impact. Improvements were also needed in mandatory training compliance, particularly in safeguarding, and in ensuring effective approaches to medicines management and equipment checks.

Where improvement work had already taken place, progress was evident since the previous inspection in November 2022. For example, documentation relating to nutrition and hydration had improved, with fluid balance charts now completed to a high standard. This reflects focused work to develop a maternity-specific approach and shows the service's ability to respond to findings and translate improvements into practice.

Overall, this inspection found a service with a strong culture, positive patient experience and effective core systems. However, greater consistency in the application of governance and assurance processes is needed. Continued focus on embedding these improvements will be important to ensure risks are identified, escalated and addressed across the service.



NHS key themes and learning across services

Across all services, several themes emerged.

Compassionate, person-centred care remains a clear strength, with patients reporting positive interactions with committed and professional staff.

System pressure continues to affect services differently, with patient flow challenges in hospitals and access pressures in general practice.

Variation in the quality of care remains a key issue, with patients not always experiencing the same standards of care across services.

Core safety processes are not embedded, particularly in medicines management, training, documentation, risk assessment and infection prevention and control.

Governance and assurance remain variable, limiting early risk identification, learning and sustained improvement.

Environmental and infrastructure issues affect care delivery, including estate condition, overcrowding, privacy and unsuitable care environments.

Workforce pressures continue to affect service delivery across all settings, affecting consistency, timeliness and sustainability of care.

Welsh language and equality remain variable across services, with differences in support for language needs and the delivery of the Active Offer.

Whole-system working is essential, as key challenges such as flow, access and workforce cannot be addressed in isolation.



Ensuring safe use of ionising radiation in healthcare

Ionising radiation plays a vital role in modern healthcare. It is used in:

- **diagnostic imaging –** such as X-rays and CT scans to view internal structures
- **radiotherapy –** to treat conditions such as cancer
- **nuclear medicine –** which uses small amounts of radioactive material to diagnose or treat a range of conditions.

As these procedures involve exposure to radiation, they must be carefully controlled to protect patients and staff. This is set out in the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R), which define how radiation is used safely in medical settings, including roles, responsibilities, patient information and monitoring.

HIW is responsible for monitoring compliance with IR(ME)R in Wales. In 2025-2026 we inspected eight NHS and independent healthcare settings that use ionising radiation. Inspections are announced in advance and include a self-assessment by the provider. This allows inspection teams, supported by technical experts from the UK Health Security Agency (UKHSA), to focus on the environment and how procedures are carried out in practice.

As part of this programme, we also asked the UKHSA Medical Exposures Group to review reports of significant accidental or unintended exposures (SAUEs) submitted between 1 April 2024 and 31 March 2025.

What we found in 2025–2026

Overall, our inspections found that services across Wales delivered safe care, with patients reporting positive experiences.

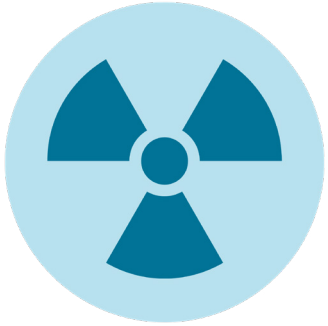
Patients told us they were treated with dignity and respect, felt well informed, and were involved in decisions about their care.

We observed:

- engaged and professional staff, with strong patient communication
- effective leadership within radiology and imaging services
- positive cultures, with services open to feedback and committed to improvement.

Survey feedback and patient comments reinforced this, with patients describing services as welcoming, professional and reassuring.

We also identified examples of innovation. In one service, radiologists were using an Artificial Intelligence (AI) stroke evaluation tool to support initial triage. This acted as an early indicator to identify patients who may require urgent treatment, before full clinical review by a radiologist. However, we found that Employer's Procedures had not been updated to reflect this use of AI, which could lead to ambiguity about roles and responsibilities.



Areas for improvement

While overall care was positive, we identified several areas where further work is needed to strengthen consistency, governance and compliance.

Diagnostic Reference Levels (DRLs)

DRLs are used to help monitor and optimise radiation doses for patients undergoing imaging procedures. One inspection identified a significant weakness in the process for establishing and reviewing DRLs. There was no clear evidence of how DRLs were approved or how actions from Medical Physics Expert advice were implemented. Services must ensure clear processes are in place to define, monitor and act on DRLs to maintain safe exposure levels.

Governance and referral pathways

We identified inconsistent governance arrangements where IR(ME)R activities sit outside core radiology departments, particularly across multi-disciplinary pathways. This includes variation in referrer compliance and communication processes. As services become more complex, stronger governance and clearer accountability are required.

Employer's Procedures (EPs)

There was variation in how the role of the IR(ME)R employer was understood and applied in practice. Employer's Procedures were not always regularly reviewed or aligned with actual practice. EPs must be clear, up to date and implemented, particularly following recent regulatory changes.

Audit and learning

We saw variation in clinical audit programmes and how learning from incidents is used. Some services need to strengthen audit arrangements, including clear schedules, follow-up actions and feedback mechanisms to ensure continuous improvement rather than compliance alone.

Clinical and equipment governance

Opportunities remain to strengthen systems for equipment governance, including maintaining accurate inventories and ensuring quality assurance processes are in place. Services must also ensure full alignment with updated IR(ME)R requirements, including those relating to training and employer cooperation.

Good practice

We identified examples of person-centred innovation. One service created a child-friendly waiting area, including interactive activities and a pictorial book developed by staff to explain imaging procedures to children. This initiative, recognised by the British Nuclear Medicine Society, helped reduce anxiety and improve understanding for younger patients.



A closer look: Compliance with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R)

A previous inspection of a national screening service found that it was not fully compliant with IR(ME)R regulations. There were concerns about the lack of clear procedures, protocols and quality assurance arrangements needed to support safe practice.

HIW issued an Improvement Notice under the Health and Safety at Work etc. Act 1974. Since then, we have worked closely with the service at both strategic and operational levels to support improvement. The provider responded positively, taking action to strengthen governance and safety processes, and the notice was lifted within a short timescale.

This case highlights HIW's approach to regulation. We take decisive action where risks are identified, but we also work collaboratively with providers to support improvement and achieve sustainable compliance.



Making an impact through reviews

We publish a range of reviews and other reports every year.

National reviews help us to evaluate how healthcare services in Wales are delivered.

In 2025–2026, our review programme tackled some of the most sensitive and complex areas of care, with a focus on consistency, collaboration, and compassion.



Follow-up: Supporting the mental health needs of children and young people

In November 2024, we published **our joint review with Estyn and Care Inspectorate Wales (CIW)** examining how healthcare, education and children's services support the mental health needs of children and young people.

During 2025–2026, we undertook a stage one follow-up by reviewing updated improvement plans from health boards, local authorities and regional partnership boards.

We found that:

- most actions assigned directly to health boards were reported as completed
- just over half of actions requiring joint working between organisations were completed
- all organisations demonstrated progress across key areas.

It was encouraging to see examples of strengthened practice and improved ways of working. However, progress was more variable where joint action is required, reflecting the challenge of delivering coordinated improvement across organisational boundaries.

We will continue to monitor progress and are planning a stage two follow-up in autumn 2026 to assess whether improvements have been sustained and are making a difference for children and young people.



Follow-up: Vascular services, Betsi Cadwaladr University Health Board

As part of our stage two assurance work following **our 2023 vascular services review**, we undertook further follow-up activity with Betsi Cadwaladr University Health Board.

The initial response provided by the health board did not provide us with sufficient assurance, and further clarification and evidence were requested. A Service of Concern meeting, as part of our formal escalation process to address risks to quality and safety, was held in January 2026, where the health board set out its progress and improvement plans in detail.

Following this, we saw evidence of:

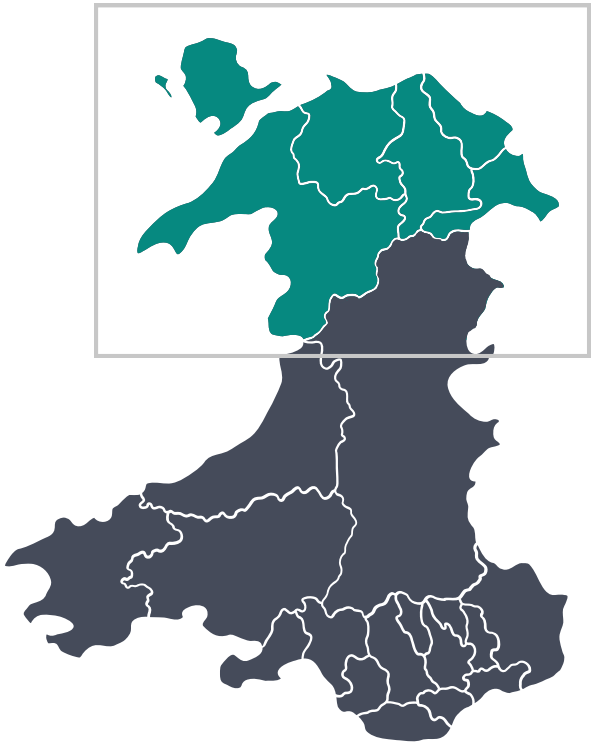
- clearer governance arrangements
- defined leadership responsibilities
- improved structures for clinical audit, oversight and learning.

However, overall assurance remains partial. While the health board has established more structured plans and monitoring arrangements, much of this work is still in development or at an early stage of implementation. There is currently limited evidence that these actions have led to sustained improvement in patient outcomes, service consistency or staff experience.

The health board must now demonstrate that improvements are:

- fully implemented across all services
- consistently applied in practice
- supported by clear evidence of impact on safety, quality and outcomes.

HIW will continue to seek assurance through ongoing engagement and scrutiny, including reviewing progress against planned actions and evidence of sustained improvement. Overall, our follow-up work this year shows that progress is being made, but that improvement is not always delivered at scale or maintained over time.



Sustained focus, strong leadership and effective partnership working continue to be essential in ensuring that improvements are delivered at pace and maintained over time. HIW will continue to use its review programme to provide independent challenge, monitor progress and support system-wide improvement.

06

Mental health in Wales: Our findings and impact

At a glance: Our activity this year

Mental health and learning disability services across Wales continue to face significant and sustained pressures. These pressures are particularly evident within NHS services, although independent providers also face challenges in delivering safe, effective and person-centred care. From HIW's perspective, this remains one of the most complex and high-risk areas we inspect and regulate. It requires strong leadership, safe environments, a skilled workforce and a continued focus on improvement across the whole system.



What we did in 2025–2026

During the year, HIW carried out

31 **onsite inspections** across mental health and learning disability services in Wales,

including

19 **NHS settings**

and

12 **independent healthcare settings**

Our programme covered a broad range of services, including:

- Community Mental Health Teams (CMHTs)
- Community Learning Disability Teams (CLDT), undertaken jointly with Care Inspectorate Wales
- NHS learning disability inpatient services
- Child and Adolescent Mental Health Services (CAMHS) inpatient setting
- A wider programme of inpatient mental health inspections across NHS and independent providers.

Our inspections focused on patient experience, the delivery of safe and effective care, and the strength of leadership, governance and oversight. Across services, patients described staff as caring and supportive, and we saw many examples of compassionate, person-centred care.

What we're seeing across Wales

Across the services we inspected, there was clear evidence of committed staff, effective multidisciplinary working and generally robust care and treatment planning aligned with the Mental Health (Wales) Measure 2010. Patients described staff as caring and supportive, and we saw many examples of compassionate, person-centred care.

Mental Health Act arrangements were largely compliant, with patients supported to understand their rights and to access advocacy services. Medicines management systems were generally safe, although issues remain around the consistency and completeness of documentation. Some services also need to improve how information is provided, including the use of accessible formats.

In learning disability services, we saw positive examples of person-centred care, with staff demonstrating a strong understanding of communication needs and applying least restrictive approaches effectively. Families and carers were generally well involved, and care planning reflected individual needs and references. While some improvements were required in areas such as governance, documentation and aspects of the care environment, the quality of direct care was generally positive.

However, these strengths are being delivered within a system facing ongoing pressure. The most significant concern remains the environment of care, particularly within NHS settings. Ageing infrastructure, maintenance issues and delays in addressing known risks continue to affect patient safety, dignity and the therapeutic quality of services. In several cases, previously identified issues had not been resolved, indicating that improvements are not always being delivered at the pace required.

Workforce pressures remain evident across both NHS and independent services. These include challenges in maintaining training compliance, access to specialist roles and achieving the right skill mix.

In NHS settings, reliance on temporary staff and wider system pressures continue to affect continuity of care and access to therapeutic activity. Independent services generally demonstrated more stable workforce models, well-maintained environments and access to structured therapeutic activity. However, some services continued to experience pressures in maintaining staffing levels and responding to increasingly complex needs.

Governance arrangements were generally in place across services. However, weaknesses in documentation, oversight, record keeping and the use of learning from incidents reduced assurance that risks were always being identified and addressed effectively.

Overall, the evidence shows that direct care remains a strength, supported by committed and compassionate staff. However, environmental limitations, workforce pressures and delays in resolving known issues continue to affect the reliability and sustainability of care across Wales.

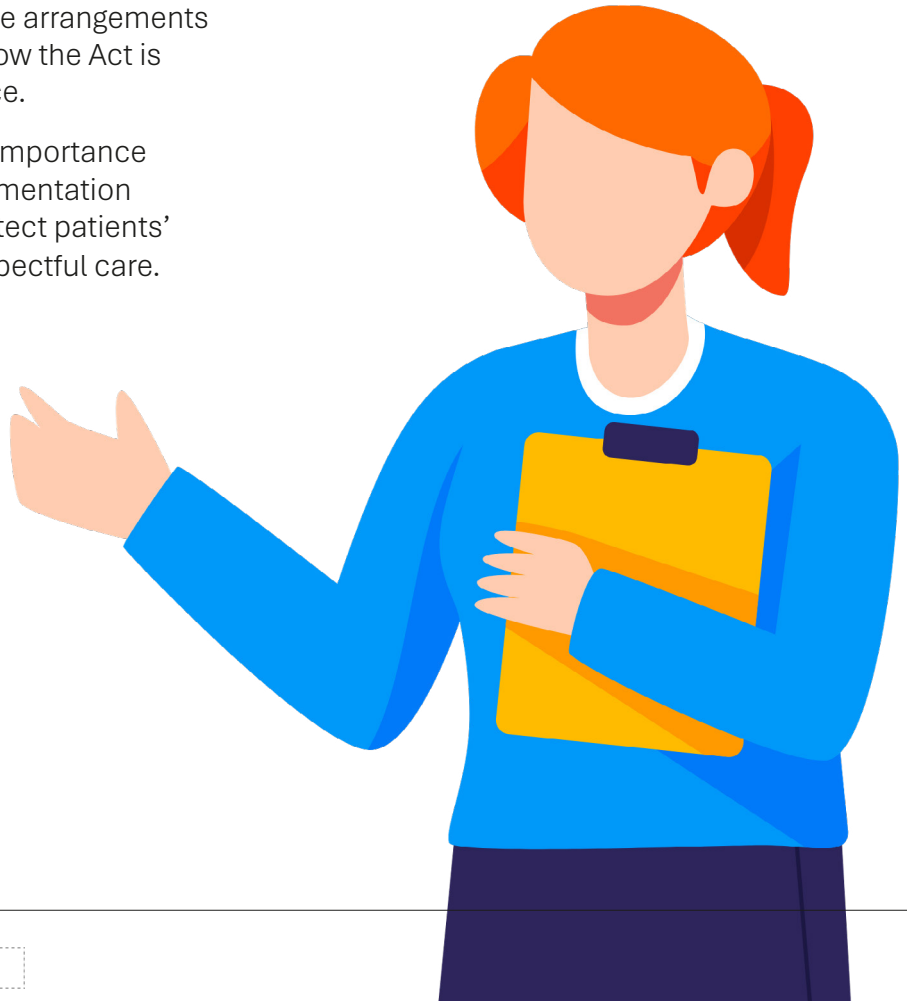
Monitoring the Mental Health Act

The Mental Health Act 1983 provides the legal framework for detaining and treating people with serious mental health conditions when this is necessary for their safety or the safety of others. As part of our regulatory role, HIW continues to monitor how services apply the Act in practice.

In 2025–2026, our assurance work found that Mental Health Act arrangements were largely compliant, with patients generally supported to understand their rights and access advocacy services. Across the services inspected, there was evidence that legal safeguards were usually being applied appropriately.

However, as in previous years, some areas still require improvement. In particular, services need to ensure that documentation is complete, that information is accessible to patients, and that governance arrangements provide strong oversight of how the Act is applied in day-to-day practice.

These findings reinforce the importance of clear systems, good documentation and ongoing oversight to protect patients' rights and ensure lawful, respectful care.



Second Opinion Appointed Doctor (SOAD) Service



The Second Opinion Appointed Doctor (SOAD) service is a vital safeguard for patients detained under the Mental Health Act who are unable or unwilling to consent to certain treatments. SOADs are independent consultant psychiatrists who review proposed treatment plans to ensure they are clinically appropriate, lawful and in a patient's best interests. This provides an important layer of external challenge and protection for patients.

HIW continues to manage the SOAD service in Wales, ensuring that robust arrangements are in place to support the timely and effective delivery of independent second opinions. This includes overseeing operational processes, promoting consistency in decision-making, and ensuring that learning from inspections and wider assurance activity informs the service.

Service activity and delivery

Between 1 April 2025 and 31 March 2026, the SOAD service received 873 requests. Of these:

- 808 related to patients detained in hospital settings (SOAD 1 cases)
- 65 related to patients being treated in the community (SOAD 2 cases)

This represents an increase compared with recent years, while remaining broadly in line with activity seen over the past five years.

The service continues to operate through a hybrid delivery model, combining onsite and remote assessments, supported by a cohort of around 14 active SOADs across Wales. While remote certification remains an important part of service flexibility and timeliness, onsite assessments continue to be regarded as best practice wherever possible because of the additional value they provide in patient engagement and assurance.

Work has also continued to strengthen the digital systems supporting the service. Enhanced security measures for the digital operating model are being tested and implemented to improve resilience, information governance and efficiency.

Service development and improvement

During the year, several steps were taken to strengthen consistency and quality in SOAD practice. This included the introduction of a revised SOAD toolkit, with updated guidance and practical resources to support SOADs in carrying out their statutory role.

The annual training programme was also delivered, with a particular focus on peer review, reflective practice, and thematic sessions on the use of Electroconvulsive Therapy (ECT), a treatment used in certain severe mental health conditions where a controlled electrical stimulus is applied under anaesthetic to improve symptoms. These were identified as priority areas to support consistency in decision-making and reinforce good practice.

In addition, HIW carried out a comprehensive audit of SOAD certifications from the previous reporting period. Findings were shared with the SOAD cohort to promote learning and continuous improvement, particularly in relation to documentation standards and the consistency of reasoning within certification decisions.

HIW also continued to discharge its responsibilities under Section 61 of the Mental Health Act 1983, reviewing the administration of treatment to detained patients. These reviews found generally high levels of compliance with statutory requirements. Where issues were identified, these were mainly minor administrative errors, and these were followed up with providers to ensure appropriate remedial action.

Challenges and forward look

A significant challenge for the service continues to be the recruitment and retention of SOADs. Despite ongoing efforts, the current cohort has not been expanded, which continues to place pressure on service capacity and resilience. This challenge is likely to become more pressing with the anticipated impact of Mental Health Act Reform (2025), which is expected to increase demand for SOAD services.

Looking ahead to 2026–2027, the focus will be on strengthening capacity and resilience, progressing actions to address recruitment challenges, and ensuring readiness for any increase in demand. Further work will also continue to improve the digital delivery model, integrate into practice learning from audit and training, and promote consistency and quality across SOAD decision-making.

Overall, the SOAD service continues to provide an essential safeguard within the mental health system in Wales, helping to protect patient rights and ensuring independent scrutiny of significant treatment decisions.



07

Concerns, investigations and notifications



Concerns: Our activity this year

We are committed to managing concerns fairly, efficiently and effectively. Concerns raised with us about the quality, safety and experience of healthcare services are a vital source of intelligence that help us identify risks, highlight areas of good practice and drive improvement across healthcare services in Wales.



Why concerns matter

Much of our work in responding to concerns takes place outside the public spotlight. While this activity is less visible than inspections or published reports, it is a critical part of how we hold organisations to account.

Through concerns, we may identify early warning signs of risk, seek assurances from providers and, where needed, escalate issues to protect patients.

This intelligence directly informs our inspection programme, assurance work and wider regulatory decisions.

We also continue to see increasing complexity in the concerns raised. Many involve multiple services, higher levels of risk and require more direct follow-up. In 2025–2026, we sought further assurance from services in around 30% of concerns received, reflecting the seriousness of issues being reported.

How we respond

We act quickly on high-risk concerns, seeking immediate assurances from healthcare providers and taking further action where necessary.

All concerns about the quality, safety or experience of healthcare services are triaged according to risk, with clear target times for HIW's response to the person raising the concern:

- **High-risk concerns** require immediate action and a response from HIW within 2 working days.
- **Medium-risk concerns** require a response from HIW within 5 working days and may involve direct engagement with the provider.
- **Low-risk concerns** are typically signposted to local complaints processes, with a response from HIW within 7 working days.

Where concerns indicate potential risks to patient safety or quality of care, we may seek assurances directly from the provider. High-risk concerns may require immediate assurance, while medium-risk concerns would typically require a response from the provider within 5 working days.

Concerns at a glance

In 2025–2026, we received 783 concerns, an increase of 40 compared to the previous year and continuing a strong upward trend over time.

Concerns received over the last six years:

- 2020–2021: 434
- 2021–2022: 514
- 2022–2023: 659
- 2023–2024: 614
- 2024–2025: 743
- **2025–2026: 783**

This sustained increase reflects greater public awareness, confidence in raising concerns, and ongoing pressures within healthcare services.



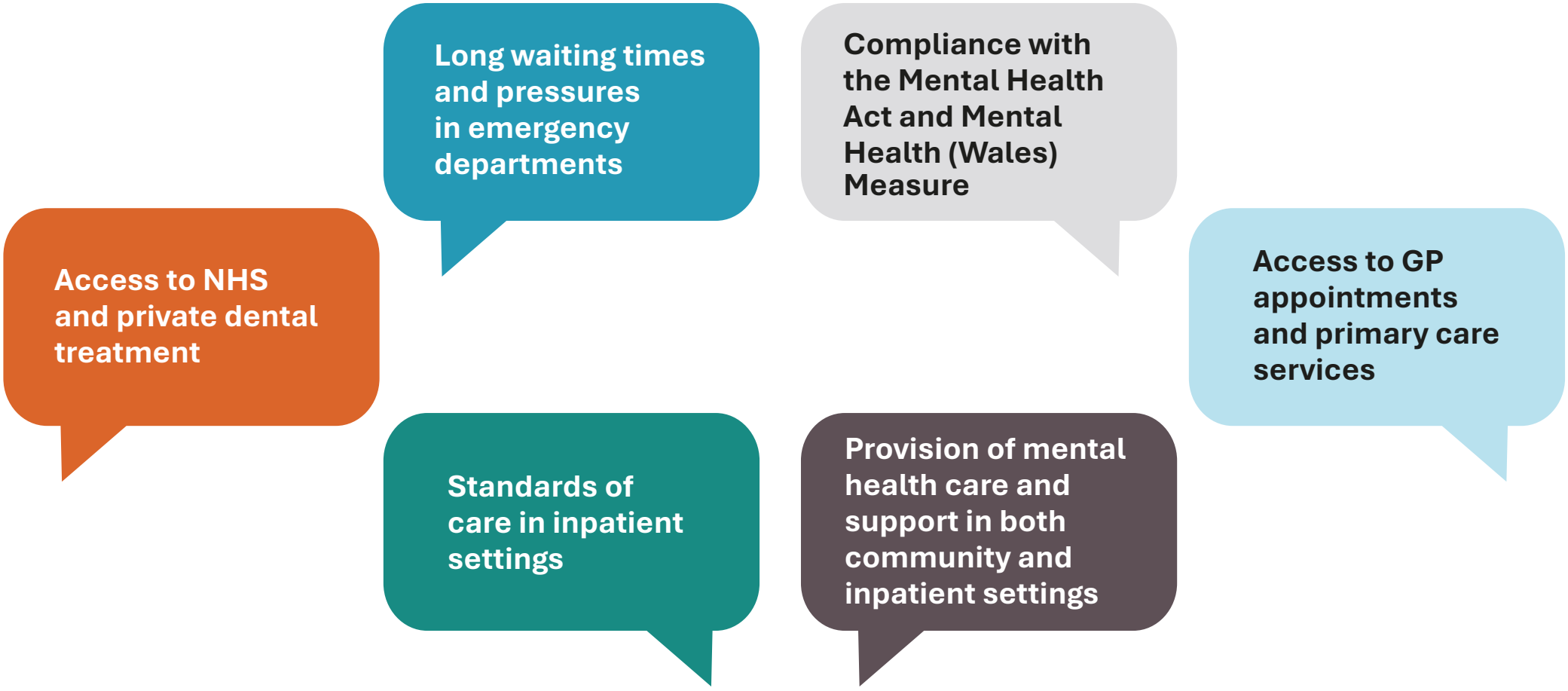
What the concerns were about

115	Betsi Cadwaladr University Health Board
110	Swansea Bay University Health Board
110	Independent healthcare
96	Aneurin Bevan University Health Board
87	Hywel Dda University Health Board
85	Cwm Taf Morgannwg University Health Board
80	Cardiff and Vale University Health Board
52	Dental
20	Powys Teaching Health Board
17	Other
5	Welsh Ambulance Services University NHS Trust
2	Public Health Wales
2	Velindre University NHS Trust
2	NHS Wales

Note: The figures shown represent the number of concerns received by HIW during 2025–2026. Health boards serve populations of different sizes and provide services across different geographical areas. As a result, these figures should not be used to compare organisations directly or interpreted as a measure of performance.

What people told us

The most common themes raised in concerns during the year included:



These themes reflect wider system pressures and highlight where patients are finding it most difficult to access timely, safe and effective care.

Whistleblowing: Speaking up for safety

Whistleblowing plays a vital role in protecting patients and improving services. It allows staff to raise concerns about unsafe practice, poor quality care, or organisational culture where they may not feel able to do so internally.

As a prescribed body, HIW has a key role in receiving and acting on these concerns. Staff come to us not only to report immediate risks, but also to highlight deeper issues relating to governance, leadership and culture.

In 2025–2026, we received 117 whistleblowing concerns, a small decrease from the previous year of 120.

These concerns mostly related to:

- staffing levels, turnover and skill mix
- staff conduct and clinical practice
- environment and infection prevention and control
- culture, including bullying and discrimination
- standards of care and treatment
- leadership, support and governance arrangements
- lack of action following concerns being raised.

We take all whistleblowing concerns seriously and may seek assurances or share information with other regulatory bodies where appropriate.



Regulatory notifications: Keeping us informed

Independent healthcare providers and private dental services are required by law to notify us of certain incidents. We also receive notifications relating to ionising radiation under IR(ME)R regulations.

In 2025–2026, we received 2,385 statutory notifications, an increase of 154 (7%) compared to the previous year. This increase was primarily driven by Regulation 30/31 notifications.

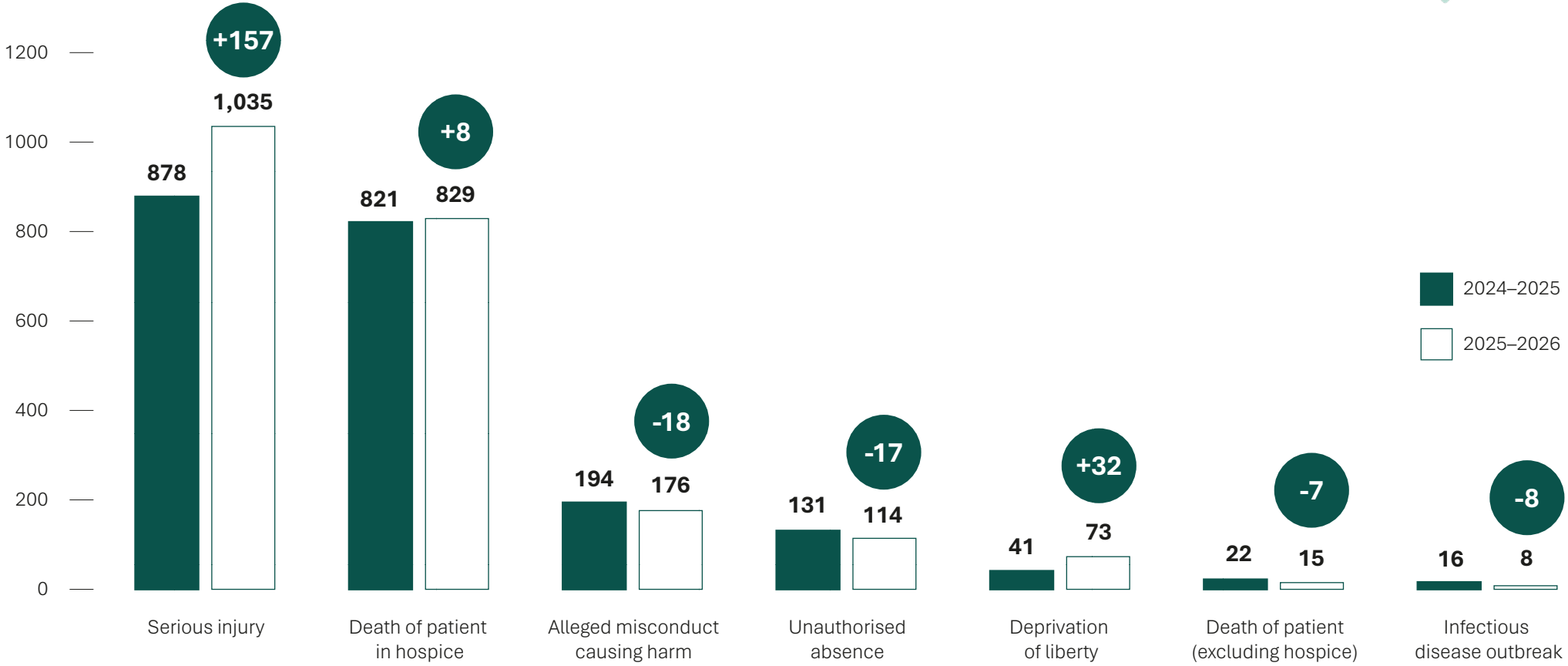
Breakdown of notifications received:



These notifications are reviewed and assessed to determine risk and whether further action is required. They also provide valuable insight into emerging trends and help inform our inspection and regulatory activity.

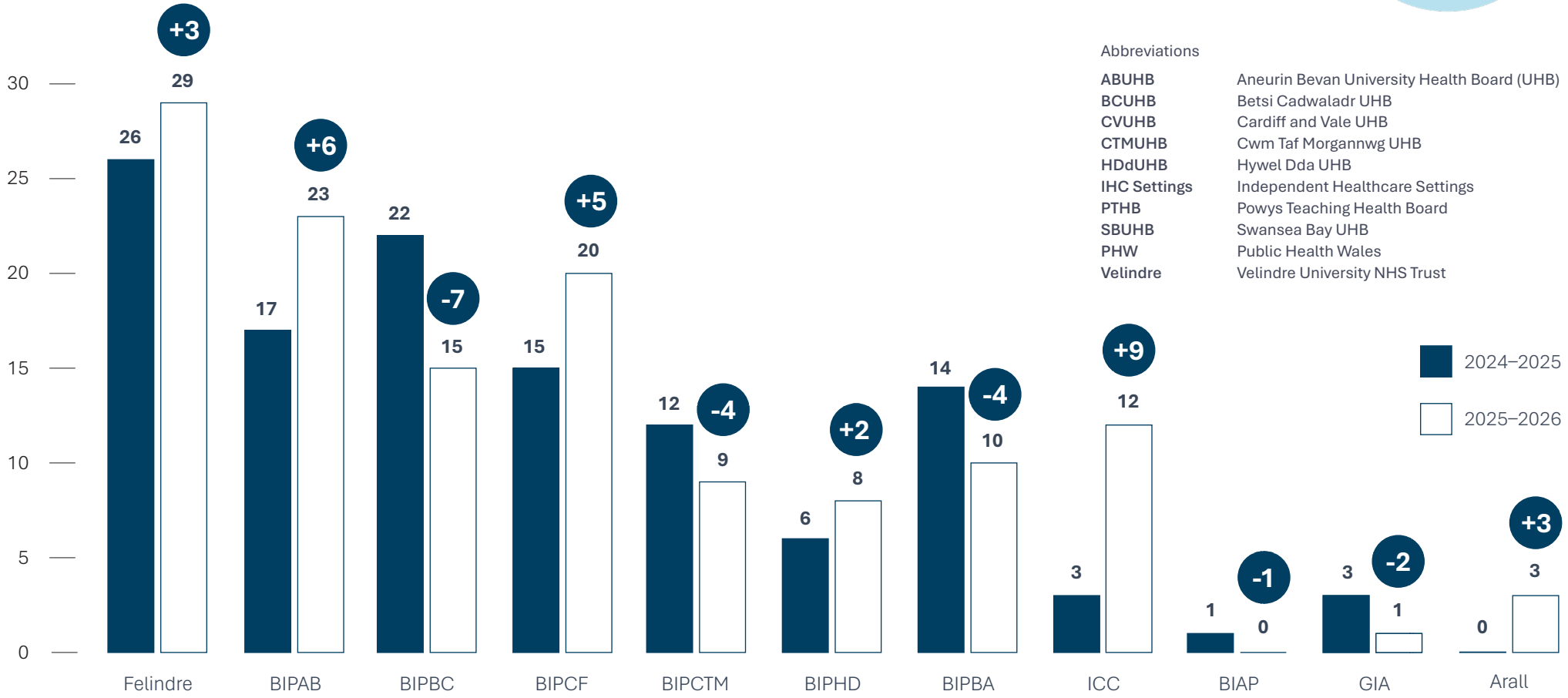
Regulation 30/31 notifications

Regulation 30/31 notifications increased during 2025–2026, driven primarily by a rise in serious injury notifications, which increased from 878 to 1,035. Notifications relating to deprivation of liberty also increased, while reports of alleged misconduct causing harm, unauthorised absences, infectious disease outbreaks and deaths outside hospices decreased. Death notifications from hospices remained broadly consistent with the previous year.



IR(ME)R notifications by location

Overall, the number of concerns and statutory notifications received in 2025–2026 increased compared with the previous year. This intelligence remains central to our role, enabling us to identify risks early, target our regulatory activity and support improvements in the quality and safety of care across Wales.



Private dental notifications

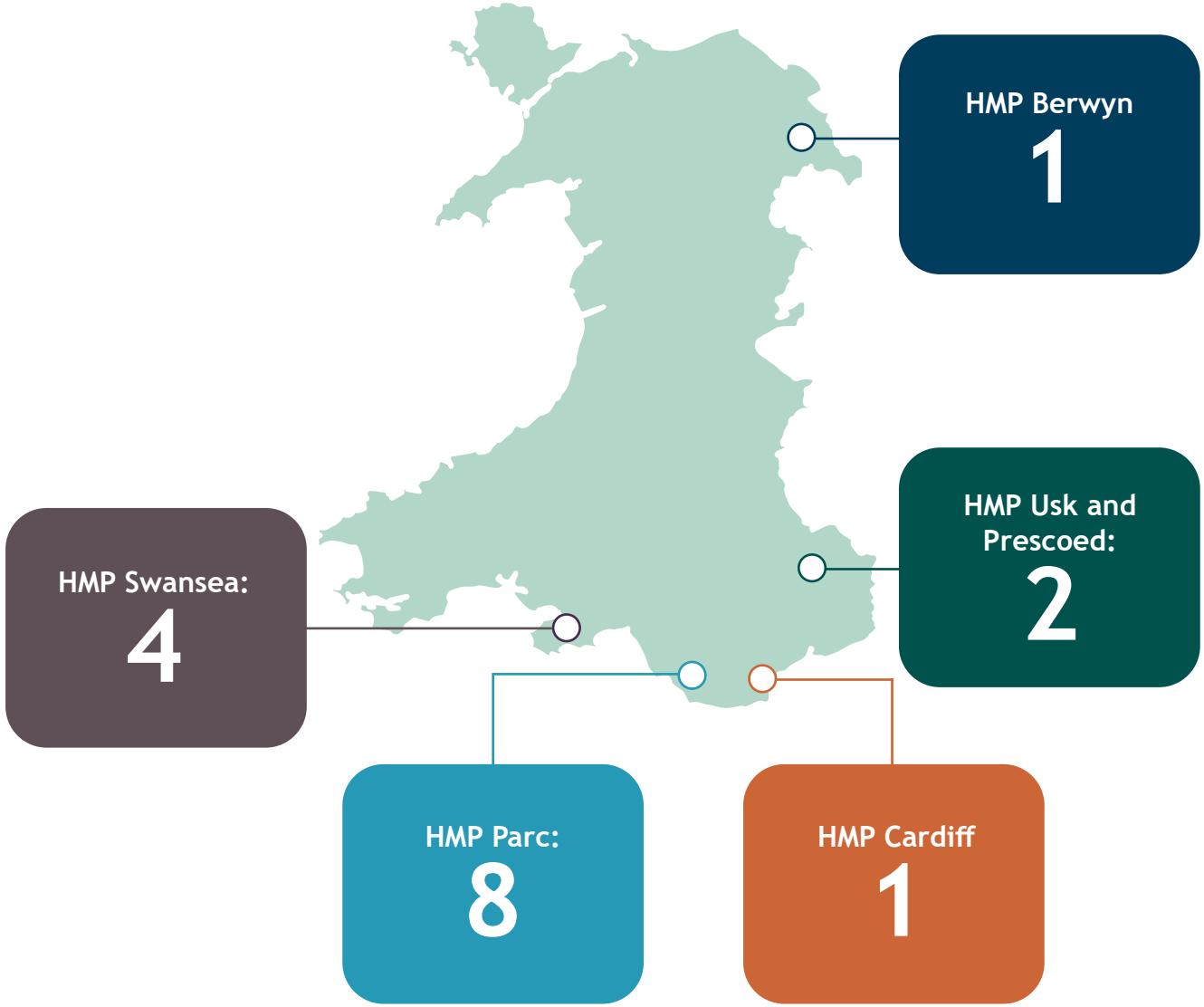
Private dental notifications remained low during 2025–2026. Serious injury notifications decreased from seven to four, while alleged misconduct notifications reduced from two to one. No notifications relating to infectious disease outbreaks or patient deaths were received.



Death in custody

In Wales, every death in custody is subject to independent investigation by the Prisons and Probation Ombudsman (PPO). As part of this national process, HIW undertakes clinical reviews to assess whether the healthcare provided was equivalent to that available in the community. These reviews focus on the timeliness, appropriateness and continuity of care.

Between 1 April 2025 and 31 March 2026, HIW was commissioned to undertake 16 clinical reviews across Welsh prisons, of which 11 were completed by year end. These were spread across the prison estate as shown in the map.



HMP Parc: Complex needs and systemic challenges

As in previous years, most reviews were undertaken at HMP Parc. Our findings highlight ongoing challenges in managing individuals with complex and multiple health needs, including chronic physical conditions, mental health issues, substance misuse and frailty.

Several reviews identified concerns in the early stages of custody, including delays or omissions in second-stage health assessments, and gaps in baseline observations and risk assessments. In several cases, there were missed opportunities to respond to deteriorating clinical indicators, such as abnormal test results or significant weight loss.

These findings reflect similar issues to those identified last year, highlighting ongoing challenges in ensuring early intervention and effective management of clinical risk.

There were also ongoing issues in the management of long-term conditions, particularly respiratory and cardiovascular disease, and in the care of frail individuals. Fragmentation between primary healthcare and substance misuse services limited effective information sharing and continuity of care. Delays in accessing clinical information and poor integration between services continued to contribute to gaps in care.

The use of remote GP provision, particularly out of hours and at weekends, was also linked to delays in clinical decision-making and, in some cases, reduced diagnostic accuracy. This highlights the impact that service models can have on the quality and timeliness of care.

Systemic weaknesses

Across other prisons, our reviews identified a pattern of system-wide issues, many of which mirror those seen in previous years. Individuals often presented with multiple vulnerabilities, including mental health needs, substance misuse and complex physical health conditions. However, care was not always coordinated or proactive.

A key concern was the quality and completeness of clinical documentation. In several cases, important information about health status, risks and clinical history was not fully recorded. This limited the ability of clinicians to make informed decisions and contributed to fragmented care.

We also identified variability in the use of risk assessment processes. In some cases:

- risk assessments were not completed or updated
- clinical decisions, including those related to medication or segregation, were not supported by full assessment
- face-to-face reviews were not always carried out where clinically indicated.

This reflects ongoing inconsistency in the application of safeguarding processes, including the use of Assessment, Care in Custody and Teamwork (ACCT) procedures and other risk management tools.

Oversight of individuals in segregation or restricted regimes was also variable. We identified gaps in:

- regular clinical review
- documentation of welfare checks
- healthcare involvement in decision-making.

These gaps are particularly significant given the vulnerability of this group and reflect concerns identified in previous years.

Across services, we also found limited proactive management of individuals with complex or deteriorating conditions, including those with frailty, self-neglect or multiple co-morbidities. Care plans were not always adapted to reflect changing needs, and escalation was inconsistent, leading to missed opportunities for earlier intervention.

There were also gaps in follow-up after clinical incidents, including falls, head injuries and reported health concerns. In some cases, appropriate monitoring and review were not clearly evidenced, particularly where staffing or access constraints applied. In addition, involvement of specialist mental health and in-reach services was variable at key points of risk.



Key findings and next steps

Taken together, our findings highlight continuing weaknesses in:

- integration between healthcare and custodial services
- the consistency of clinical assessment and decision-making
- proactive identification and management of risk
- oversight of vulnerable individuals, particularly in restricted settings.

While governance structures and clinical processes are generally in place, their effectiveness was mixed in the cases we reviewed, and key issues identified in 2024–2025 persist. This indicates limited progress in addressing underlying system challenges.

There is a clear need to strengthen:

- information sharing and coordination across services
- the consistency of clinical assessment, monitoring and follow-up
- multidisciplinary approaches to managing complex needs
- oversight and safeguarding for those at greatest risk.

These findings reinforce the need for a whole-system approach to healthcare, where clinical, custodial and support services work together to ensure risks are identified early and managed effectively. HIW will continue to provide independent scrutiny and challenge to support improvements in the quality and safety of care for individuals in custody.

08

Engagement and partnerships



Partnerships

During the year, HIW continued to strengthen its role as a system connector, enabling the sharing and triangulation of intelligence and the identification of emerging risks.

By working closely with partners across healthcare, regulation and government, we have supported collective oversight and improvement in the quality and safety of care across Wales. Through formal agreements and structured engagement, we have supported the sharing and triangulation of intelligence, helping partners to identify emerging risks and develop a collective understanding of system-wide challenges.



Formal agreements and intelligence sharing

HIW maintains close working relationships with a wide range of organisations. Formal **Memoranda of Understanding (MoUs)** underpin this work, setting out how we share information, manage risks, and coordinate activity.

These agreements support timely intelligence sharing, clear routes for escalating concerns, joint approaches to emerging risks and system pressures, and better alignment of regulatory and improvement activity. Together, they provide a framework for sharing intelligence, escalating concerns and supporting coordinated responses to risks affecting the quality and safety of care.

We regularly review these arrangements to ensure they remain effective and up to date. Between March 2025 and April 2026, HIW established or updated MoUs with the Independent Sector Complaints Adjudication Service (June 2025), the National Institute for Health and Care Excellence (June 2025), and the Royal College of Midwives (September 2025).

In addition, HIW strengthened partnership working through a number of wider agreements, including a strategic agreement with Audit Wales, Care Inspectorate Wales and Estyn (January 2026), an agreement with NHS Wales Performance and Improvement (February 2026), and a joint arrangement with Welsh Ministers, Care Inspectorate Wales and Healthcare Inspectorate Wales (March 2026).

These arrangements strengthen our ability to take a coordinated, system-wide view of quality and safety.

Engagement with NHS Wales

During 2025–2026, HIW introduced a new NHS Wales Engagement Process to strengthen how we engage with health boards and NHS trusts across Wales.

The process provides a structured approach to engagement between HIW and NHS organisations, supporting regular discussions with senior leaders and strengthening opportunities to share intelligence, explore emerging issues and seek assurance. It complements our inspection, review and

regulatory activity by helping us build a broader understanding of the challenges and risks affecting healthcare services across Wales.

Through this approach, HIW engaged with a range of senior leaders, including Executive Directors of Nursing, Medical Directors and Directors of Therapies and Health Science. Discussions covered key issues such as workforce pressures, service resilience, patient flow, governance, quality and safety risks, infection prevention and control, and wider system pressures affecting urgent and emergency care.

This engagement strengthens HIW's ability to gather timely intelligence, apply constructive challenge and better understand how organisations are responding to risks, pressures and recovery priorities. It also supports a more informed, evidence-based and risk-focused approach to our work.

National Healthcare Summits

In May and November 2025, HIW convened national Healthcare Summits, bringing together organisations from across audit, inspection, regulation and improvement to share intelligence on the quality and safety of healthcare services in Wales.

The Summits are a key mechanism for triangulating insight from across NHS Wales, enabling partners to develop a collective understanding of performance, emerging risks, and areas requiring improvement. They provide a structured forum for triangulating intelligence from across the system, helping partners to develop a shared understanding of performance, emerging risks and areas requiring improvement. Insight from the summits informs organisational work programmes, supports alignment between partners, and enables coordinated responses to system pressures.

Across both summits, partners identified a set of system-wide challenges:

Access to care and patient flow

There has been some progress in improving access to healthcare, including the use of virtual appointments and more targeted GP services. However, long waiting times for planned care remain a major concern, with delays in diagnosis and treatment continuing to affect patient safety.

While some health boards have improved emergency care performance, significant pressures remain. Emergency departments continue to experience crowding, ambulance handover delays persist, and difficulties in discharging patients mean beds are not always available when needed. These issues continue to affect the flow of patients through the system.

Mental health and vulnerable groups

There are examples of positive local work to improve mental health services, including faster access to support in some areas. However, serious concerns remain.



Partners highlighted issues with access to crisis support, the quality of inpatient care, safeguarding arrangements, and support after discharge. There were also concerns about how risks are managed, including gaps in observation, inconsistent discharge planning, and weaknesses in how services keep people safe.

Quality, safety and governance

The summits identified ongoing concerns about how organisations manage incidents, respond to complaints, and learn from what goes wrong.

Delays in investigating incidents and taking action remain a challenge, and in some cases learning is not followed through effectively. Challenges with data quality, and inconsistent use of the duty of candour, make it harder to clearly understand risks and ensure improvements are made.

Workforce, culture and leadership

Staffing pressures continue to affect services across Wales. These include difficulties recruiting staff, high levels of sickness absence, and a continued reliance on temporary staff.

In some services, there are concerns about training compliance and reliance on a small number of key individuals, creating risks if those staff are not available. Cultural issues also remain significant in some areas, including concerns about bullying, poor staff engagement, and staff feeling unable to speak up.

System sustainability and strategic pressures

There are growing concerns about the long-term sustainability of some services. Financial pressures are increasing and were identified as a growing risk to the quality and delivery of care.

A key issue raised was the continued focus on short-term actions to manage immediate pressures, rather than longer-term planning to address underlying challenges and support sustained improvement across the system.



Clinical insight

Over the past year, HIW's Clinical Team has continued to play a vital role in embedding clinical expertise at the heart of our inspection, assurance and regulatory work. Their contribution has strengthened how we assess concerns, plan inspections and interpret findings, ensuring our work reflects current clinical practice and remains focused on quality, safety and patient experience.



Use of Peer Reviewers

HIW continues to use clinical peer reviewers to bring frontline expertise and specialist insight into our work. These professionals, who remain active in clinical practice, provide an independent and practical perspective on how care is delivered.

During the year, we further strengthened this approach by identifying and matching the right expertise to specific areas of inspection activity. Peer reviewers have supported a wide range of assurance work, provided external challenge and helped ensure our findings are clinically credible, evidence-based and relevant to the services we review.

Their involvement also helps us stay connected to the realities of service delivery and supports a culture of shared learning and improvement across the healthcare system.

Providing expert advice

The Clinical Team provided expert advice and challenge across a broad range of inspection and review activity. This includes supporting inspection planning, identifying areas of clinical risk, and reviewing immediate assurance and non-compliance findings to ensure clinical accuracy.

Throughout the year, the team evaluated whether organisational responses and action plans from healthcare services following our inspections provided sufficient assurance, helping ensure that our conclusions are robust and focused on the issues of greatest importance to patients and services.

Throughout the year, the team responded to a wide range of clinical and operational issues, including patient safety concerns, infection prevention and control, safeguarding, governance matters and emerging incidents. This included providing informed clinical input on complex and evolving issues, such as outbreak management and situations requiring detailed professional judgement.

This work enabled HIW to respond in a timely and informed way, ensuring that decisions were supported by sound clinical expertise and a clear understanding of the wider healthcare context.

Engagement – Listening and learning

Listening to the people who use and work in healthcare services remains at the core of our work. Their experiences help us understand how care is delivered across Wales and where change is needed most.

We build this understanding through every part of our approach. During inspections and reviews, we speak directly with staff, patients and carers, using conversations and surveys to gather real, lived experience. Beyond inspections, we continue to expand how we engage using digital platforms, campaigns, and face-to-face opportunities to reach more people and hear more voices.



This year:

216
on-site inspections carried out

1,628
staff surveys completed

4,407
patient, carer and public surveys returned

2,353
responses to Strategy Consultation

This insight strengthens our findings, challenges assumptions and drives improvement. People's voices are not just captured; they actively shape our work and influence change across healthcare services.

Raising awareness and building public confidence

During 2025–2026, we continued to publish inspection reports and key findings, with many attracting regional and national media coverage across major outlets. This included both live and recorded interviews, helping raise awareness of HIW's role and reinforcing public confidence in independent scrutiny.

We have also strengthened our digital presence and reach, ensuring more people understand who we are and how we work.

Our latest engagement data shows:

50%
of the public now recognise HIW, up from 47% in 2024

19%
of people became aware of HIW through online sources or websites

23%
through radio

20%
through social media

This growing visibility is important as it supports transparency, reassures the public that services are independently monitored, and encourages providers to maintain high standards of care.

Accessible, inclusive and impactful engagement

We are continuing to build an approach to engagement that is accessible, inclusive and reflects the diversity of communities across Wales.

During 2025–2026, we have:

- Strengthened our digital offer, including expanding use of video, animation and new platforms to reach wider audiences.
- Continued to improve accessibility across our website and publications, with a sustained focus on clear language and inclusive formats including Easy Reads.
- Increased the use of web-based content instead of PDFs to make information easier to access and keep up to date.
- Developed internal guidance and tools to support staff in producing accessible, inclusive content.

We are also exploring new ways to engage, testing different channels, formats and approaches to ensure we are reaching people in ways that work for them.

Learning and insight that drives improvement

We continue to strengthen how we share learning from our work to support improvement across healthcare.

- Our **Insight Bulletins** continue to reach a growing audience, sharing key findings, risks and examples of good practice.
- Engagement with our News and Insight Bulletins has increased, showing strong interest in our work and findings.
- We have expanded digital content and improved how we present insights online, making them clearer and easier to use.

By making our insight more accessible and practical, we are helping providers, policymakers and the public understand what good care looks like and where improvement is needed.

Being visible, building trust

We are more visible than ever, with increased participation in national events, stakeholder forums and public engagement opportunities.

This year, we:

- attended major national events such as the Mental Health and Wellbeing Show, and professional conferences
- engaged directly with healthcare professionals, stakeholders and the public
- promoted our work and increased awareness of opportunities to get involved, including peer reviewer roles.

We also refreshed our exhibition materials to ensure they are engaging, inclusive and environmentally sustainable reflecting our values in both design and delivery.

Engagement highlights

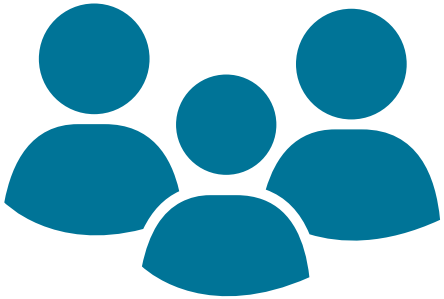
- 8.1% increase in new social media followers
- 29k video views across platforms (+437% from 5.4k last year)
- 1.6k social media posts published (+14.3% from 1.4k last year)
- 833k impressions across social media (+24.4% from 670k last year)
- 556k website views (+8.8% from 511k last year)
- 180 inspection reports and 38 news items published
- 13 press notices issued
- 9k+ newsletter subscribers
- 48 editions of our internal newsletter ‘Connect’ shared with staff

Championing Equality, Diversity and Inclusion (EDI)

We remain committed to ensuring our work reflects the diversity of the communities we serve. Our **Joint EDI Strategy (2024–2028)** with **Care Inspectorate Wales (CIW)** continues to guide this work, aligning with Welsh Government priorities and strengthening collaboration across inspectorates.

Why EDI matters

People's experiences of healthcare are shaped by their identity, background and circumstances. By recognising this, we can better assess whether services are accessible, respectful and responsive.



What we have delivered this year

- **Embedding EDI in inspections:** Equality and inclusion considerations are now built into inspection processes, including accessibility, language, disability and digital exclusion.
- **Improving how we use data and insight**: We are strengthening how we capture and analyse equality data to identify trends and risks across the system.
- **Strengthening engagement with diverse communities:** We have increased engagement with organisations representing underrepresented groups to better understand lived experience.
- **Developing our workforce:** Staff have taken part in EDI learning and development, alongside dedicated sessions focused on lived experience.
- **Internal EDI Champions Group:** Continues to provide leadership, challenge and oversight, ensuring EDI is embedded across our work.

These actions are helping us build a more inclusive organisation and improve how we engage with people, providers and partners.

Working with our Stakeholder Advisory Group

Our **Stakeholder Advisory Group (SAG)** continues to play a critical role in shaping our work.

The group brings together organisations representing a wide range of communities across Wales, helping us better understand the needs, experiences and barriers faced by diverse groups. This ensures our work reflects the issues that matter most to people and communities.

This year, the group has:

- expanded its membership, strengthening representation from diverse communities
- contributed to our Strategy 2026–2030 consultation and wider engagement activity
- provided insight on accessibility, inclusive communication and lived experience.

How the group is shaping our work

The group plays an active role in influencing how we plan, deliver and improve our work. Their input has helped us to:

- **design and improve our engagement approaches, ensuring they are accessible and reach a wider range of people**
- **strengthen how we capture and interpret lived experience, particularly from underrepresented groups**
- **shape our priorities and areas of focus, including where we direct our assurance and improvement activity**
- **improve how we communicate, making our content clearer, more inclusive and easier to understand**
- **identify potential inequalities and barriers, helping us challenge where services may not be meeting people's needs**

Their insight helps us better understand where healthcare services are working well, and where improvement is needed, particularly for those most at risk of poorer experiences or outcomes. Their input helps ensure our work is informed by real experiences and that our approach remains inclusive, relevant and focused on improving healthcare for everyone across Wales.

Welsh language – The Active Offer

We are committed to making the Welsh language a natural, visible and integral part of how people experience healthcare in Wales. For many people in Wales, particularly children, older people, people with dementia, those with learning disabilities and people experiencing mental ill health, being able to communicate in Welsh is not simply a matter of preference. It can be fundamental to dignity, understanding, participation in care and wellbeing.



Strengthening how we assess and influence Welsh language provision

This year, we have taken a more structured approach to assessing Welsh language provision through our inspection work. This includes:

- routinely reviewing how services deliver the Active Offer, including communication, signage, patient information and staff visibility
- checking whether services ask and record patients' language preference, which remains a key area for improvement
- including Welsh language considerations in inspection questions and findings, ensuring they inform our recommendations and follow-up work.

We are also supporting national progress by sharing clear evidence from inspections on how services enable people to receive care in their preferred language.

What we are seeing

Our inspection findings show a mixed picture:

- There is strong practice in some services, where Welsh is used confidently, bilingual information is visible, and patients are actively supported to speak Welsh.
- While we continue to identify positive examples of the Active Offer in practice, our findings show that access to Welsh-language services remains variable. Too often, provision depends on individual staff members rather than being effectively built in to organisational systems, workforce planning and service delivery.

Through our wider engagement and strategy consultation, we also heard that:

- access to Welsh-medium care is not always reliable in practice
- the Active Offer is not consistently delivered
- barriers include workforce capability, confidence and training.

Through our inspections and engagement work, people continue to tell us that whether or not they get to receive care in their preferred language affects their ability to understand information, express concerns, participate in decisions and maintain their dignity. This can be particularly important when people are at their most vulnerable.

Driving improvement across the system

We are using these insights to strengthen expectations and drive improvement. We are:

- highlighting the need for services to embed the Active Offer consistently, not just in principle but in day-to-day practice
- reinforcing the importance of recording language preferences from the outset of care
- supporting a stronger focus on Welsh language workforce planning, ensuring services have the skills needed to meet patient needs.

We continue to identify and share positive examples, including:

- staff proactively offering services in Welsh
- clear use of bilingual materials
- improved visibility of Welsh-speaking staff.

At the same time, we are clear where improvement is required, particularly where Welsh language provision is variable, not visible, or not fully integrated into systems and processes.



Our commitment

We will continue to strengthen how we assess, report and follow up on Welsh language provision. This includes being more visible, more consistent and more proactive in highlighting where change is needed. People should not have to rely on chance to receive healthcare services in Welsh. The Active Offer should be a routine feature of care across Wales, not something dependent on individual staff, local enthusiasm or good fortune. While progress is being made, our work shows there is still some way to go before Welsh language provision is fully embedded across the healthcare system.

By doing this, we aim to ensure that the Welsh language is not an add-on, but a core part of safe, high-quality and person-centred care across Wales.

In addition, all of our public-facing communications continue to be fully bilingual, and we have strengthened how the Welsh language is embedded across our public engagement work.

We also publish key communications bilingually and support staff to build confidence and understanding through initiatives such as Cornel Cymraeg (Welsh Corner) within our internal staff newsletter.

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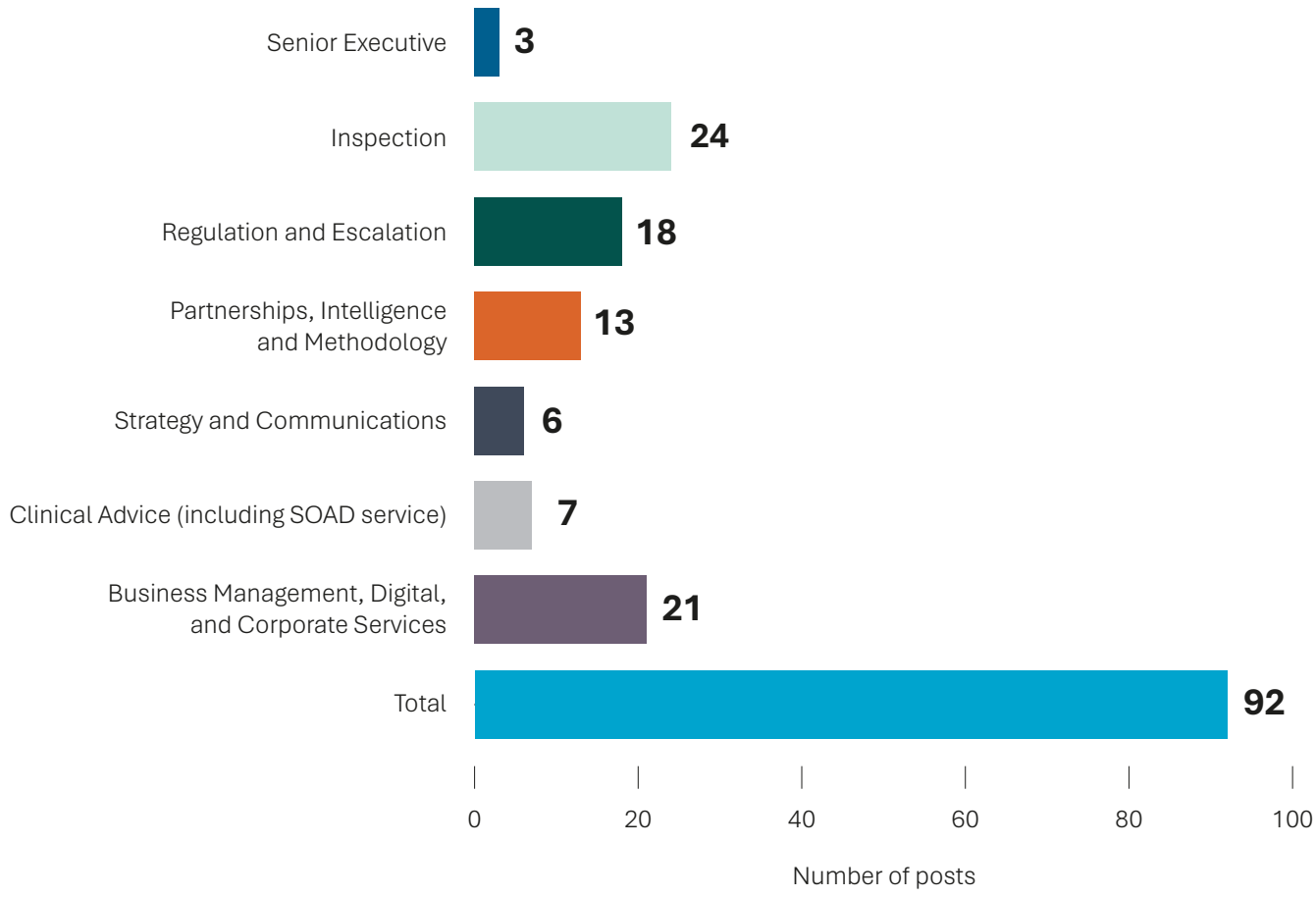
Our resources

Our people remain our most important resource. In 2025-2026, we continued to invest in a comprehensive programme of learning and development opportunities, shaped directly by staff feedback. This was complemented by a series of Lessons Learnt exercises, enabling us to reflect on our work and continuously improve.

Our internal People Forum was reviewed and strengthened. It remains a valuable and credible source of feedback, providing senior HIW managers with insight on staff experience and supporting organisational development.

We are supported by a strong pool of specialist expertise. This includes over 150 Peer Reviewers with clinical backgrounds, alongside our Mental Health Act Administration specialists and a panel of psychiatrists delivering our Second Opinion Appointed Doctor (SOAD) service. In addition, our 44 Patient Experience Reviewers and Experts by Experience play a vital role in assessing care through direct engagement with patients.

Our Customer Relationship Management (CRM) system migrated to updated software in early 2026 and continues to generate valuable data, supporting the work of teams across HIW.



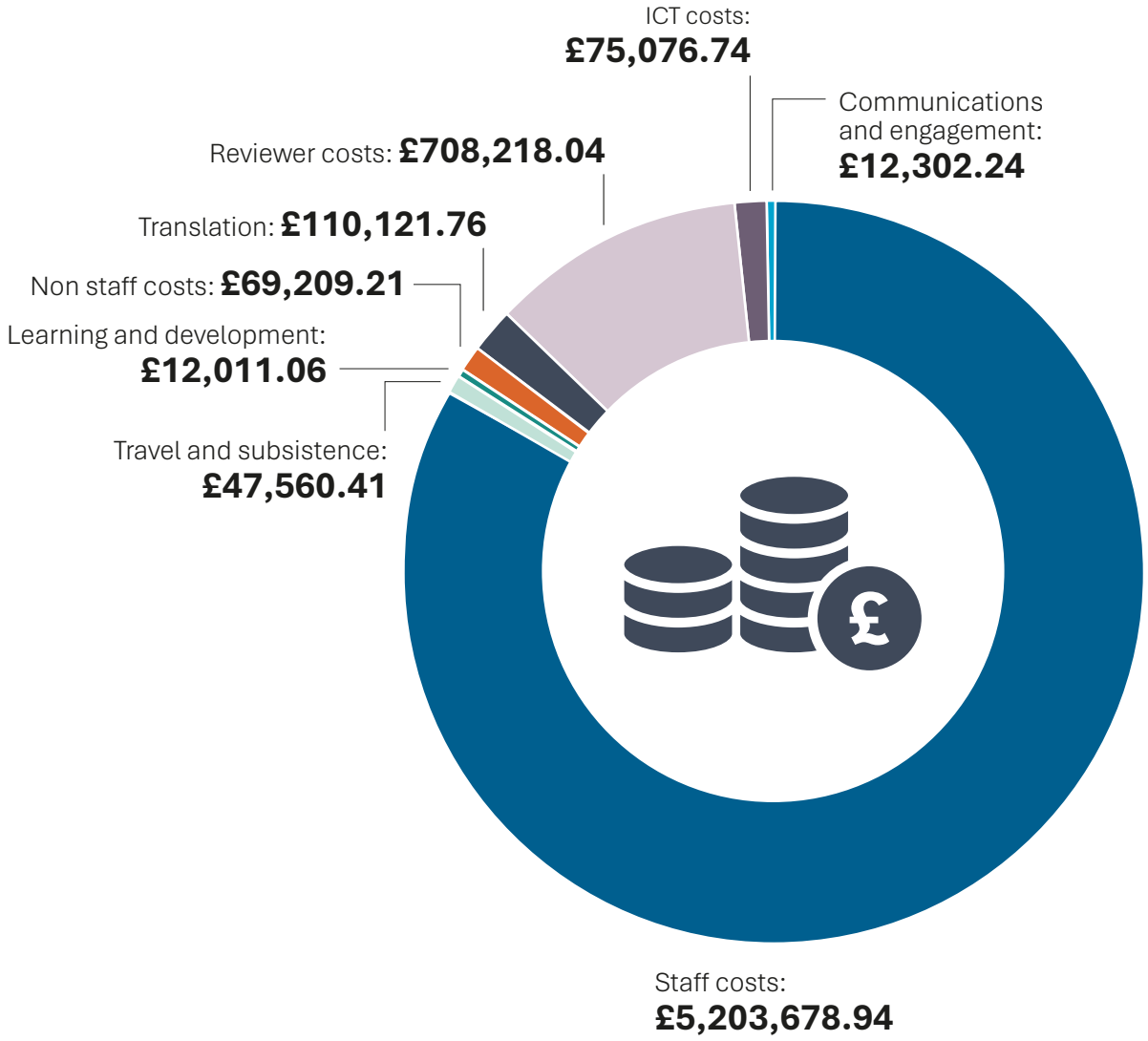
Finance

For 2025-2026 we had a budget of approximately £6.2m, which includes fee income from our regulatory role in the independent sector. The table below shows how we used the financial resources available to us in the last financial year to deliver our work in 2025-2026.

Total expenditure (a)
£6,238,178

Income from independent healthcare (b)
£580,350

Total net expenditure (a – b)
£5,657,827



Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Contact us

This publication and other HIW information can be provided in alternative formats or languages on request.

There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our website or by contacting us:

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Mae'r ddogfen hon ar gael yn Gymraeg hefyd / This document is also available in Welsh
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg / We welcome correspondence and telephone calls in Welsh

7.2

7.2 - Listening and Learning Sub Committee Update Report

Louise O'Connor (Hywel Dda Health Board - Assistant Director), Mark Henwood (Hywel Dda UHB - Executive Medical Director)

For assurance

Attachments

3As report sept 2026 - Listening and Learning Sub-Committee.pdf

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

Date of last meeting/ Dyddiad y cyfarfod diwethaf: 10 September 2026
Quoracy/ Cworwm: Met
Report by/ Adroddiad gan: Eiry Edmunds, Sub-Committee Vice Chair

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

Alert[1] (may require discussion)/ Rhybuddio (efallai y bydd angen trafodaeth)
The Listening and Learning Sub-Committee had no matters of which to **alert** the Committee:

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

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

- A patient story relating to early pregnancy loss highlighted a significant gap in access during evenings, weekends and bank holidays. The patient reported making 126 calls to the dedicated early pregnancy line when the service was not staffed and no clear or reliable alternative route was available. Members requested a comprehensive action plan covering call handling, answerphone ownership, out-of-hours and bank holiday arrangements, medical and nursing input, psychological support, pathway review and measurable evidence of improvement.

- Members noted that unstaffed telephone lines, unclear answerphone messages and inconsistent signposting were not confined to gynecology and represented a wider organisational risk. In particular, patients may be given an expectation that messages will be received or returned when a service is unavailable. The Sub-Committee will monitor development of the single point of contact and communication hub to ensure that streamlined access does not introduce additional hand-offs or barriers to clinical advice. A further update is expected in early 2027.

- The Sub-Committee identified pain management and preparation for outpatient hysteroscopy as requiring prompt action. Among the 64 completed procedures reviewed, 60% of patients reported moderate pain or above, including 23 who scored pain at 8 or 9. Members noted the implications for consent, pain relief, dignity and the accuracy of pre-procedure information. Subject to final approval, the service intends to introduce Penthrox in the outpatient setting and repeat the patient survey following an initial three-month

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[2] *There are areas of concern where assurance has been taken on actions in place but requires close monitoring. An early warning of an emerging and potentially serious concern*.

implementation period. Benchmarking against relevant best-practice guidance and review of conversion rates will also be undertaken.

- Triangulation of patient experience, complaints, claims and redress information identified consistent themes relating to communication, continuity, pathway ownership, follow-up, implementation of multi disciplinary team decisions, consent, expectation management and safety-netting. Members noted that patient experience feedback remained predominantly positive, particularly in relation to kindness, compassion, professionalism, respect and teamwork. Overall experience scores were 93% at Withybush, 87.5% at Bronglais and approximately 80% at Glangwili and Prince Philip Hospital. Further improvement is required in communication, access, follow-up and continuity, supported by clear evidence of impact.

- The comparative review of gynecology complaints for January to June 2025 and the corresponding period in 2026 will return to the Sub-Committee. Members requested clear ownership across medical, nursing and service delivery teams, together with evidence that learning has been shared and translated into action.

- Members emphasised that communication improvement must extend beyond individual skills and reflect accessible information standards, language and sensory needs, neurodiversity, sufficient time and appropriate environments for sensitive discussions.

- The patient and carer information policies require broader clinical review and a clear implementation approach. Members highlighted the need to strengthen accessibility, use of approved information resources, documentation, consent, confirmation of patient understanding and compliance monitoring.

- A potential Public Services Ombudsman for Wales public interest report relating to colorectal care remains under consideration. The Health Board has submitted a clinical response and requested that the Ombudsman reconsider whether the public interest threshold has been met.

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

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

- The draft Welsh Risk Pool assurance and audit report provided substantial assurance across incident management, Duty of Candour, complaints, redress and claims. The report recognised positive governance arrangements, the quality of complaint response letters and strong redress and claims practice. A formal action plan will be presented following receipt of the final report.

- Two final Ombudsman reports received since the previous meeting were not upheld. Members also noted that no Ombudsman investigation relating to gynecology had been initiated since October 2024.

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

Review Of Risks/ Adolygiad O Risgiau

The principal risk is that recurring concerns relating to access, communication, consent, pathway coordination and follow-up are addressed in isolation rather than as connected areas for improvement. This may result in avoidable distress, delays in care, poor patient understanding, inconsistent safety-netting and increased complaints or liability exposure.

Ongoing oversight is required in relation to out-of-hours contact arrangements, the early pregnancy pathway, and pain management and consent for outpatient hysteroscopy.

Recommendation/ Argymhelliad

The Quality, Safety and Experience Committee is asked to:

- **Note** the matters identified for ongoing monitoring; and
- **Take assurance** from the items that the Sub-Committee is providing assurance on.

Date of next meeting/ Dyddiad y cyfarfod nesaf: 19 November (theme radiology)

7.3

7.3 - Infection Prevention and Control Assurance Report

Sharon Daniel (Hywel Dda UHB - Executive Director of Nursing, Quality & Patient Experience), Cathie Steele (Hywel Dda UHB - Interim Assistant Director of Nursing Assurance and Safeguarding), Rebecca Richards (Hywel Dda UHB - Head of infection prevention)

For assurance

Attachments

IPC Assurance Report to QSEC October 2026.pdf

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	08 OCTOBER 2026
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Infection Prevention and Control Assurance Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Sharon Daniel, Executive Director of Nursing, Quality and Patient Experience
SWYDDOG ADRODD: **REPORTING OFFICER:**	Cathie Steele, Interim Assistant Director of Nursing Assurance and Safeguarding Rebecca Richards, Head of Infection Prevention

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to enable the Quality, Safety and Experience Committee (QSEC) to consider the effectiveness of the Health Board's infection prevention and control (IPC) arrangements. It sets out progress against the IPC Organisational Improvement Plan 2026–27, Welsh Government targeted intervention requirements and Internal Audit recommendations; the current healthcare-associated infection (HCAI) performance position; evidence of improvement and organisational learning; and the areas where further evidence, action or sustained improvement is required.

Cefndir / Background

Infection Prevention and Control remains a key organisational priority due to the Health Board's ongoing targeted intervention status relating to healthcare associated infections.

In January 2026, Welsh Government confirmed that the Health Board would remain in targeted intervention for quality of care associated with HCAIs and identified requirements relating to:

- Sustained reduction in hospital-onset infections.
- Delivery of a robust quality improvement programme.
- Strong governance and leadership arrangements.
- Effective outbreak response mechanisms.
- Clear Board oversight and scrutiny of improvement activity.

Following the Internal Audit review of IPC, which resulted in a 'Limited Assurance' opinion, the Health Board developed and implemented an IPC Organisational Improvement Plan. The plan provides the framework through which improvement activity, surveillance, governance, quality assurance, quality control and quality improvement are coordinated and monitored.

The Improvement Plan has been developed using the principles of Quality Planning, Quality Control, Quality Assurance and Quality Improvement and aligns organisational priorities with Welsh Government expectations, the IPC Quality Statement and requirements associated with targeted intervention.

A detailed summary of progress against the IPC Organisational Improvement Plan 2026/27 is provided in Appendix 1.

Asesiad / Assessment

The evidence presented demonstrates strengthened governance, audit and improvement arrangements, alongside active management of outbreaks and delivery of workforce education. However, the position remains mixed: hospital-onset infections continue to be a key concern, IPC Level 2 training compliance remains below expectation and further evidence is required that improvement actions are consistently embedded across Clinical Care Groups and are producing sustained improvement in outcomes. These areas are set out below to support the Committee's consideration of whether current controls and improvement arrangements are sufficiently effective.

Quality Assurance

Governance and Assurance Framework

The Infection Prevention Strategic Steering Group (IPSSG) provides strategic oversight of IPC arrangements and delivery of the Organisational Improvement Plan. Progress is routinely monitored through established governance arrangements and reported through organisational oversight mechanisms.

Since approval of the Improvement Plan, significant progress has been made in strengthening organisational assurance arrangements through:

- Development of an IPC Assurance Framework.
- Implementation of a comprehensive IPC Audit Programme.
- Continued HCAI assurance reviews.
- Strengthened governance and reporting expectations across Clinical Care Groups and IPSSG subgroups.

The IPSSG Terms of Reference have been reviewed to strengthen the Group's authority, membership, reporting expectations and escalation arrangements. The revised Terms of Reference will require each Clinical Care Group (CCG) to report routinely to IPSSG on progress against its IPC improvement actions, HCAI performance, audit findings, workforce compliance, risks and exceptions. Progress will be reviewed at each IPSSG meeting using the agreed improvement plan and exception-reporting arrangements, with CCG leads accountable for explaining variance, confirming remedial action, ownership and timescales. Actions will only be recorded as complete when the required evidence has been submitted and validated through the agreed governance process. Actions that remain overdue, off trajectory or unsupported by sufficient evidence will be escalated through the relevant CCG governance route and, where unresolved or of material significance, to the Executive Team and QSEC for further scrutiny.

These arrangements provide greater triangulation of surveillance, audit findings, training, improvement activity and outbreak management, supporting enhanced organisational assurance and oversight.

To further strengthen organisational assurance and support improvement, the Health Board hosted a supportive visit by the Head of Nursing for Infection Prevention/ The Healthcare

Associated Infection, Antimicrobial Resistance and Prescribing (HARP) Public Health Wales (PHW) on the 9 September 2026 at Glangwili Hospital (GGH). The visit provided independent professional challenge and expert advice, enabling the organisation to benchmark progress against national expectations, identify opportunities for improvement and share examples of good practice.

Internal Audit Progress
Substantial progress has been made in responding to recommendations arising from the Internal Audit review.

Key improvements include:

- Implementation of a Board-approved IPC Organisational Improvement Plan.
- Development of a comprehensive IPC Audit Programme.
- Strengthening of governance and reporting arrangements.
- Increased oversight of workforce compliance and improvement actions.

Progress has been made in responding to the Internal Audit recommendations.

Targeted Intervention
The Health Board remains subject to targeted intervention arrangements relating to HCAIs. Progress against improvement actions and delivery against Welsh Government requirements continues to be monitored through established governance structures.

Focus remains on:

- Hospital-onset Clostridioides difficile infections.
- Hospital-onset bacteraemias.
- Delivery of the IPC Improvement Plan.
- Governance and organisational assurance arrangements.
- Demonstration of sustainable improvement and organisational learning.

<u>Quality Control and Quality Planning</u>
Quality Statement for IPC
Work continues to progress against the Welsh Government Quality Statement for IPC. Assessment against the quality attributes is being used to inform organisational priorities, identify improvement opportunities and align delivery of the IPC Organisational Improvement Plan with national expectations.

NHS Wales National Standards of Healthcare Cleanliness
Work is continuing to align local assurance, audit and improvement arrangements with the NHS Wales National Standards of Healthcare Cleanliness. These standards provide a national framework for the provision and maintenance of safe, clean healthcare environments and support IPC quality assurance arrangements.

Healthcare Associated Infection Performance
Performance against Welsh Government HCAI Improvement Goals remains mixed.

Areas currently performing in line with trajectory include:

- Methicillin-resistant Staphylococcus aureus (MRSA) overall and hospital-onset performance.
- Overall Klebsiella trajectory.
- Overall Pseudomonas trajectory.

Areas requiring continued improvement include:

- Overall and hospital-onset Clostridioides difficile.
- Hospital-onset Meticillin-sensitive Staphylococcus Aureus (MSSA).
- Hospital-onset Klebsiella.
- Hospital-onset Pseudomonas.
- Overall and hospital-onset E. coli.

Hospital-onset infections remain the principal determinant of future de-escalation discussions and continue to be a primary area of organisational focus.

An Executive-led Weekly C. difficile Review Panel has been introduced to provide focused oversight of each new hospital-onset case and the delivery of associated improvement actions. The Panel brings together executive, IPC, antimicrobial stewardship and Clinical Care Group representation to review the findings of case investigations, identify contributory factors and recurring themes, agree immediate corrective action and monitor delivery to completion. Clinical Care Groups are required to account for identified lapses, confirm responsible owners and timescales, and provide evidence that actions have been implemented and tested. Actions will only closed when the Panel is satisfied that sufficient evidence of completion and impact has been provided; unresolved, repeated or material exceptions are escalated through IPSSG and the relevant executive governance route, with significant concerns reported to QSEC.

Community Infection Prevention and Health Protection

The Community IPC and Health Protection Team continues to provide specialist support across community services, care providers and partner agencies to prevent and manage infection risks.

During 2026/27, significant closed setting activity has been associated with management of:

- Respiratory outbreaks.
- Gastrointestinal outbreaks.
- COVID-19 incidents.
- Scabies outbreaks, including incidents involving crusted scabies.

Management of these incidents has demonstrated effective multi-agency working involving Health Protection Teams, Primary Care, Local Authorities, community providers and IPC specialists.

Learning arising from outbreak investigations has informed improvements relating to:

- Early recognition and escalation of infection risks.
- Treatment and prescribing pathways.
- Contact management processes.
- Environmental decontamination.
- Education and support for community-based staff.

Recurrent scabies outbreaks continue to present a system risk. Incidents are being identified, escalated and managed through multi-agency arrangements, and learning has informed treatment, contact management, decontamination and staff education.

Winter Preparedness

A Winter Acute Respiratory Infection Preparedness Framework has been developed in response to lessons identified during previous winter periods.

Priority areas include:

- Respiratory cohorting and isolation arrangements.

- Escalation planning.
- Workforce surveillance.
- Respiratory dashboards.
- Enhanced monitoring and audit processes.
- Respiratory outbreak preparedness.

The Winter Acute Respiratory Infection Preparedness Framework sets out organisational arrangements for cohorting, isolation, escalation, surveillance, dashboard monitoring and outbreak management.

Quality Improvement

Workforce Development, Education and Training

Workforce development remains a key component of the IPC Organisational Improvement Plan and supports sustainable improvement in infection prevention practice, outbreak management and patient safety.

Current IPC Level 2 mandatory training compliance is:

- Required staff: 9,489
- Completed: 7,107
- Compliance: 74.9%

IPC Level 2 compliance is 74.9% (an improvement from 71% noted by Internal Audit in December 2025), with Medical and Dental staff compliance at 56.0% (an improvement from 41.12% noted by Internal Audit). This position indicates that essential IPC knowledge may not yet be consistently embedded across the workforce.

Current Aseptic Non-Touch Technique (ANTT) compliance is:

- Required staff: 6,980
- Completed: 5,960
- Compliance: 85.4%

Whilst the overall ANTT position exceeds the organisational target of 85%, Medical and Dental staff compliance remains lower at 65.2% and will continue to be monitored through established governance arrangements.

In addition to mandatory training programmes, the IPC Team has maintained a significant programme of targeted opportunistic education.

Between April and September 2026, the IPC Team delivered 205 opportunistic training interactions across acute hospital sites. Training was delivered directly within clinical environments and focused on real-time learning in response to outbreaks, surveillance findings, incidents and quality improvement priorities.

Key educational themes included:

- Scabies awareness and management.
- Hand hygiene.
- Chain of infection.
- Commode cleaning and decontamination.
- Personal Protective Equipment (PPE).
- Equipment decontamination.

Approximately 125 interactions related to scabies awareness, reflecting learning from acute and community outbreak activity. A further 42 interactions focused on hand hygiene improvement.

Training activity was principally delivered at GGH, Withybush Hospital (WGH), Prince Philip Hospital (PPH) and Bronglais Hospital (BGH) and involved a broad range of multidisciplinary staff groups.

Organisational Learning and Improvement
Learning from HCAI reviews, outbreak investigations, surveillance findings and assurance activity is disseminated through IPSSG, Clinical Care Groups, locality meetings and targeted education sessions.

Recent learning has focused on:

- Clostridioides difficile management.
- Scabies outbreak management.
- Environmental decontamination.
- Hand hygiene compliance.
- Escalation and outbreak management processes.
- Aseptic technique and device-associated infection prevention.

This approach supports a culture of continuous improvement and ensures that learning is translated into practical improvement activity across services.

Improvement Programmes
Improvement activity continues through:

- Clostridioides difficile improvement initiatives.
- Antimicrobial stewardship programmes.
- Hand hygiene improvement activity.
- ANTT monitoring and improvement work.
- Local Clinical Care Group improvement plans.
- Delivery of actions arising from the IPC Organisational Improvement Plan.

Taken together, the evidence shows strengthened IPC governance, audit, surveillance, education and improvement arrangements. It also shows that hospital-onset HCAI performance remains mixed, workforce compliance is variable and several changes require further evidence of consistent implementation and sustained impact.

Argymhelliad / Recommendation

The Quality, Safety and Experience Committee is asked to:

- Consider the evidence presented on delivery of the IPC Organisational Improvement Plan, implementation of Internal Audit recommendations, current HCAI performance, workforce compliance, outbreak management and organisational learning.
- Consider whether the governance arrangements, controls and improvement actions described are operating effectively and providing sufficient evidence of sustained improvement.
- Identify any areas where further evidence, escalation or corrective action is required.
- Receive assurance regarding the effectiveness of executive oversight arrangements for hospital-onset infection trajectories, workforce compliance, Clinical Care Group

accountability, community outbreak management and delivery of the IPC Organisational Improvement Plan.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	3.7 Receive assurance on delivery against the areas of targeted intervention, and the required elements for de-escalation, that are aligned to the Committee
Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	838 Risks of substandard provision of Microbiology services at WGH due to poor laboratory Infrastructure 1640 Risk of harm to patients due to a lack of recommended Airborne Isolation Suites 2457 Risk to patient, staff and visitor safety due to feral pigeon population control at Withybush General Hospital
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	Not Applicable
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Nodau Cynllunio 2026/27 Planning Goals 2026/27	6. Safe, Timely, High Quality Care 1. Healthy, Thriving Teams 3. 20Four7 Population Health
Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	7. Improve health and well-being by focusing on prevention and early intervention, while working in partnership to ensure everyone has equal access to care and opportunities for good health

Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau) A Social Model for Health and Wellbeing: (*complete for strategic change and/or significant service changes)*	5. A more preventative approach, including earlier identification and intervention, will be taken to support people to maintain and improve their health and wellbeing.
Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	Public Health Wales. (2023). *Code of practice for the prevention and control of healthcare associated infections*. Public Health Wales. Welsh Government. (2024). *Quality statement for infection prevention and control*. Welsh Government. Welsh Government. (2024). *Antimicrobial resistance and healthcare associated infection improvement framework for NHS Wales* (Welsh Health Circular). Welsh Government.
Rhestr Termau: Glossary of Terms:	AMR – Antimicrobial Resistance. ANTT – Aseptic Non-Touch Technique. ARI – Acute Respiratory Infection. CCG – Clinical Care Group. C. difficile – *Clostridioides difficile*, a bacterium that can cause diarrhoea and colitis. HCAI – Healthcare Associated Infection. HON – Head of Nursing. IPC – Infection Prevention and Control. IPSSG – Infection Prevention Strategic Steering Group. MRSA – Methicillin-Resistant *Staphylococcus aureus*. MSSA – Methicillin-Sensitive *Staphylococcus aureus*. PPE – Personal Protective Equipment. PHW – Public Health Wales. QSEC – Quality, Safety and Experience Committee. RAG Rating – Red, Amber, Green status used to indicate progress or risk. TBP – Transmission-Based Precautions. WHC – Welsh Health Circular. WG – Welsh Government.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn:	

Parties / Committees consulted prior to this meeting:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No additional recurrent revenue or capital requirement is identified for approval through this report. Delivery of the IPC Organisational Improvement Plan, assurance arrangements, audit programme and workforce education is currently being managed within existing Health Board resources. However, healthcare-associated infections and outbreaks can create material, variable operational costs through additional diagnostics and treatment, personal protective equipment, enhanced cleaning and decontamination, staff absence or additional staffing, isolation and cohorting requirements, extended length of stay, and loss of available bed capacity. Sustained reductions in avoidable infections and earlier outbreak control therefore have the potential to release capacity and reduce avoidable expenditure, although financial benefits have not been quantified in this report. Any future investment or capital requirements identified through the improvement programme—including those relating to isolation facilities, infrastructure, digital surveillance or workforce capacity—will be subject to prioritisation, financial appraisal and the appropriate business case and governance processes.
Ansawdd / Gofal Claf: Quality / Patient Care:	The report supports improved quality and patient care by strengthening prevention, early identification and management of healthcare-associated infections and outbreaks. Effective delivery of the IPC Organisational Improvement Plan, audit programme, surveillance, case review, workforce education and escalation arrangements should reduce avoidable infection, deterioration, extended length of stay and disruption to care. Current mixed hospital-onset HCAI performance and variable workforce compliance indicate an ongoing potential for adverse patient outcomes if controls are not consistently embedded. These risks are mitigated through executive oversight, Clinical Care Group accountability, targeted improvement activity, assurance reviews and escalation of exceptions. No separate Quality Impact Assessment is required for this assurance report; any material service changes arising from the programme will be subject to proportionate QIA before implementation.
Gweithlu: Workforce:	Delivery requires sustained clinical, IPC, medical, nursing, pharmacy, estates, facilities, digital and managerial engagement. HCAIs and outbreaks can adversely affect workforce capacity through staff infection or exposure, sickness absence, exclusion from work, additional workload, enhanced cleaning, cohorting and outbreak

	response requirements. IPC Level 2 compliance remains below expectation overall, particularly among Medical and Dental staff, creating a risk that required knowledge and practice are not consistently embedded. Mitigation includes targeted education, opportunistic ward-based training, monthly compliance monitoring, named Clinical Care Group accountability and escalation through IPSSG and executive governance. No immediate change to the funded establishment is proposed; any emerging requirement for additional specialist or operational capacity will be assessed through workforce planning and the appropriate business-case process.
Tegwch Iechyd: **Health Equity:**	Potential impacts on health equity have been considered. Infection risk and the consequences of outbreaks may be greater for older people, people with frailty or long-term conditions, care-home residents, people requiring invasive devices, and communities experiencing barriers to timely access, prevention advice or treatment. The report supports a positive equity impact through system-wide surveillance, early recognition, targeted prevention, vaccination promotion, community IPC support and partnership working across primary care, local authorities and care providers. Data and improvement activity should be reviewed by population group and setting where available to identify unwarranted variation and ensure proportionate support. A separate equity-focused health impact assessment has not been undertaken because this is an assurance report and does not itself propose a service change; one will be completed if subsequent proposals could materially affect access, outcomes or particular population groups.
Risg: **Risk:**	The principal risks are continued hospital-onset HCAIs, inconsistent implementation of IPC controls, workforce training below the required level, recurrent community and closed-setting outbreaks, limitations in isolation and laboratory infrastructure, and insufficient evidence that improvement actions are embedded and sustained. These risks may result in avoidable harm, service disruption, additional cost and delayed de-escalation from targeted intervention. Mitigations include the Board-approved IPC Organisational Improvement Plan, executive-led review of hospital-onset cases, routine surveillance and audit, strengthened IPSSG and Clinical Care Group accountability, outbreak control arrangements, workforce education, evidence-based closure of actions and escalation through established governance routes. Related organisational risks remain recorded and managed through the Datix risk register.
Cyfreithiol: **Legal:**	The Health Board is required to provide safe care and maintain effective systems for the prevention and control

	of infection in accordance with applicable health and safety, public health, patient safety, quality and employment obligations. Failure to apply appropriate precautions, respond effectively to outbreaks, act on identified risks or evidence compliance could increase exposure to regulatory action, claims, enforcement or challenge. The governance, surveillance, audit, training, risk-management and escalation arrangements described in this report support compliance and organisational due diligence. Specific legal advice will be sought where an incident, proposed control measure or service change raises a material legal issue.
Enw Da: **Reputational:**	The Health Board's targeted intervention status, HCAI performance and management of significant outbreaks may attract interest from patients, the public, staff, regulators, Welsh Government and the media. Reputational risk would increase if preventable infections continued, actions were not delivered, or assurance was not transparent and evidence based. Conversely, open reporting of the mixed position, demonstrable executive oversight, timely escalation, shared learning and sustained improvement will support confidence in the organisation's response. Communications relating to outbreaks or material concerns will continue to be coordinated through established governance and communications arrangements.
Gyfrinachedd: **Privacy:**	This report presents aggregate assurance information and does not include directly identifiable patient or staff information. IPC surveillance, case review, contact tracing, occupational health and outbreak management may require confidential information to be processed and shared with authorised Health Board teams and partner agencies. Information must continue to be limited to what is necessary, accessed on a need-to-know basis, shared through approved secure routes, retained appropriately and handled in accordance with data-protection, confidentiality and information-governance requirements. Any new or materially changed use of personal data arising from digital surveillance or service redesign will be subject to information-governance review and, where indicated, a Data Protection Impact Assessment.
Cydraddoldeb: **Equality:**	Equality impacts have been considered. The report does not propose a change to eligibility, access or service provision and no direct adverse impact on people with protected characteristics has been identified. Effective IPC arrangements are expected to have a positive impact by reducing avoidable infection and supporting consistent standards of care. Implementation should nevertheless take account of individual communication, language, disability, cultural, religious and other reasonable-adjustment needs when providing information, applying

	precautions, arranging isolation, treatment or visitor restrictions, and planning outbreak responses. Equality monitoring and engagement should inform any subsequent material service change. EqIA screening has not been undertaken for this assurance report; proportionate screening and, where indicated, a full EqIA will be completed for future policies or service changes arising from the improvement programme.

Appendix 1

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

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

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

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

Objective	Action	Evidence expected	Date to be achieved	Action lead	Update
Quality Planning					
Establish a single Board-approved IP&C improvement programme	Develop and approve one integrated IP&C improvement plan aligned to escalation requirements, HCAI trajectories and the QMS framework	Plan approved by QSEC	**30 June 2026**	ADON (A&S) / Head of IPC	Each action has been added to AMaT and monitoring of implementation will be undertaken through IPSSG
		Improvement plan monitored through use of AMaT and updates on delivery provided to each IPSSG meeting.	**31 Dec 2026**	ADON (A&S) / Head of IPC	

Define the IP&C governance and accountability framework	Review and ratify the IP&C governance structure, including IPSSG, subgroups, CCG reporting lines and revised Terms of Reference	IPSSG Terms of Reference reviewed and approved by QSIG	**30 June 2026**	ADON (A&S)	
		Letter to be sent to all IPSSG members reminding members about submission of written reports and attendance at meetings	**30 June 2026**	EDoNQPE	
		100% of subgroups reporting to IPSSG bi-monthly	**30 Sept 2026**	IPSSG Sub-group chairs	
		CCG reporting arrangements clarified with 100% of CCGs reporting bimonthly (as per workplan)	**30 Sept 2026**	ADPS,Q&E (for each CCG)	
Translate organisational priorities into ward-level IP&C plans	Ensure all Clinical Care Groups (CCGs) have local IP&C plans aligned to organisational priorities, local infection challenges and incidence, with a focus on high-impact interventions such	All CCG plans include named leads, escalation routes, HCAI reduction targets, and defined high-impact interventions aligned to local infection risks.	**31 July 2026**	ADPS,Q&E (for each CCG)	

	as care bundles and targeted ward-based controls.				
Strengthen public health partnership working for infection prevention	Establish a formal joint work programme with Public Health, local authority and primary/community services to coordinate surveillance, outbreak prevention, vaccination promotion, antimicrobial stewardship and health protection messaging.	Agreed work programme with named leads	**31 Dec 2026**	Head of Nursing Health Protection / Senior Community Infection Prevention Nursing Team	
		Regular joint review meetings in place	**31 Dec 2026**	Head of Nursing Health Protection / Senior Community Infection Prevention Nursing Team	
		Shared reporting on risks, outbreaks and prevention priorities	**31 Dec 2026**	Head of Nursing Health Protection / Senior Community Infection Prevention Nursing Team	

		Evidence of coordinated system action	**31 Dec 2026**	Head of Nursing Health Protection / Senior Community Infection Prevention Nursing Team	
Quality Control					
Implement a standardised IP&C audit and surveillance system	Implement an IPSSG-approved IP&C audit programme covering environment, hand hygiene, device care and antimicrobial practice	100% of high-risk, due to surveillance data, areas audited monthly	**30 Sept 2026**	ADON (A&S) / Head of IPC / Clinical Director Pharmacy. Deputy Medical Directors (Acute and Primary Care)	
		≥90% completion of planned audits	**30 Sept 2026**	ADON (A&S) / Head of IPC / Clinical Director Pharmacy. Deputy Medical Director	

		100% of audits with documented action plans	**31 Dec 2026**	ADPS,Q&E (for each CCG)	
Strengthen real-time HCAI surveillance and escalation	Further develop and embed the existing HCAI dashboard so that it supports routine use for infection surveillance, audit compliance, incidents, outbreaks and escalation.	Dashboard refined and used consistently across all sites.	**31 Dec 2026**	ADON (A&S) / Head of IPC / Head of Performance / Director of Digital	
		Reviewed at each IPSSG meeting.	**31 Dec 2026**	ADON (A&S)	
		Reviewed weekly within the CCG and CSG	**31 Mar 2027**	ADPS,Q&E (for each CCG)	
Improve workforce compliance with key IP&C practices	Achieve ≥85% compliance with IP&C training (Levels 1 and 2), with targeted improvement for Medical and Dental staff Baseline: Medical/Dental Level 2 compliance 41.12%	≥85% compliance with IP&C training	**31 Dec 2026**	Medical Director / AMD (for each CCG)	
		≥85% compliance with IP&C training	**31 Dec 2026**	EDoNQPE / ADoNPS,Q&E (for each CCG)	
		≥85% compliance with IP&C training	**31 Dec 2026**	Executive Director of Allied Health and Health Science /	

				ADPS,Q&E (Op AH&HS)	
		Compliance reports to be monitored monthly by each CCG and updates provided to IPSSG through the required CCG reports	**31 Dec 2026**	ADPS,Q&E (for each CCG)	
Strengthen device and antimicrobial controls	Strengthen high-impact interventions for device and antimicrobial management, including care bundles, EPMA-enabled prescribing oversight, daily review of invasive devices, and operational scrutiny of compliance and exceptions.	≥95% compliance with device care bundle and review documentation.	**30 September 2026**	ADPS,Q&E (for each CCG) / AMD (for each CCG)	
		≥90% compliance with antimicrobial stewardship and EPMA-related audit measures.	**30 April 2027**	ADPS,Q&E (for each CCG) / AMD (for each CCG)	
		Evidence of routine operational scrutiny at ward, site or CCG level.	**30 September 2026**	ADPS,Q&E (for each CCG) / AMD (for each CCG)	
Deliver measurable reductions in	Deliver the required improvement trajectories for hospital-onset HCAIs, with	Monthly reduction trajectories achieved and	**June 2026–**	ADPS,Q&E (for each CCG) / AMD	

hospital-onset HCAIs	monthly reductions in hospital-onset infections: • *E. coli* − 2 • *C. diff* − 2 • *Klebsiella* − 1 • MRSA − 0.5 • MSSA - 2	reported for each priority organism.	**March 2027**	(for each CCG)	
Improve antimicrobial stewardship across community settings	Work with Primary Care and Public Health to strengthen community antimicrobial stewardship through prescribing review, guideline compliance, audit and targeted support for high-prescribing areas.	Community prescribing baseline established	**31 Mar 2027**	Head of Nursing Health Protection / Senior Community Infection Prevention Nursing Team / Deputy Medical Director Primary Care	
		Audit programme in place	**31 Mar 2027**	Head of Nursing Health Protection / Senior Community Infection Prevention Nursing Team / Deputy	

				Medical Director Primary Care	
		Reduction in inappropriate antimicrobial prescribing	**31 Mar 2027**	Head of Nursing Health Protection / Senior Community Infection Prevention Nursing Team / Deputy Medical Director Primary Care	
		Improvement in compliance with local antimicrobial guidance	**31 Mar 2027**	Head of Nursing Health Protection / Senior Community Infection Prevention Nursing Team / Deputy Medical Director Primary Care	

Strengthen community surveillance, learning and escalation	Develop routine reporting arrangements for community-onset infection data, outbreaks in non-acute settings, and recurring themes from case review, so that learning informs prevention activity across the whole system.	Community surveillance reporting incorporated into governance structure	**31 Dec 2026**	Head of Nursing Health Protection / Senior Community Infection Prevention Nursing Team	
		Escalation triggers defined for community infection risks	**31 Dec 2026**	Head of Nursing Health Protection / Senior Community Infection Prevention Nursing Team	
		Learning from cases/outbreaks shared across services	**31 Dec 2026**	Head of Nursing Health Protection / Senior Community Infection Prevention Nursing Team	

		Collation of evidence of actions taken in response to trends (action maybe needed by Local Authority and Primary Care)	**31 Dec 2026**	Head of Nursing Health Protection / Senior Community Infection Prevention Nursing Team	
Quality Assurance					
Strengthen the IP&C assurance framework and evidence pack	Strengthen the existing IP&C assurance framework and evidence pack, aligned to the organisational improvement plan and the Welsh Government Quality Statement, for Board and Welsh Government scrutiny.	Assurance framework/evidence pack includes HCAI trends, audit compliance, training, risks, improvement actions and alignment to the Quality Statement. Used in 100% of QSEC reports.	**31 July 2026**	ADON (A&S) / Head of IPC	
Demonstrate readiness for de-escalation	Provide assurance to IPSSG, QSEC and Welsh Government on reduced hospital-onset infections, effective governance and sustained improvement	Quarterly assurance reports evidencing de-escalation readiness	**Quarterly from Q2 2026/27**	ADPS,Q&E (for each CCG) / ADON (A&S) / Head of IPC	
Quality Improvement					

Target high-risk wards and services	Identify the top three high-risk wards per site and implement intensive improvement plans	Weekly oversight by Heads of Nursing and Senior Nurses in place	**31 July 2026**	ADPS,Q&E (for relevant CCGs)	
		≥30% reduction in repeat infections and outbreaks in targeted areas	**31 July 2026**	ADPS,Q&E (for relevant CCGs)	
Embed a structured QI methodology	Implement PDSA-based improvement cycles for IP&C in all CCGs, with support from QI-trained staff within services across the organisation identified through liaison with Health Board QI Team	≥1 documented QI project per CCG.	**31 March 2027**	ADPS,Q&E (for each CCG) / AMD (for each CCG)	
		Evidence of implemented change and measurable outcome.	**31 March 2027**	ADPS,Q&E (for each CCG) / AMD (for each CCG)	
		QI support identified and linked to priority projects through Health Board QI Team	**31 March 2027**	ADPS,Q&E (for each CCG) / AMD (for each CCG)	
Strengthen organisational learning and response	Implement a structured review and learning process for all HCAI cases and outbreaks	100% of HCAI cases reviewed	**31 July 2026**	ADPS,Q&E (for each CCG) / Head of IPC / IP&C Team	

		Learning shared monthly across the organisation	**31 July 2026**	Head of IPC / IP&C Team	
Reduce community-onset infections through earlier prevention and intervention	Work with Primary Care, Local Authority, Community Services, Care Homes and Public Health to identify the main drivers of community-onset infections (for example UTIs, cellulitis, respiratory infections and community-onset bacteraemias) and implement targeted prevention measures.	Agreed list of priority community-onset infections	**31 Dec 2026**	Head of Nursing Health Protection / Senior Community Infection Prevention Nursing Team	
		Baseline and trajectory for community-onset cases established	**31 Dec 2026**	Head of Nursing Health Protection / Senior Community Infection Prevention Nursing Team	
		Joint prevention plan in place with primary and community partners	**31 Dec 2026**	Head of Nursing Health Protection / Senior Community Infection Prevention Nursing Team	

		Reduction trend demonstrated for priority community-onset infections	**31 Dec 2026**	Head of Nursing Health Protection / Senior Community Infection Prevention Nursing Team	
Improve prevention of infections associated with long-term conditions and frailty in the community	Target high-risk populations, including older people, care home residents and patients with recurrent infections, with focused interventions such as hydration, catheter care, wound care, vaccination uptake and early recognition/escalation pathways.	High-risk cohorts identified	**31 Dec 2026**	Head of Nursing Health Protection / Senior Community Infection Prevention Nursing Team	
		Targeted prevention bundles implemented	**31 Dec 2026**	Head of Nursing Health Protection / Senior Community Infection Prevention Nursing Team	
		Training/resources provided to community teams and care homes	**31 Dec 2026**	Head of Nursing Health	

				Protection / Senior Community Infection Prevention Nursing Team	
		Reduction in avoidable infection-related admissions from targeted groups	**31 Dec 2026**	Head of Nursing Health Protection / Senior Community Infection Prevention Nursing Team	

7.4

7.4 - Insourcing 52 week First Consultant Appointment Quality Assurance Report

Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Keith Jones (Hywel Dda UHB - Director of Operational Planning & Performance)

For assurance

Attachments

52 Week National Outpatient Insourcing – Quality Assurance Report.pdf

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	**08 OCTOBER 2026**
TEITL YR ADRODDIAD: TITLE OF REPORT:	52 Week National Outpatient Insourcing Patient Experience Quality Assurance Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Andrew Carruthers, Chief Operating Officer
SWYDDOG ADRODD: REPORTING OFFICER:	Keith Jones, Director of Operational Planning & Performance Lisa Humphrey General Manager Planned Care

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report provides an assessment of patient experience of those patients who received first outpatient clinical assessments via the nationally coordinated Outpatient (OPA) Insource programme delivered during 2025/26 and describes the clinical pathway legacy issues which remain under active management review.

Cefndir / Background

In 2025, the Welsh Government (WG) commissioned Healthcare Business Solutions (UK) Limited (HBSUK) to conduct a national insourcing project targeting stage 1 (new patient, first outpatient appointment after referral) appointments across Wales, known as the national OPA Insourcing Plan. HBSUK was commissioned to deliver outpatient assessments for all Health Boards with the exception of Betsi Cadwaladr University Health Board (UHB) where an alternative provider was commissioned.

The programme for Hywel Dda University Health Board (HDUHB) commenced in September 2025 to its delivery completion in March 2026. During this period, OPA Insource project generated a total of 11,919 additional outpatient attendances for HDUHB and provided a significant positive impact in reducing both waiting times and the overall volume of patients awaiting outpatient assessments.

In order to assess the experience of patients who were assessed via the OPA Insource project, all patients were provided with the opportunity to reflect on their experience via the Friends & Family Test (FFT). To date, a total of 972 responses have been received and collated.

Whilst delivery of the HBSUK clinical activity via the project concluded at the end of March 2026, all health boards have experienced a period of residual closure and reconciliation work to support patient progression via resultant diagnostic and investigative pathways where

applicable. At the inception of the national OPA Insource Project, this was expected to continue for an approximate period of two months through to June 2025. However, all health boards have continued to work with HBSUK beyond this period to secure resolution of outstanding operational (administrative and clerical) issues to support closure of individual patient pathways.

Within HDUHB, the dedicated project team established to administer the project continues to hold weekly review meetings with HBSUK, supported by clinical, operational, administrative, informatics and patient experience teams.

Asesiad / Assessment

Location	Responses	Good/very good	Poor/very poor
Glangwili General Hospital	577	91.2%	3.6%
Prince Philip Hospital	229	88.6%	3.9%
Withybush General Hospital	166	89.8%	3.6%

Day	Responses	Good/very good
Saturday	511	90.2%
Sunday	461	90.5%

Patient experience

Anonymous responses to the NHS Wales People's Experience Survey (FTT) shows a predominantly positive patient experience to the insourcing clinics hosted at HDUHB through this project.

A total of 972 weekend outpatient responses to the Friends and Family Test (FFT) were provided. Overall, 90.3% rated their experience as good or very good, while 3.7% rated it poor or very poor. The feedback is predominantly positive, particularly in relation to staff manner, reassurance and prompt care. However, recurring concerns indicate opportunities to improve waiting-time communication, parking and travel impacts, appointment administration, and clarity of follow-up arrangements.

The CIVICA report generated contains a dedicated weekend insourcing dataset with 972 valid dated response across Prince Philip Hospital, Glangwili General Hospital, and Withybush General Hospital (Bronglais Hospital was not used in the first Outpatient Plan). Differences in feedback between sites and between weekend date seen are minimal.

Summary reflection from the total responses received are as below:

- Positive experience: 878 responses (90.3%) were good or very good.
- Negative experience: 36 responses (3.7%) were poor or very poor.
- **Key strengths:** compassionate, friendly and professional staff, often linked to feeling reassured and listened to.
- **Key improvement areas:** delays and communication about waits, parking and travel burden, and administrative continuity following appointments.

Feeback and reflections from the patient experience data collated is being considered by the Planned & Specialist Care Clinical Care Group (CCG) which oversees outpatient department

delivery and actions/proposals for further improvements will be considered via the CCG Integrated Governance mechanisms.

Clinical pathway legacy issues remaining under active management.

In keeping with the experience of all health boards, the HDUHB OPA Insource project team has continued to work with HBSUK beyond March 2026 to secure resolution of outstanding operational (administrative and clerical) issues to support closure of individual patient pathways. To support the work of the HBUHB OPA insource project team, HBSUK have provided a data reconciliation analyst to support post-project closure activities.

Legacy issues are summarised below:

Clinical correspondence:

On completion of clinical assessments at the end of March 2026, approximately 2419 outstanding clinical letters (i.e. not yet uploaded to HDUHB electronic patient records, Welsh Patient Administration System (WPAS) were initially identified. This mirrored the proportionate experience of other health boards. By the end of September 2026, this volume has reduced to 441. Continued oversight remains in place for all outstanding patients to mitigate the potential risk that delayed correspondence may affect patient and GP understanding, follow-up, and continuity of care.

Waiting-list proformas:

At completion of insourced clinical activity, approximately 150 waiting list proformas (referrals for surgery) remained incomplete (missing key information such as; clinician name, date of referral, or clinical priority). These outstanding proformas have been completed by HBSUK consultants and cleared completely as of September 2026.

Diagnostic reconciliation:

Of the 11,919 patients reviewed via the OPA Insource clinics, approximately 700 patients (5%) are awaiting clinical decisions regarding the next phase of their diagnostic pathways. In addition, approximately 400 patients who have received diagnostic investigations remain under review pending confirmation of resultant clinical reports. The HBUHB OPA Insource Project team will remain in place until all outstanding diagnostic investigations have been completed and results reported, clinically reviewed, recorded and acted upon.

Cardiology specific issues:

At the end of May, concerns were identified regarding a significant backlog of administrative work for Cardiology patients reviewed by HBSUK clinicians who had completed diagnostic testing but were awaiting consultant review and confirmation of next steps. In response HBSUK has provided additional consultant support to resolve outstanding cases. Appropriate clinical information in respect of the 125 patients identified at the end of May 2026 has now been received and recorded.

Quality Assurance of clinical decision making:

Throughout the programme, robust clinician credential and curriculum vitae checking process were established with local Clinical Team Leads vetting all HBSUK clinicians. Where isolated concerns arose regarding clinical practice or outcomes, use of the clinician was immediately stopped and a replacement requested. Circa 90 patients impacted had repeat appointments scheduled.

Separately, clinical review identified a limited number of orthopaedic referrals for ultrasound-guided joint injections which did not reflect the established clinical pathway in place within the Health Board. Local clinical teams have provided HBSUK with appropriate advice and forward management plans for the patients concerned along with appropriate patient communication.

Patient concerns:

Weekly meetings involving the Waiting List Support Service, Patient Advice and Liaison Service and HBSUK continue to resolve queries and concerns promptly. At the point of reporting, one concern remains open.

Closure reporting and learning.

A final programme report will be completed once the outstanding clinical pathway legacy issues above have been sufficiently resolved and evidenced. This will be utilised to inform an end of project lessons learned to be undertaken jointly with HBSUK.

Argymhelliad / Recommendation

The Committee is requested to take assurance from the reported patient experience and the continuing governance arrangements in place to manage and resolve remaining clinical pathway legacy issues following completion of the outpatient assessment phase of the project in March 2026.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	3.9 Provide assurance to the Board in relation to improving the experience of patients, including for those services provided by other organisations or in a partnership arrangement. Patient Stories, Patient Charter and Board to Floor Walkabouts will feature as a key area for patient experience and lessons learnt.
Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	1. Safe 2. Timely 6. Person-Centred 3. Effective 5. Equitable 7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	5. Whole systems persepctive
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Nodau Cynllunio 2026/27 Planning Goals 2026/27	6. Safe, Timely, High Quality Care

Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	4. Create an inclusive culture where every voice matters, individual needs are considered and staff well-being is promoted and supported 5. Foster a learning culture by sharing knowledge and applying new ways of working that enhance local and global well-being
Model Cymdeithasol ar gyfer lechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau) A Social Model for Health and Wellbeing: (*complete for strategic change and/or significant service changes)*	6. A culture of testing and learning will be encouraged, enabled, supported and celebrated.
Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	Contained within the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	Planned & Specialist Care Clinical Care Group

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
Ariannol / Gwerth am Arian: **Financial / Service:**	Not Applicable
Ansawdd / Gofal Claf: **Quality / Patient Care:**	Contained within the report
Gweithlu: **Workforce:**	Not Applicable
Tegwch Iechyd: **Health Equity:**	Not Applicable

Risg: **Risk:**	Contained within the report
Cyfreithiol: **Legal:**	Not Applicable
Enw Da: **Reputational:**	Not Applicable
Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	Not Applicable

8

8 - Clinical Care Group Assurance Reports

8.1

8.1 - Mental Health and Learning Disabilities Clinical Care Group Assurance Report

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

For assurance

Attachments

MHLD CCG report.pdf

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	08 October 2026
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Mental Health and Learning Disabilities (MHLD) Clinical Care Group Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Andrew Caruthers, Chief Operating Officer
SWYDDOG ADRODD: **REPORTING OFFICER:**	Liz Carroll, Service Director for the Mental Health and Learning Disabilities Clinical Care Group, Becky Temple-Purcell, Assistant Director of Nursing, Quality, Patient Safety, Quality and Experience, Mental Health and Learning Disabilities Clinical Care Group

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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

Cefndir / Background

The MHLD Clinical Care Group has established and embedded governance arrangements aligned to the Health Board's quality governance framework. Governance processes integrate quality planning, improvement, control and assurance activities to support safe, effective and person-centred care.

Current priorities include delivery of the National Mental Health and Wellbeing Strategy, implementation of the Mental Health and Self-Harm Quality Statements, progression of the Learning Disabilities Transformation Programme and development of Open Access Mental Health Support through four local demonstrator projects. Quality improvement activity continues through the Enabling Quality Improvement in Practice (EQIiP) programme, national patient safety initiatives, clinical audit, and implementation of evidence-based practice. Governance oversight is provided through established Care Group forums, performance review arrangements, triangulation of quality intelligence, patient and staff feedback, audit activity and organisational learning processes.

Asesiad / Assessment

Quality Governance Areas of Focus
Three areas remain subject to enhanced oversight through the Health Board escalation framework:

Complaints Management

Complaint volumes have reduced since October 2025, alongside improvements in complaint handling performance and reductions in open and overdue complaints. Early resolution approaches and adoption of the People's Experience Framework have supported a more responsive and person-centred approach to concerns.

Clinical Treatment/Assessment, Medication and Attitude and Behaviour continue to represent the most frequently reported themes. Review of individual cases has not identified concerns relating to specific teams, services or practitioners. Complaints more commonly reflect disagreements regarding clinical assessment, treatment or risk management decisions. Learning continues to be incorporated into supervision, reflective practice and service improvement activity.

By month received

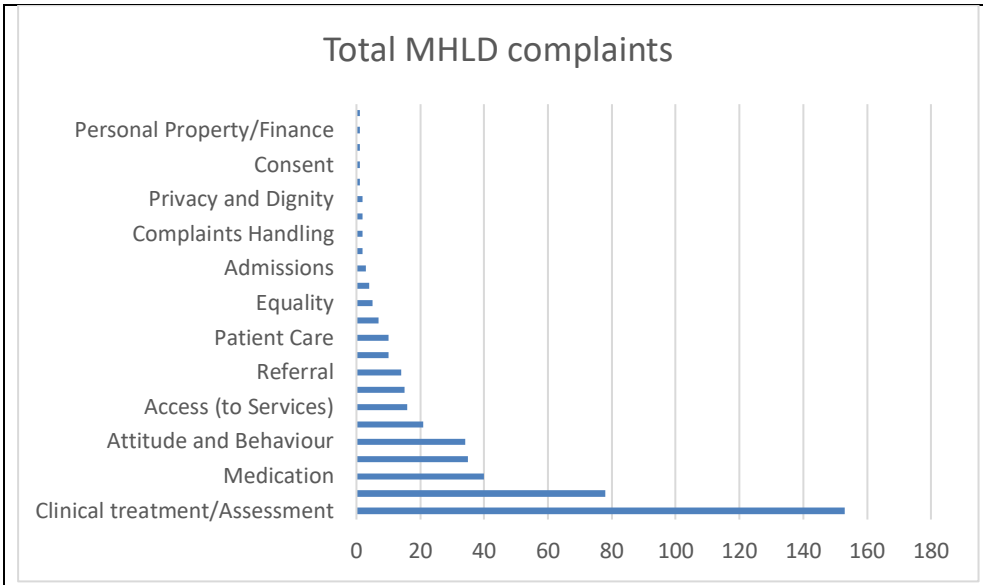


Number open complaints



Number of overdue complaints

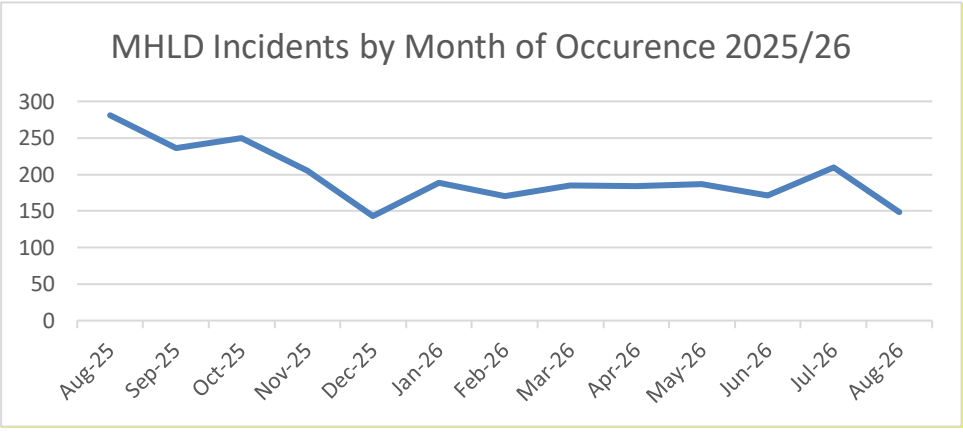


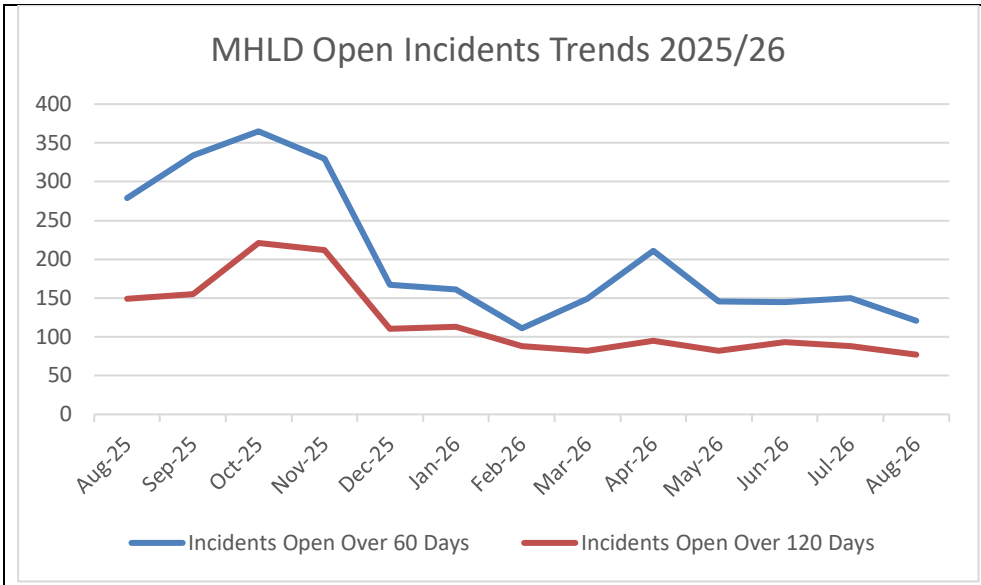


Incident Management and Nationally Reported Incidents

Incident reporting levels have continued to stabilise following implementation of revised restrictive intervention reporting arrangements and improved staff understanding of reporting requirements. Performance relating to aged incidents has improved, with sustained reductions in incidents open beyond 60 and 120 days.

As of September 2026, six Nationally Reported Incidents remain open, with fourteen historical cases closed since May 2026. Most remaining reviews are expected to conclude within the next quarter, with a small number dependent on external processes. Progress provides assurance that historic backlogs continue to reduce and review processes are becoming more timely.





Improvement Actions

Key actions supporting improvement include:

- Strengthened oversight through the MHLD Head of Nursing role.
- Enhanced governance review arrangements for complaints, incidents and organisational learning.
- Implementation of a revised serious incident review framework.
- Development of a reviewer training programme.
- Appointment of a Clinical Quality Assurance and Practice Development Lead.
- Continued triangulation and dissemination of organisational learning.

Risk Overview

The Clinical Care Group currently manages 28 risks, including five extreme risks.

Open risks	Risks overdue	% overdue	Open actions	Actions overdue	% overdue
22	0	0%	52	0	0%

Risk heatmap

Likelihood

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

Open Access Mental Health Support Local Demonstrator Projects

The Clinical Care Group continues to progress four Open Access Mental Health Support demonstrator projects:

- Perinatal Open Access and One-at-a-Time.
- CAMHS Open Access and One-at-a-Time.
- Primary Care Liaison Open Access Skills.
- Lived Experience and Peer Support Workforce Development.

Work during this period has focused on pathway development, workforce preparation, stakeholder engagement, governance arrangements and outcome measurement. The CAMHS and Perinatal projects are approaching implementation, whilst Primary Care Liaison and Lived Experience programmes continue to establish the infrastructure required to support delivery and evaluation.
Together, these projects provide assurance that the Clinical Care Group is actively testing approaches intended to improve timely access, strengthen community-based support and inform future implementation of the Open Access Mental Health Support model.

Conclusion and Key Leadership Challenges

The Clinical Care Group continues to strengthen quality governance arrangements, with particular progress evident in complaints management, reduction of aged incidents, progression of Nationally Reported Incident reviews and delivery of improvement and transformation programmes.
However, significant challenges remain. Demand continues to exceed capacity across several key pathways, particularly inpatient mental health services, ADHD and autism assessment services, and access to timely assessment and treatment. These pressures are compounded by workforce and financial constraints.

The principal leadership challenge remains balancing immediate operational, quality and safety risks with delivery of longer-term service transformation. Success will depend on sustaining progress in quality governance whilst accelerating development of community-based alternatives, improving patient flow, strengthening workforce

Argymhelliad / Recommendation

The Committee is asked to take ASSURANCE on the quality governance arrangements in place within the MHLD Clinical Care Group in relation to quality, safety and patient experience.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.11 Ensure that the organisation is meeting the requirements of the Health and Social Care (Quality and Engagement) Act and recommend the Annual Duty of Quality and Duty of Candour Reports to Board for approval as soon as reasonably practicable after the end of each financial year.

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	All risks held on the Mental Health and Learning Disabilities Care Group risk register. Datix references contained within the main body of report.
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Nodau Cynllunio 2026/27 Planning Goals 2026/27	6. Safe, Timely, High Quality Care
Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	ADHD – Attention Deficit Hyperactivity Disorder ASD – Autism Spectrum Disorder CCG – Clinical Care Group DNA CPR – Do Not Attempt Cardio Pulmonary Resuscitation EQIiP – Enabling Quality Improvement in Practice MHLD – Mental Health and Learning Disabilities ND - Neurodevelopment NRI – Nationally Reported Incident
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiod:	ADHD waiting times considered through Quality and Safety Ingtelligence Group.

Parties / Committees consulted prior to Quality, Safety and Experience Committee:	

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

8.2

8.2 - Learning Disabilities Services Patient Story and Deep Dive

Rebecca Temple-Purcell (Hywel Dda UHB - Assistant Director of Nursing, Patient Safety, Quality and Experience), Kate Scott (Hywel Dda UHB - Remote email account), Eleanor OConnor (Hywel Dda UHB - Service Manager Learning Disabilities)

For assurance

Attachments

LD Deep Dive for QSEG October 2026.pdf



Deep Dive: Learning Disabilities Service

Quality, Safety and Experience Committee
October 2026

Situation

Learning Disability services operate within a complex environment supporting individuals who experience significantly poorer health outcomes, greater health inequalities and higher levels of complexity than the general population. The service is required to deliver against a wide range of statutory, professional and Welsh Government expectations.

Overall, the service continues to demonstrate positive progress following implementation of the Learning Disabilities Service Improvement Programme. Community services have been strengthened, governance arrangements for commissioned care have matured, workforce stability has improved and recent inspection activity has provided positive assurance regarding the quality of care delivered.

While performance is favourable in several key areas, continued focus is required on improving Annual Health Check uptake, strengthening implementation of the Health Equality Framework, enhancing aspects of epilepsy pathway documentation and maintaining workforce resilience for the future.

Background

Service Model and Strategic Context

The Health Board's Learning Disability Service delivers specialist care through:

- Four Community Learning Disability Teams
- Psychology and Behaviour Services
- Health Facilitation and Liaison Team
- Learning Disability inpatient pathway via Mental Health services
- Two residential units in Pembrokeshire
- Commissioned specialist community and hospital placements

The majority of the community-first service model approved following the Learning Disabilities Service Improvement Programme is now operational. The service continues to align with Welsh Government priorities focused on reducing health inequalities, strengthening community support, improving access to specialist care and reducing reliance on inpatient services

1363 - Learning Disabilities Service Spec- internal link- copy available on request

Assessment-Hywel Dda Learning Disabilities Service

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Residential Services and Commissioned Care

The Health Board provides two residential services in Pembrokeshire and commissions a significant range of specialist placements to meet the needs of individuals with highly complex health, behavioural and social care needs. Comprehensive arrangements are in place to oversee quality, safety and value through multidisciplinary review, brokerage scrutiny, contract governance and partnership working with local authorities and regulators.

Current Placement Position

Placement Type	Number	Annual Cost
Community Placements	242	£20.2m
Hospital Placements	9	£1.5m

Progression planning remains a key priority, with active support provided to identify less restrictive environments and maximise opportunities for individuals to live as independently as possible within community settings closer to home.

Reducing Health Inequalities

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People with learning disabilities continue to experience significant health inequalities, including increased risk of preventable illness and avoidable mortality. Annual Health Checks remain a key ministerial priority and an important mechanism for addressing these inequalities.

Annual Health Checks

Measure	Wales	HDUHB
Invited for Health Check	33.6%	38.4%
Health Check Completed	40.9%	46.0%

Performance exceeds the Welsh average across both measures. However, continued improvement remains dependent on primary care engagement, accuracy of Learning Disability registers, uptake by individuals and consistent application of reasonable adjustments to support attendance.

The Health Facilitation and Liaison Team continues to support improvement through training, awareness raising, register validation and targeted support for those most at risk of unmet health need.

Health Equality Framework (HEF)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

The Health Equality Framework provides a structured approach to measuring outcomes and reducing health inequalities experienced by people with learning disabilities. Hywel Dda has played a leading role in developing the digital HEF platform which is now supporting national implementation across Wales.

Measure	Wales	HDUHB Reported
Valid HEF Assessment	23.9%	12.0%

The reported position significantly understates implementation within nursing services where compliance is substantially higher. Discussions are ongoing nationally regarding reporting methodology to ensure local practice is accurately represented.

Care Closer to Home and Reduction in Inpatient Care

National policy continues to emphasise reducing inpatient admissions, preventing delayed discharges and ensuring care is provided within the least restrictive environment possible.

Performance Against National Expectations

Measure	Wales	HDUHB
Care Coordinator Allocated	94%	100%
Discharge Pathway Identified	100%	100%
Estimated Discharge Date	54%	67%
Delayed Discharges >6 Months	16	0

These outcomes provide assurance that effective community support arrangements are contributing to reduced reliance on inpatient services and timely progression through care pathways.

Clinical Quality Focus: Epilepsy Pathway Audit

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

An audit of epilepsy care pathways undertaken during 2026 demonstrated strong compliance with core clinical requirements, providing assurance regarding the overall quality of epilepsy management within Community Learning Disability Teams.

Areas of Strong Compliance

Indicator	Compliance
Epilepsy Care Plan in Place	98.8%
Risk Assessment Completed	98.8%
Epilepsy Care Plan In Date	91.0%
Staff Epilepsy Training	92.6%

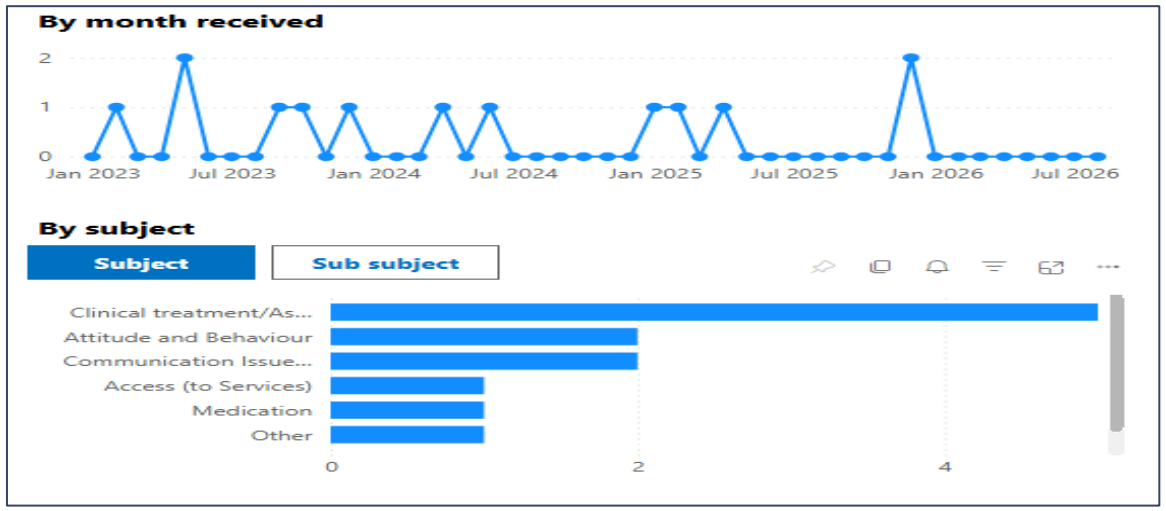
Improvement Opportunities

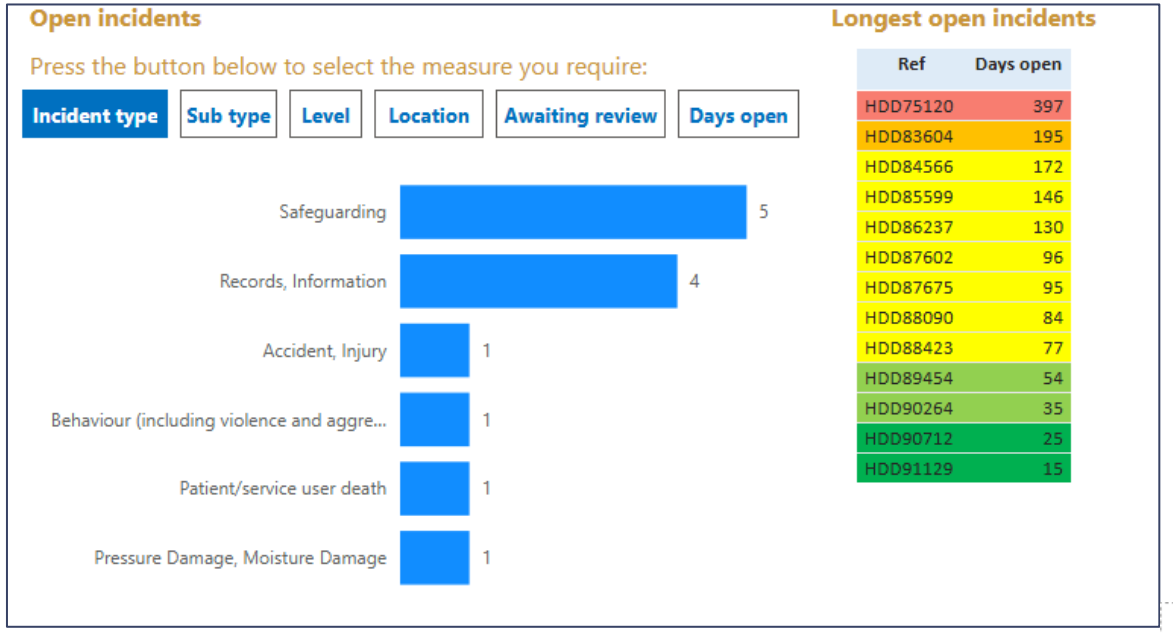
Indicator	Compliance
Care Plan Shared with GP/Support Network	39%
Capacity Assessment Evident	57.8%
Best Interest Decisions Evident	57.8%
Outcome Measure Completed	0%

Improvement work is now focused on strengthening documentation standards, outcome measurement and evidence of collaborative care planning.

Quality Assurance, Complaints and incidents

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board



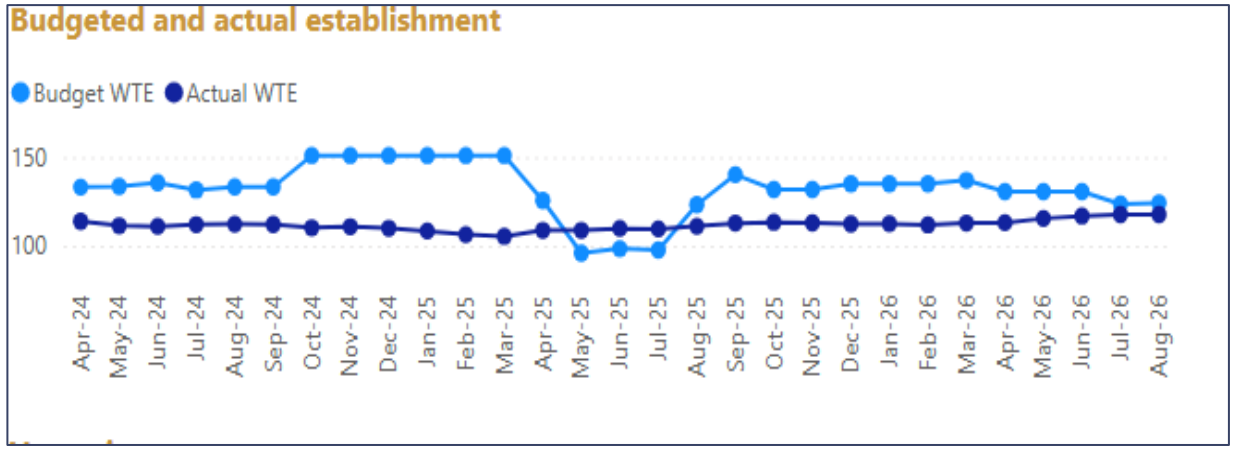


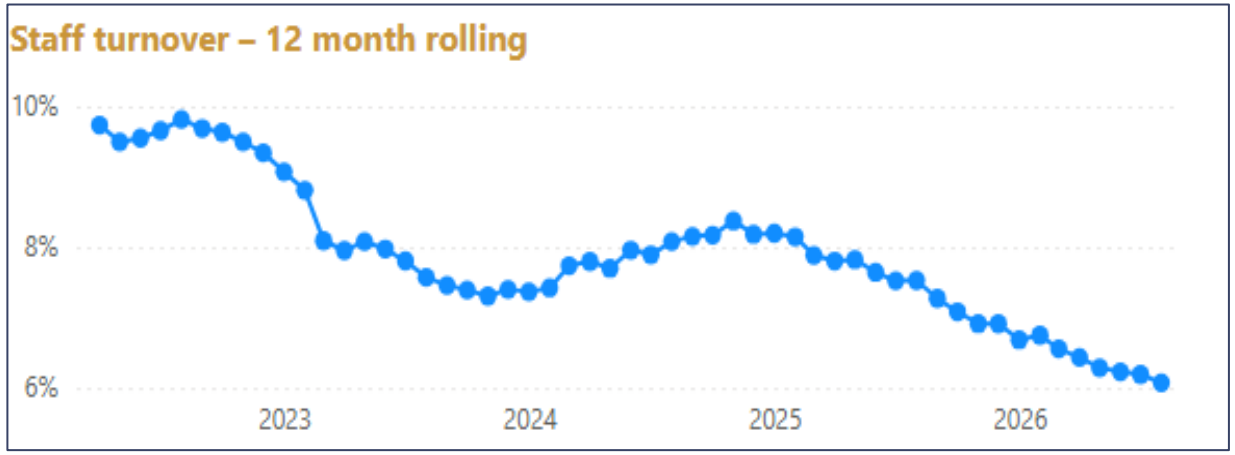
The service maintains established governance arrangements through auditing, incident review processes, safeguarding systems and quality assurance mechanisms. A recent joint Care Inspectorate Wales (CIW)/Healthcare Inspectorate Wales (HIW) review identified a positive culture characterised by person-centred practice, strong partnership working, co-production, advocacy and preventative approaches to care.

Complaint numbers remain low and largely reflect the complexity associated with Court of Protection processes, best-interest decision making and situations where professional recommendations differ from family expectations. No recurring practitioner or service-level themes have been identified.

Incident oversight remains robust, with all open incidents subject to formal monitoring and governance arrangements. Where investigations exceed expected timescales, this reflects complexity and multidisciplinary review requirements rather than a lack of oversight.

Workforce and Sustainability





The service has continued to strengthen its workforce position through successful recruitment across nursing, psychology and therapy professions. Workforce indicators demonstrate improving stability and resilience compared with previous years.

Vacancy and turnover trends indicate continued improvement, providing increased confidence regarding sustainability of service delivery. However, ongoing focus remains necessary to ensure succession planning, specialist workforce development, mandatory training compliance and successful completion of the remaining organisational change programme

Achievements, Innovation and Recognition

The service continues to demonstrate innovation and quality improvement recognised at both organisational and national level. Recent achievements include national award nominations, development of Learning Disability A&E Packs, delivery of Learning Disability Awareness Week initiatives and the successful establishment of a Community Lifestyle Café in partnership with People First.

Recognition received by staff and services reflects ongoing commitment to improving outcomes, promoting inclusion and reducing health inequalities for people with learning disabilities. Recruitment to traditionally hard-to-fill roles and development of innovative new posts has further strengthened service resilience and capability.

Conclusion and Committee Assurance

The Learning Disabilities Service continues to make good progress in delivering a community-focused model of care. Positive inspection findings, improving workforce stability, effective governance of commissioned services and favourable performance in several key areas provide assurance regarding the quality, safety and effectiveness of services currently being delivered.

Key Leadership Challenges

- Completion of the remaining Organisational Change Process.
- Improving Annual Health Check uptake and quality through partnership with Primary Care.
- Increasing implementation of the Health Equality Framework and improving reporting arrangements.
- Strengthening outcome measurement and documentation within epilepsy pathways.
- Maintaining workforce resilience, specialist expertise and succession planning.
- Continuing to reduce reliance on costly external placements and maximise community-based opportunities.

Overall Assurance

The Committee can be assured that Learning Disability services are delivering safe, effective and person-centred care, with clear improvement plans in place to address remaining strategic, workforce and quality challenges.

8.3

8.3 - Planned and Specialist Care Clinical Care Group Assurance Report

Paula Goode (Hywel Dda UHB - Service Director for Planned and Specialist Care), Tamara Bromley (Hywel Dda UHB - Assistant Director of Nursing)

For assurance

Attachments

Planned Care QSEC.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	**08 OCTOBER 2026**
TEITL YR ADRODDIAD: TITLE OF REPORT:	Planned Care and Specialist Services Quality Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Andrew Carruthers, Chief Operating Officer
SWYDDOG ADRODD: REPORTING OFFICER:	Paula Goode, Director Planned Care & Specialist Services Tamara Bromley, Assistant Director of Nursing, Planned Care & Specialist Services

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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

Cefndir / Background

The Planned Care & Specialist Services Care Group – consists of Children, Women & Family Services, Maternity Services, Specialist Services, Cancer & Outpatient Services.

The aim of the Planned Care & Specialist Services Care Group in summary is to:

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

Meeting the Duty of Quality is the highest priority for the Clinical Care Group and its governance structures and oversight has developed significantly. The Service Director, Associate Medical Director and Assistant Director of Nursing lead the agenda which is aligned

to the six domains of quality as defined by the Duty of Quality Statutory Guidance 2023. This report is set out under each of these domains.



Quality Assurance

The Clinical Care Group (CCG) Quality Governance Meeting is held monthly and serves as the primary forum for oversight of quality, safety and patient experience across the Care Group. Attendance and engagement from nursing leadership, operational managers and Service Group representatives is consistently strong, with valuable contributions from a range of multidisciplinary colleagues from across the Health Board. These members actively participate in discussions, contribute to agenda development and support decision-making, ensuring that quality governance remains a shared responsibility across services. Consistent medical engagement remains an area for improvement and is recognised as a priority to strengthen multidisciplinary clinical leadership and assurance.

Each Service Group holds a monthly Quality and Safety Meeting, providing local oversight of risks, incidents, complaints, audits, patient experience and improvement activity. These meetings report directly into the CCG Quality Governance structure, supporting a clear escalation and assurance process from frontline services to Care Group level.

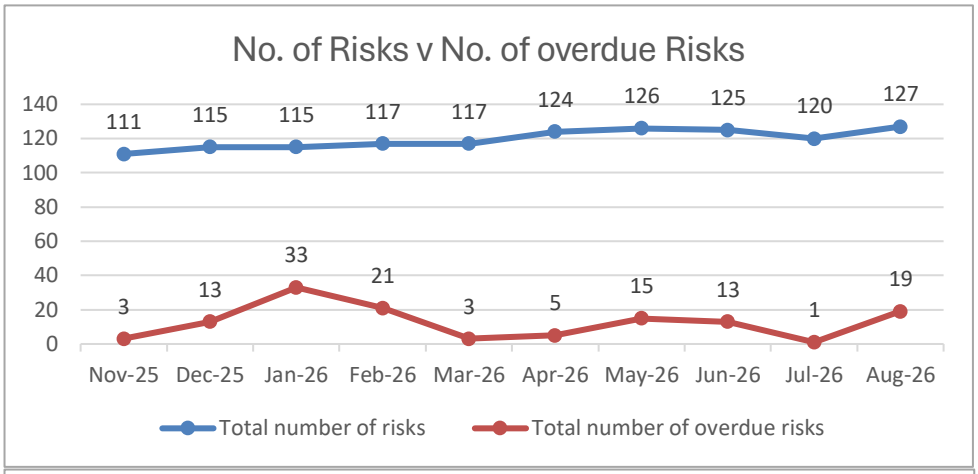
Following the recent appointment of the Assistant Director of Nursing, a review of the Care Group's governance arrangements is underway. This review aims to ensure governance processes remain robust, effective and aligned to Quality Management System principles. Key areas of focus include strengthening attendance and engagement across all professional groups, improving clarity of governance responsibilities, streamlining reporting arrangements, and enhancing communication of quality and safety information to all levels of the organisation. This work is intended to further strengthen oversight, improve organisational learning and provide greater assurance that quality improvement activity results in measurable and sustainable improvements for patients and staff.

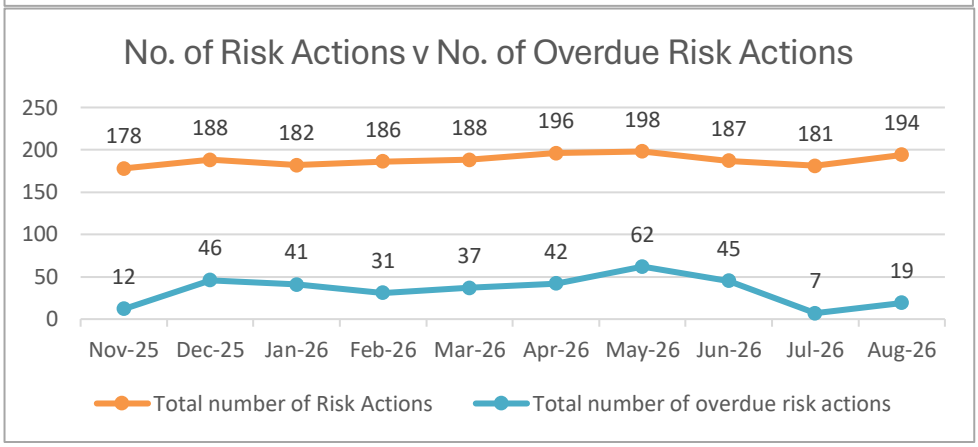
Safe Care

Current Internal escalation status for Governance Level 2
Areas for Focus
Risks and Risk Actions
15% (91 out of 127) risks were overdue for review. 10% (19 out of 194) risk actions are overdue for review
Audit and Inspections Reports 14%
14% (27 out of 192) recommendations are overdue for review

Welsh Health Circulars
9 WHCs assigned to Planned and Specialist Care 11% (1 out of 9) are overdue 33% (3 out of 9) are Unable to Complete 33% (3 out of 9) is In Progress 22% (2 out of 9) is Reliant on External Factors

Risks management overview





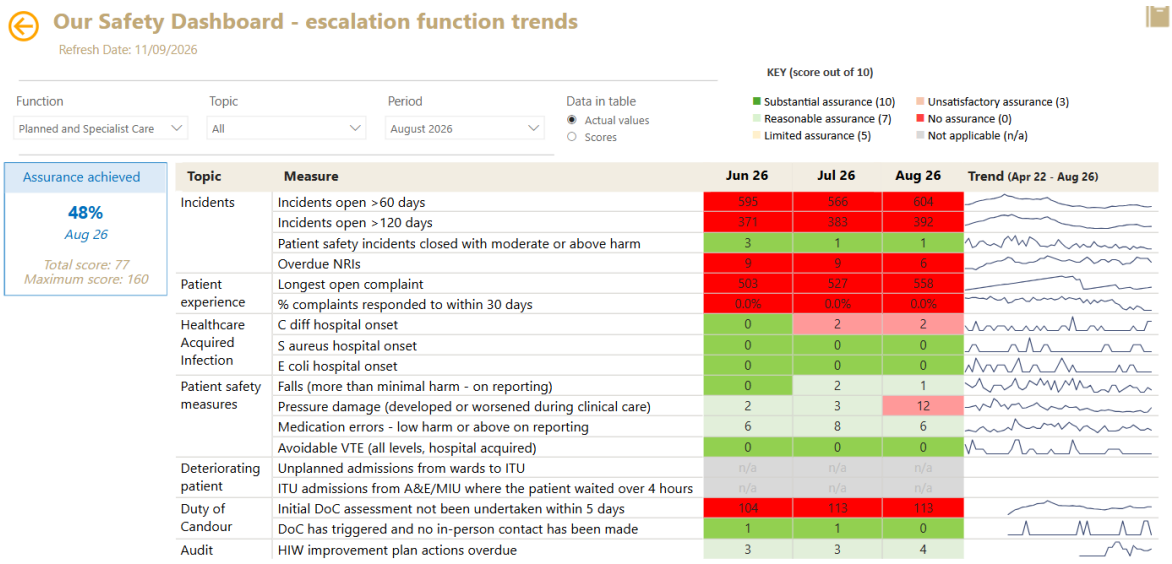
In August 2026, the CCG had a total of 127 risks with 19 overdue (15%)

The CCG continues to monitor all risks through the established governance framework, with particular focus on overdue risk reviews within the CCG. A review of the current position has identified a number of risks that have exceeded their scheduled review date. To address this, a targeted risk review programme has been implemented, led initially by the Assistant Director of Nursing and supported through the CCG Quality Governance arrangements.

All overdue risks have been allocated to a named risk owner and are being systematically reviewed to ensure risk descriptions, controls, assurances, action plans, and risk scores remain current and reflective of the present operational position. Progress is being monitored monthly through Quality Governance meetings, with escalation of any risks that remain overdue or where additional executive support is required.

As part of the current governance reset and "back to basics" approach, the aim is to eliminate the backlog of overdue risk reviews over the next three months, with all high and extreme risks prioritised for immediate review within the next four weeks. A monthly trajectory is being monitored by the Assistant Director of Nursing and senior leadership team to provide assurance that the backlog is reducing and that risks are being actively managed, reviewed, and escalated appropriately.

Updates on progress, including the number of outstanding overdue risks, risks escalated, and those reviewed and closed, will be reported through the Quality Governance structure to provide ongoing assurance to QSEC regarding improvement and compliance with risk management requirements.



Our Safety Dashboard - escalation function trends

Refresh Date: 11/09/2026

Function: Planned and Specialist Care | Topic: All | Period: August 2026 | Data in table: Actual values / Scores

KEY (score out of 10): Substantial assurance (10) | Unsatisfactory assurance (3) | Reasonable assurance (7) | No assurance (0) | Limited assurance (5) | Not applicable (n/a)

Assurance achieved: 48% Aug 26 — Total score: 77 Maximum score: 160

Topic	Measure	Jun 26	Jul 26	Aug 26	Trend (Apr 22 - Aug 26)
Incidents	Incidents open >60 days	595	566	604	
	Incidents open >120 days	371	383	392	
	Patient safety incidents closed with moderate or above harm	3	1	1	
	Overdue NRIs	9	9	6	
Patient experience	Longest open complaint	503	527	558	
	% complaints responded to within 30 days	0.0%	0.0%	0.0%	
Healthcare Acquired Infection	C diff hospital onset	0	2	2	
	S aureus hospital onset	0	0	0	
	E coli hospital onset	0	0	0	
Patient safety measures	Falls (more than minimal harm - on reporting)	0	2	1	
	Pressure damage (developed or worsened during clinical care)	2	3	12	
	Medication errors - low harm or above on reporting	6	8	6	
	Avoidable VTE (all levels, hospital acquired)	0	0	0	
Deteriorating patient	Unplanned admissions from wards to ITU	n/a	n/a	n/a	
	ITU admissions from A&E/MIU where the patient waited over 4 hours	n/a	n/a	n/a	
Duty of Candour	Initial DoC assessment not been undertaken within 5 days	104	113	113	
	DoC has triggered and no in-person contact has been made	1	1	0	
Audit	HIW improvement plan actions overdue	3	3	4	

Nationally Reportable Incidents (NRI)

	0-30days	31-60days	61-90days	91-120days	121-180days	>180days	Total
Planned & Specialist Care	2	4	1	0		0	7

Open Incidents/Closure

The CCG have a total of 249 overdue incidents that are currently being reviewed. Support has been secured from the Quality Assurance Support Team (QAST) to expedite progress and strengthen oversight.

A structured recovery plan is in place:

- 36 incidents are awaiting final closure and are being reviewed with the aim of completion imminently.

- 135 no/low harm incidents are being reviewed through a thematic approach, enabling timely closure while ensuring key learning is captured.
- 21 catastrophic/death incidents are undergoing detailed review to determine their current status and identify any outstanding actions required to progress them, including specialist clinical review where necessary.

Robust oversight arrangements have been established to identify any incidents that have stagnated or require escalation. Any incidents identified as requiring additional support or intervention will be escalated through the appropriate governance routes and highlighted to senior nursing leadership to ensure timely progression.

This work forms part of the wider quality governance reset, aimed at reducing the backlog of overdue incidents, strengthening accountability, and ensuring all incidents are reviewed, investigated, and closed in a timely manner, with learning captured and shared across services.

Patient Safety Serious Incidents, Never Events and Learning

As part of the CCG's governance reset, particular focus is being placed on strengthening oversight, accountability and assurance relating to Patient Safety Alerts (PSAs), patient safety incidents and Never Events. The Care Group recognises that the QSEC will require assurance not only that incidents are investigated appropriately, but also that identified improvements are implemented, monitored and embedded into practice.

For any PSA, Never Event or significant patient safety incident occurring within the Clinical Care Group, a designated executive, professional or operational lead will be identified at the outset to provide clear leadership and accountability for the investigation, development of action plans, and delivery of improvements. This ensures ownership remains visible throughout the process and that actions are progressed within agreed timescales.
To provide assurance, all investigations and associated action plans will be monitored through Service Group Quality and Safety Meetings and escalated to the Clinical Care Group Quality Governance Meeting. Where actions remain outstanding or risks persist, these will be subject to enhanced scrutiny and incorporated into the Care Group's three-month recovery trajectories.

The Care Group is also strengthening its approach to organisational learning. Learning identified from PSAs, Never Events, serious incidents, complaints, inquests, safeguarding reviews, audits and patient feedback will be systematically reviewed to identify recurring themes, contributory factors and opportunities for improvement. This learning will be disseminated through a range of mechanisms including:

- Clinical Care Group Quality Governance Meetings.
- Service Group Quality and Safety Meetings.
- Safety briefings and team meetings.
- Health Board-wide governance and patient safety forums.
- Targeted education and training sessions.

To ensure learning is embedded rather than simply shared, the Care Group will seek evidence of implementation and impact through audit, monitoring of quality metrics, re-measurement of performance indicators and review of incident trends. This will provide

assurance that lessons identified have resulted in meaningful changes to practice and reduced the likelihood of recurrence.

As part of the current reset phase, the Care Group's priority is to ensure that all outstanding investigations, actions and lessons learned are reviewed, tracked and completed, providing a robust baseline from which a more proactive and mature Quality Management System can be developed. This approach will provide QSEC with assurance that patient safety concerns are subject to clear leadership, effective investigation, timely implementation of actions, and the consistent sharing and embedding of learning across both the CCG and the wider Health Board.

Patient Experience

Speciality/Service	% Good	% Poor	otal Responses	Very good	Good	ner good nor poor	Poor	Very poor	Don't Know
Total	100.0%	0.0%	26	21	5	0	0	0	0
Breast	100.0%	0.0%	2	2	0	0	0	0	0
Cardiology	100.0%	0.0%	2	2	0	0	0	0	0
Chemical Pathology	100.0%	0.0%	2	2	0	0	0	0	0
Dermatology	100.0%	0.0%	8	7	1	0	0	0	0
Diabetic Medicine	100.0%	0.0%	1	1	0	0	0	0	0
Ear Nose and Throat	100.0%	0.0%	1	1	0	0	0	0	0
Gastroenterology	100.0%	0.0%	1	0	1	0	0	0	0
Geriatric Medicine	100.0%	0.0%	1	0	1	0	0	0	0
Ophthalmology	100.0%	0.0%	2	1	1	0	0	0	0
Respiratory Medicine	100.0%	0.0%	3	3	0	0	0	0	0
Trauma and Orthopaedics	100.0%	0.0%	1	1	0	0	0	0	0
Urology	100.0%	0.0%	1	0	1	0	0	0	0
Vascular	100.0%	0.0%	1	1	0	0	0	0	0

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'Too often the exceptional work carried out by NHS staff goes unrecognised, so I felt it was important to write and acknowledge the outstanding service we experienced. The commitment, teamwork and compassion displayed by the whole team reflected the very best of our healthcare services. ' (Outpatients, Prince Philip Hospital (PPH)

This feedback provides valuable recognition of the high standards of care, compassion and teamwork demonstrated by staff within Outpatients at PPH and has been shared with the team to acknowledge their contribution. However, it is recognised that there is more work to do to ensure patient feedback, both positive and negative, is consistently captured, shared and used to drive improvement across the CCG.

As part of the Quality Governance reset, a renewed focus is being placed on listening to patient feedback, improving how learning is identified and communicated, and establishing more robust mechanisms for sharing good practice across services. This will help ensure that examples of excellence are celebrated and replicated, whilst also strengthening the use of patient experience information to inform service improvement, quality assurance and organisational learning.

Psychological Safety and Freedom to Speak Up

Recognising that high-quality care is dependent upon a culture where staff feel safe, valued and empowered to raise concerns, the Clinical Care Group is committed to strengthening both psychological safety and the Freedom to Speak Up agenda across all services.

As part of this commitment, the Assistant Director of Nursing is working in partnership with the Freedom to Speak Up Team to develop and pilot a bespoke programme of work within the Clinical Care Group. The aim is to promote a culture of openness, transparency and learning, where staff at all levels feel confident to speak up about concerns, ideas for improvement, patient safety issues, workplace culture and staff wellbeing without fear of reprisal.

The programme will support greater ownership of the Speak Up agenda within the Care Group and will include the development of a network of Speak Up Champions across services. These champions will act as visible and accessible points of contact for colleagues, helping to raise awareness, encourage constructive challenge and support staff in escalating concerns through appropriate channels.

Clear governance arrangements will be established to oversee this work, ensuring that concerns raised are appropriately managed, themes and trends are identified, and learning is shared across the Clinical Care Group and wider Health Board where appropriate. Regular reporting through the Quality Governance structure will provide assurance that staff voices are being heard, concerns are acted upon, and opportunities for improvement are translated into meaningful change.

Through this approach, the Clinical Care Group aims to foster a culture of trust, inclusion and continuous improvement, recognising that creating a psychologically safe environment is fundamental to delivering safe, effective and compassionate care for patients and supporting the wellbeing of staff.

Quality Assurance, Governance Reset and Recovery Planning

The Clinical Care Group recognises that, in order to strengthen quality governance and provide robust assurance, a period of reset is required. As part of this reset, the Care Group is adopting a "back to basics" approach, focusing on addressing existing backlogs, improving oversight, strengthening accountability, and ensuring fundamental governance processes are operating effectively and consistently across all services.

This approach acknowledges that a number of quality indicators, risks, complaints, and outstanding actions require focused attention before the CCG can move forward with a more mature Quality Management System approach. The immediate priority is therefore to establish a clear understanding of the current position, reduce outstanding backlogs, and ensure that all areas of concern have effective recovery plans in place.

To support this, all quality metrics that fall below agreed thresholds, including overdue risks, complaints, incidents, mandatory training compliance, audit actions and other governance indicators, will be subject to a formal three-month recovery trajectory. These plans will provide assurance that underperformance is being actively managed and that there is a structured pathway towards improvement.

Each recovery trajectory will identify:

- The current position and extent of the backlog or performance gap.
- Outstanding actions, risks or quality concerns.
- Monthly improvement milestones over a three-month period.
- Specific actions required to achieve recovery.

- The accountable lead responsible for delivery.
- Any barriers to delivery and associated mitigating actions.

Progress will be monitored through Service Group Quality and Safety Meetings and reviewed at the monthly CCG Quality Governance Meeting. This will provide increased scrutiny, challenge and support, ensuring that improvement actions are delivered at pace and that risks are appropriately managed.

Through this reset phase, the CCG aims to re-establish strong governance foundations, improve visibility of quality performance, clear historic backlogs, and strengthen assurance processes. This will place the organisation in a stronger position to move beyond retrospective management towards a proactive, data-driven approach that demonstrates measurable improvements in quality, safety and patient experience.

Argymhelliad / Recommendation

The Quality, Safety and Experience Committee is asked to take an assurance on the quality governance arrangements in place within the Planned Services and Specialist Care CCG in relation to quality, safety and patient experience.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	2.1 Provide the Board with assurance that care across the Health Board is safe, timely, efficient, effective, equitable and person-centred.
Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable All Strategic Objectives are applicable
Nodau Cynllunio 2026/27 Planning Goals 2026/27	1. Healthy, Thriving Teams 5. People First, Digital Always 6. Safe, Timely, High Quality Care 7. Future Orientated 8. Fit for Purpose, Modern Facilities and Services

Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	9. All HDdUHB Well-being Objectives apply
Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau) A Social Model for Health and Wellbeing: (*complete for strategic change and/or significant service changes)*	6. A culture of testing and learning will be encouraged, enabled, supported and celebrated.
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Contained within the report
Rhestr Termau: Glossary of Terms:	Contained within the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	Planned Services and Specialist Care Clinical Care Group meetings

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Contained within the report.
Ansawdd / Gofal Claf: Quality / Patient Care:	Contained within the report.
Gweithlu: Workforce:	Contained within the report.
Tegwch Iechyd: Health Equity:	Not Applicable
Risg: Risk:	Contained within the report.
Cyfreithiol: Legal:	Not Applicable

Enw Da: **Reputational:**	Contained within the report
Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	Not Applicable

9

9 - Policies/ Procedures for Approval

9.1

9.1 - 004 Claims Management Policy Extension

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

Attachments

SBAR - Policy 004 Claims Management Policy Deferral to December 2026.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	08 OCTOBER 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Policy 004: Claims Management Extension
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Sharon Daniel, Executive Director of Nursing, Quality and Patient Experience
SWYDDOG ADRODD: REPORTING OFFICER:	Louise O'Connor, Assistant Director of Legal Services and Patient Experience

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

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

The Claims Management Policy (004), is due for review on 5 October 2026. The policy requires updating to reflect the implementation of the Listening to People Regulations and the consequential changes to the relationship between concerns, redress and claims management.

The Committee is asked to approve an extension of the policy until January 2027. This will enable the revised policy to take account of the Welsh Risk Pool Management of Concerns Assessment Report 2025–26 and any recommendations arising from that assessment. 004 - Claims Management Policy

Cefndir / Background

Policy 004 defines the Health Board's policy, roles and responsibilities for the management of redress matters, clinical negligence claims, personal injury claims and General Medical Practice Indemnity claims. The current version was approved on 5 October 2023, became active on 10 October 2023 and has a review date of 5 October 2026.

A full review is required to replace or amend references to Putting Things Right and to ensure that the claims and redress arrangements are aligned with the Listening to People Regulations and the Health Board's revised concerns management arrangements.

The final report Welsh Risk Pool Management of Concerns Assessment 2025–26 is awaited. It is therefore appropriate that the policy review reflects any relevant findings or recommendations arising from the assessment.

Asesiad / Assessment

The requested to extend is limited to the period required to consider the assessment report and complete the necessary policy amendments, submission to the Listening and Learning Sub-Committee, and consultation period. The current policy will remain in force during this period, ensuring continuity of the Health Board's established claims and redress arrangements.

Extension until January 2027 will support a more complete and robust review by allowing the updated policy to:

- reflect the Listening to People Regulations and associated terminology;
- clarify the interface between concerns, redress and claims management;
- incorporate any relevant recommendations from the Welsh Risk Pool Management of Concerns Assessment Report 2025–26; and
- avoid the need for successive amendments within a short period.

The proposed extension is therefore considered proportionate.

Argymhelliad / Recommendation

The Quality, Safety and Experience Committee is asked to approve the extension of Policy 004, Claims Management Policy, from 5 October 2026 until 31 January 2027.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	.3.12 Ensure that the organisation is meeting the requirements of the NHS Concerns, Complaints and Redress Arrangements (Wales) Regulations.
Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	No specific Datix risk is cited in this report.
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	Safe; Effective; Efficient; Person-centred.
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	1. Striving teams 3. Great care

Nodau Cynllunio 2026/27 Planning Goals 2026/27	2. Customer Service Excellence 6. Safe, Timely, High Quality Care
Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	7. Improve health and well-being by focusing on prevention and early intervention, while working in partnership to ensure everyone has equal access to care and opportunities for good health.
Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau) A Social Model for Health and Wellbeing: (*complete for strategic change and/or significant service changes)*	6. A culture of testing and learning will be encouraged, enabled, supported and celebrated.
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Policy 004, Claims Management Policy; Listening to People Regulations; Welsh Risk Pool requirements and the awaited Management of Concerns Assessment Report 2025–26.
Rhestr Termau: Glossary of Terms:	Contained in the policy.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	Listening and Learning Sub-Committee. Further consultation will be undertaken as part of the policy review, where required.

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No direct financial impact arises from the requested deferral. The review will consider any relevant Welsh Risk Pool recommendations, including matters affecting claims and redress governance or reimbursement requirements.
Ansawdd / Gofal Claf: Quality / Patient Care:	The current approved policy will remain in force during the short deferral period. The updated policy will support alignment between claims, redress and the Listening to People arrangements.
Gweithlu: Workforce:	Staff will continue to follow the current policy until the revised version is approved. Any changes arising from the

	review will be communicated through the implementation arrangements for the updated policy.
Tegwch Iechyd: **Health Equity:**	No specific health equity impact arises from the deferral. Relevant impacts will be considered through the policy review and Equality Impact Assessment process.
Risg: **Risk:**	The principal risk is that the current policy will pass its scheduled review date. This is mitigated by the short, time-limited deferral, continuation of the existing approved policy and completion of the review by December 2026. Completing the review before the assessment findings are known may result in omissions or an immediate need for further amendment.
Cyfreithiol: **Legal:**	The review is required to ensure that the policy reflects the Listening to People Regulations and remains aligned with applicable claims, redress and Welsh Risk Pool requirements.
Enw Da: **Reputational:**	The controlled deferral supports a complete and evidence-informed policy review. Failure to reflect relevant regulatory changes or assessment recommendations could create reputational and governance risk.
Gyfrinachedd: **Privacy:**	No additional privacy impact arises from the deferral. Information governance, confidentiality, disclosure and legal professional privilege requirements will continue to apply under the existing policy and will be reviewed as part of the update.
Cydraddoldeb: **Equality:**	The Equality Impact Assessment will be reviewed and updated, where required, alongside the revised policy.

9.2

9.2 - 1561 - ‘Listening to People’ Integrated Patient Safety, Concerns Management and Resolution Policy

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

Attachments

Policy 894 Listening to People SBAR - Committee.pdf

1561- Listening to People Policy - for approval.pdf

EqIA Screening 894 - LTP.pdf

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

DYDDIAD Y CYFARFOD / DATE OF MEETING:	**08 OCTOBER 2026**
TEITL YR ADRODDIAD: TITLE OF REPORT:	Policy 894: Listening to People - Integrated Patient Safety, Concerns Management and Resolution Policy
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Sharon Daniel, Executive Director of Nursing, Quality and Patient Experience
SWYDDOG ADRODD: REPORTING OFFICER:	Louise O'Connor, Assistant Director of Legal Services and Patient Experience

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Committee is asked to approve Policy 894, Listening to People: Integrated Patient Safety, Concerns Management and Resolution Policy, for implementation across Hywel Dda University Health Board (the Health Board). The policy has been developed in accordance with the Health Board's Written Control Documentation requirements and provides the strategic framework for transition from Putting Things Right to the national Listening to People arrangements introduced from 1 April 2026.

The policy establishes a single, integrated and person-centred approach to concerns, complaints, patient safety incidents, claims, redress and wider quality intelligence. It positions listening, learning and improvement as core organisational responsibilities and supports the Health Board's duties of quality, candour, openness and continuous improvement.

Cefndir / Background

Listening to People represents a significant change in how NHS organisations in Wales respond to concerns. It strengthens the emphasis on early and compassionate engagement, accessible communication, proportionate review, timely resolution, learning and demonstrable improvement.

Policy 894 brings previously connected but sometimes separately managed routes into one strategic framework. This includes complaints, incidents, claims, redress and patient experience feedback, together with interfaces such as safeguarding, Medical Examiner concerns, mortality review, inquests, Prevention of Future Death reports, Ombudsman matters and external scrutiny.

The policy reflects the National Patient Safety Plan's Quality Management System approach by bringing together quality planning, control, assurance and improvement. It also aligns the Health Board's arrangements with the Listening to People statutory framework, the NHS

concerns and redress regulations, the Duty of Quality, the Duty of Candour and Public Services Ombudsman for Wales complaint-handling principles.

The policy has been informed by consultation through the Listening and Learning Sub-Committee and the Health Board's staff and trade union consultation process.

Asesiad / Assessment

The policy provides a clear strategic foundation for an integrated patient safety and concerns management system. Its central features are:

• a single integrated triage approach, so concerns are assessed consistently regardless of how they enter the organisation;

• proportionate decision-making based on harm, risk, complexity, safeguarding, potential qualifying liability and learning potential;

• an expectation of early resolution where appropriate, supported by a mandatory offer of a Listening Discussion;

• coordinated review through the principle of 'Investigate Once, Investigate Well', reducing duplication and the burden on patients, families and staff;

• multidisciplinary oversight of complex, high-risk or significant concerns through Concern Management Groups;

• clear accountability for Clinical Care Groups and services to investigate, implement actions, evidence delivery and evaluate impact; and

• stronger organisational learning, with themes and actions triangulated across complaints, incidents, claims, patient feedback, safeguarding, legal and other quality intelligence.

The policy supports a Just Culture and psychological safety, recognising the importance of compassionate support for staff as well as patients and families. It also strengthens expectations concerning accessibility, reasonable adjustments, advocacy, equality monitoring and the identification of potential inequity or discrimination.

The principal strategic risk is not the policy itself, but inconsistent implementation. This could result in fragmented pathways, duplicated investigations, missed safeguarding, candour or redress considerations, variable investigation quality, delayed responses and insufficient evidence that learning has improved care. These risks will be mitigated through supporting procedures, integrated triage, role-specific training and competence arrangements, clear governance and escalation, performance reporting and monitoring of the implementation and impact of improvement actions.

Assurance will be provided through the Listening and Learning Sub-Committee, with escalation and assurance reporting to the Quality, Safety and Experience Committee and, where appropriate, the Board. The primary measure of success will be the extent to which concerns lead to measurable learning, improvement and reduced risk of future harm, rather than compliance with timescales alone.

Argymhelliad / Recommendation

The Quality, Safety and Experience Committee is asked to approve Policy 894 for implementation across the Health Board.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)	
Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	3.22 Approve policies and plans within the scope of the Committee, having taken an assurance that the quality and safety of patient care has been considered within these policies and plans.
Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	No specific Datix risk is cited in this report. Implementation risks will be monitored and escalated through established quality and safety governance arrangements.
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	All applicable: Safe; Timely; Effective; Efficient; Equitable; Person-centred.
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	1. Striving teams 3. Great care
Nodau Cynllunio 2026/27 Planning Goals 2026/27	2. Customer Service Excellence 1. Healthy, Thriving Teams 6. Safe, Timely, High Quality Care 5. People First, Digital Always Choose an item.
Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	7. Improve health and well-being by focusing on prevention and early intervention, while working in partnership to ensure everyone has equal access to care and opportunities for good health
Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau) A Social Model for Health and Wellbeing: (*complete for strategic change and/or significant service changes)*	6. A culture of testing and learning will be encouraged, enabled, supported and celebrated.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	NHS (Concerns, Complaints and Redress) Arrangements (Wales) Regulations 2011, subsequent amendments – Listening to People Process 2026 Quality and Engagement Act
Rhestr Termau: Glossary of Terms:	Contained in body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	Listening and Learning Sub-Committee Global Staff and TU consultation process

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No direct financial approval is sought through this report. Implementation will require coordinated operational capacity, training, investigation capability, digital and performance support, and sustained leadership oversight within existing planning and governance arrangements. Any material resource pressures identified through implementation should be escalated through the appropriate planning route.
Ansawdd / Gofal Claf: Quality / Patient Care:	Positive strategic impact. The policy is intended to improve early engagement, accessibility, proportionality, coordination, investigation quality, organisational learning and evidence that concerns lead to safer care and better patient experience.
Gweithlu: Workforce:	All staff have responsibilities to listen, act, report, escalate and contribute to learning. Clinical Care Groups and services must ensure staff capacity, competence and oversight for early resolution, investigation and improvement. The policy promotes Just Culture, psychological safety and compassionate support for staff involved in concerns.
Tegwch Iechyd: Health Equity:	The policy strengthens requirements for accessible communication, reasonable adjustments, advocacy, language support and equality monitoring. It requires analysis of barriers, disparities, discrimination-related concerns and differential outcomes to inform improvement action. An updated Equality Impact Assessment is attached.
Risg: Risk:	Key risks relate to inconsistent implementation, fragmented pathways, delayed or duplicated investigations, missed statutory considerations, variable investigation quality, insufficient workforce capability and failure to demonstrate learning impact. Mitigations include integrated triage, Concern Management Groups, defined accountabilities, training

	and competence arrangements, action tracking, performance reporting and committee escalation.
Cyfreithiol: **Legal:**	The policy supports compliance with the NHS concerns and redress regulations as amended for Listening to People, the Duty of Quality, the Duty of Candour, safeguarding duties, Public Services Ombudsman for Wales complaint-handling standards and associated statutory guidance. Safeguarding requirements take precedence where applicable.
Enw Da: **Reputational:**	Effective implementation should strengthen transparency, trust and public confidence. Inconsistent, delayed or inaccessible handling of concerns, or failure to evidence learning, would create reputational and regulatory risk.
Gyfrinachedd: **Privacy:**	Information must be managed through approved Health Board systems and communication channels, with appropriate recording, access and information-governance controls. Detailed operational requirements will be set out in supporting procedures.
Cydraddoldeb: **Equality:**	Updated Equality Impact Assessment attached. The policy includes explicit requirements concerning accessibility, inclusion, reasonable adjustments, advocacy, equality monitoring and action on identified disparities or discrimination.

‘Listening to People’ Integrated Patient Safety, Concerns Management and Resolution Policy

Policy information

Policy number: 1561
Classification: Corporate
Supersedes: 514/894
Version number: 1
Date of Equality Impact Assessment: ***

Approval information

Approved by: QSEC
Date of approval:
Date made active:
Review date:

Summary of document:
This policy replaces the previous Putting Things Right approach with an integrated Listening to People framework. It brings together concerns, complaints, patient safety incidents, claims and redress, alongside related interfaces such as Medical Examiner cases, inquests, safeguarding referrals and external reviews, within a unified patient safety and learning system.

The purpose is to establish a single integrated framework for listening, responding, resolving, learning and improving from concerns, patient safety events and feedback.

The National Patient Safety Plan for NHS Wales 2026–2031 places Quality Management Systems (QMS) at the centre of patient safety improvement, bringing together quality planning, quality control, quality assurance and quality improvement into a single, coherent framework. The Health Board's Integrated Patient Safety Triage Model reflects this approach by ensuring that complaints, incidents, claims, redress cases, patient experience feedback, safeguarding concerns and other quality intelligence are considered together, enabling a proportionate, learning-focused response and supporting continuous improvement in the quality and safety of care.

This policy is also compliant with the Public Services Ombudsman for Wales Act (2019) and the Complaints Standards Authority Principles for Complaint Handling; and the Health and Social Care (Quality and Engagement) (Wales) Act (2020).

This policy incorporates the all Wales Listening to People, NHS Wales Complaints, Incidents and Redress Process – Guidance for organisations 2026 Hywel Dda Patient Experience - LTP - Organisational Guidance.pdf - All Documents (opens in a new tab)

Scope:

This policy applies to all staff who have a responsibility to report, manage and / or formally review concerns or be engaged in the formal review of a concern.
The Policy covers concerns about:

- Health Board services;
- Services provided by Health Board employed staff; and
- Services provided by the independent or voluntary sector which are funded by the Health Board.

The Health Board expects its independent contractors to have processes in place that meet the requirements of the Listening to People Regulations and the Duty of Candour requirements and this should be clearly specified within any contractual documentation and agreements.

To be read in conjunction with:
Accessible Communication and Information Standards in Healthcare (Welsh Government, 2025): view the standards

982 – Incident, near Miss and hazard Reporting Policy – opens in a new tab
429 - Management and Distribution of Safety Alerts and Notices Policy – opens in a new tab
004 - Claims Management Policy – opens in new tab
018 - Staff Attending Inquests / Court and Assisting with Police Investigations Guideline – opens in new tab
558 - Management of Nursing and Midwifery Medication Errors / Near Misses Policy – opens in new tab
All national and local guidance documents – found at : Hywel Dda Quality, Assurance and Safety - Home (intranet site containing information on concerns management, guidance and training materials and the learning library).
Listening to People Standard Operating Procedures and Clinical Care Group supporting guidance are available through the relevant Health Board intranet pages.

Patient information:
Patient support services (complaints & feedback) - Hywel Dda University Health Board (website page) – opens in new tab

Owning group:
Nursing, Quality and Patient Experience Directorate
Listening and Learning Sub Committee

Executive Director job title: Director of Nursing, Quality and Patient Experience

Reviews and updates:
1.0 – New Policy superseding 894 Putting things right policy PTR - Management and Resolution of Concerns Policy

Keywords
Listening to People, Incident, Complaint, Claim, Concern, Duty of Candour, Being Open, Investigation, patient safety, experience and feedback, accessible communication, equality, discrimination and reasonable adjustments.

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Introduction

Listening is everyone's responsibility. Learning is everyone's responsibility. Improving is everyone's responsibility.

By creating a culture of compassion, openness, psychological safety and continuous learning, Hywel Dda University Health Board is committed to ensuring that every concern contributes to safer care, better experiences and improved outcomes for the people and communities we serve.

The true measure of effectiveness is not how efficiently concerns are processed, but how successfully they are used to improve quality, reduce avoidable harm, enhance patient experience and strengthen public trust in our services.

Providing safe, effective and person-centred care is a fundamental responsibility of NHS Wales. Despite significant advances in healthcare, patient harm remains a recognised challenge internationally. The World Health Organisation (WHO) continues to report that around one in ten patients experience harm during healthcare, with more than half of such harm considered preventable. Patient safety incidents occur across all healthcare settings, including hospitals, community services, primary care and mental health services. Common sources of avoidable harm include diagnostic error, delays in treatment, communication failures, inaccessible information, medication-related harm, healthcare-associated infections and failures in care coordination. [who.int][who.int]

The WHO Global Patient Safety Report 2024 highlights that improving patient safety requires strong organisational cultures, effective incident reporting and learning systems, patient and family engagement, compassionate communication, and the continuous use of information to identify risks and prevent recurrence. Importantly, the report emphasises that listening to patients, families and staff is essential to creating safer systems of care. [who.int].

In Wales, the introduction of Listening to People from 1 April 2026 represents a significant evolution in the way NHS organisations respond to concerns, complaints, incidents and redress. Listening to People replaces the previous Putting Things Right arrangements and reflects a strengthened national commitment to openness, compassion, early resolution, learning and improvement. The framework is designed to ensure that every person who raises a concern is treated with dignity, fairness, respect and compassion, whilst ensuring organisations learn effectively from feedback, concerns and adverse events. [New Listen...o concerns | SharePoint], [01.-FINAL-...l-Guidance | PDF]

The principles underpinning Listening to People are to:

- Enhance and improve safer care delivery through listening and acting;
- Promote an open and just culture;
- Increase transparency and trust;
- Mitigate against future harm;
- Support staff development and learning; and
- Meet legal duties and ethical standards.

Accordingly, the Health Board has a responsibility to maintain systematic arrangements that safeguard patients, service users, staff, visitors, NHS resources and organisational reputation. This responsibility extends beyond identifying what happened when concerns arise; it requires a commitment to understanding why events occurred, examining contributory factors, listening to the experiences of those affected, and implementing meaningful actions that reduce the risk of recurrence.

An integrated approach to incidents, complaints, claims, patient safety events, safeguarding concerns and feedback enables the organisation to identify themes, learn across traditional organisational boundaries and strengthen the quality and safety of services.

The focus of all concern management activity should therefore be on improvement, proportionality, transparency, accountability and organisational learning.

This policy incorporates the arrangements required for the management of concerns in accordance with the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011, as amended by the Listening to People statutory framework and associated guidance introduced on 1 April 2026.

These arrangements establish a consistent approach to managing concerns across NHS Wales, including requirements relating to listening discussions, early resolution, investigations, redress, duty of candour, learning and service improvement. [gov.wales], (opens in a new tab).

Where concerns identify actual or potential risks to children or adults at risk, these will be managed in accordance with safeguarding legislation and procedures, including the duty to report under the Social Services and Well-being (Wales) Act 2014.

Safeguarding concerns are not managed primarily through Listening to People. Where information received through a concern, complaint, incident, Medical Examiner communication or other route indicates actual or suspected abuse, neglect, exploitation, deliberate harm or risk to a child or adult at risk, the All-Wales Safeguarding Procedures and relevant Health Board safeguarding policies take precedence. The Listening to People process must not delay or interfere with immediate safeguarding action, statutory reporting, strategy discussions, enquiries, police involvement or multi-agency protection arrangements.

In some circumstances, the presence of safeguarding concerns may mean that the issues raised are not suitable for the Listening to People process, either in whole or in part. Decisions about whether Listening to People activity can proceed, should be paused, adapted or undertaken in parallel must be made in consultation with safeguarding leads and clearly documented.

The Health Board is also required to comply with the Public Services Ombudsman (Wales) Act 2019, which established the Complaints Standards Authority (CSA) for Wales. The CSA requires public bodies to ensure complaint handling arrangements are:

- Complainant Focused
- Simple
- Fair and Objective
- Timely and Effective
- Accountable
- Committed to Continuous Improvement. [ombudsman.wales], (opens in a new tab).

These principles align closely with the values and expectations of Listening to People and with the Health Board's duties under the Health and Social Care (Quality and Engagement) (Wales) Act 2020, including the Duty of Quality and Duty of Candour. Together they provide the framework through which

the organisation listens, learns and improves in response to concerns raised by patients, families, unpaid carers, staff and partners.

This policy and all associated procedures are designed to ensure that every concern is managed in a manner that is person-centred, proportionate, compassionate, transparent and focused on learning and improvement, so that the experiences of people who use our services lead to safer care and better outcomes for all.

Policy statement

At Hywel Dda University Health Board, listening, learning and improving are fundamental to the delivery of safe, effective and compassionate care. We are committed to creating a culture in which the voices of patients, families, unpaid carers, staff and partners are actively welcomed, valued and acted upon to improve experiences, outcomes and services.

We recognise that concerns – no matter how they are raised whether this be a complaint, an incident, an adverse event, a near miss, a claims, or a letter from the medical examiner – and compliments and feedback provide powerful opportunities to understand what matters most to people and to learn from both excellence and when things go wrong. We are committed to responding to concerns with empathy, kindness, openness and respect, ensuring that every individual is listened to, treated fairly and supported throughout the process.

Delivering safe, high-quality care and responding appropriately when concerns are raised is everyone's responsibility. Every member of staff, irrespective of role or profession, has a duty to listen, act, escalate concerns appropriately, support learning and contribute to continuous improvement. This responsibility extends to leaders at all levels, who must foster an environment in which people feel safe to speak up, ask questions, share experiences and report concerns without fear of blame, discrimination or reprisal.

The Health Board is committed to promoting a Just Culture that seeks to understand why events occur rather than simply identifying who was involved. We will approach concerns with professional curiosity, compassion and fairness, recognising that most errors arise from a combination of human, system, organisational and environmental factors. Investigations and reviews will therefore focus on understanding contributory factors, identifying opportunities for improvement and reducing the likelihood of future harm, whilst maintaining appropriate accountability where required.

We recognise that involvement in adverse events, complaints, investigations and claims can have a significant emotional and psychological impact on staff. We are committed to supporting the wellbeing of our workforce and ensuring that staff involved in concerns are treated with dignity, compassion and respect. We will promote psychological safety, encourage reflective practice and provide appropriate support so that staff feel able to contribute openly to learning and improvement processes.

Through the Listening to People framework, the Duty of Quality, the Duty of Candour and our wider quality and safety arrangements, we will ensure that concerns are managed in a timely, proportionate, transparent and person-centred manner.
We will actively demonstrate how learning from concerns leads to improvements in care, strengthens public confidence and contributes to safer services for the population we serve.

Above all, we are committed to creating a culture where every voice matters, every concern is an opportunity to learn, and every interaction is grounded in compassion, respect and a shared commitment to continuously improving the quality and safety of healthcare.

Scope

This policy applies to all staff who have a responsibility to identify, receive, report, acknowledge, triage, manage, investigate, review, respond to, learn from or provide assurance in relation to concerns. It applies regardless of how the concern enters the organisation, including concerns received directly by any member of staff by email, telephone, letter, online form, in person or through another communication method, and concerns raised directly by patients, families, unpaid carers or representatives; complaints; incidents; near misses; adverse events; staff-reported patient safety issues; Medical Examiner communications; mortality review findings; inquests; Prevention of Future Death reports; claims; redress considerations; safeguarding concerns; commissioned service concerns; independent contractor issues; Ombudsman matters; regulator feedback; external scrutiny; or other quality, safety, experience or governance intelligence.

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The policy covers concerns relating to NHS-funded care, treatment, support, communication, access, experience, safety, quality, professional practice, systems, processes and outcomes where Hywel Dda University Health Board is the responsible body, provider or commissioner.

The Policy covers concerns about:

- Health Board services;
- Services provided by Health Board employed staff; and
- Services provided by the independent or voluntary sector which are funded by the Health Board.

The Health Board recognises that independent contractors are responsible bodies under the Listening to People arrangements where they provide NHS-funded care.

The Health Board expects independent contractors and commissioned providers to maintain processes that meet the requirements of the Listening to People Regulations, Duty of Candour and relevant contractual obligations.

Where a concern includes safeguarding issues, the All-Wales Safeguarding Procedures and relevant Health Board safeguarding policies take precedence over this policy. Such concerns must be referred and managed through the appropriate safeguarding pathway without delay. The Listening to People process must only proceed where it is appropriate and does not compromise safeguarding enquiries, statutory duties, police involvement or multi-agency protection arrangements.

Where a matter is excluded from, unsuitable for, or paused under Listening to People, the rationale must be recorded and the person raising the concern must be signposted to the appropriate process wherever this can be done safely and lawfully.

Aim

The aim of this policy is to establish a single, integrated and person-centred approach to the management of concerns, ensuring that patients, families, unpaid carers and staff are listened to, treated with compassion and respect, and supported throughout the process.

Through timely, proportionate and transparent review of concerns, the Health Board seeks to understand not only what happened, but why it happened, so that learning can be translated into

meaningful improvement, safer care, better experiences and improved outcomes for the people and communities we serve.

Objectives

This policy aims to:

- Promote a culture of openness, compassion, professionalism and continuous improvement, where feedback, concerns and adverse events are welcomed as opportunities to learn.
- Ensure compliance with the Listening to People framework, the Duty of Candour, the Duty of Quality and all relevant statutory and regulatory requirements.
- Create an environment of psychological safety in which patients, families, unpaid carers and staff feel confident to speak up, raise concerns, share experiences and contribute to learning without fear of blame or disadvantage.
- Ensure concerns are reviewed in a timely, proportionate and person-centred manner, with the level of review informed by risk, harm, complexity and learning potential.
- Support a Just Culture approach that seeks to understand human, organisational and system factors contributing to events, promoting learning and improvement rather than inappropriate blame.
- Use intelligence from concerns, incidents, complaints, claims, letters from the medical examiner, patient feedback and staff experiences to identify themes, reduce avoidable harm and drive service improvement.
- Ensure learning is translated into demonstrable improvements in patient safety, quality of care, patient experience and workforce wellbeing.
- Support staff involved in incidents, complaints, investigations and claims, recognising the importance of wellbeing, reflective practice and compassionate leadership.

Principles

The management of concerns within Hywel Dda University Health Board will be underpinned by the principles of compassion, openness, fairness, proportionality, transparency, inclusivity, learning and continuous improvement. The Health Board is committed to ensuring that every concern is managed in a way that reflects the values of Listening to People and recognises the needs of individuals raising concerns, those affected by concerns and staff involved in their review.

To achieve this, the Health Board will ensure that:

- Every concern is treated as an opportunity to listen, learn and improve.
- People who raise concerns are treated with dignity, empathy, respect and courtesy, and are actively involved in the process wherever possible.
- Concerns are acknowledged within five working days and managed promptly, openly and in accordance with statutory requirements and agreed timescales.
- Listening Discussions are offered at the earliest appropriate opportunity through the person's preferred and accessible communication method, to understand what matters most to those affected and the outcomes they hope to achieve.
- Reviews and investigations are proportionate to the level of harm, complexity, risk and learning potential presented by the concern.
- Reviews focus on understanding contributory factors, system influences and underlying causes rather than assigning blame, whilst maintaining accountability where appropriate.

- Patients, families, carers and staff are provided with accessible information, reasonable adjustments, advocacy and communication support where required.
- A named Health Board contact is identified to provide continuity, support and communication throughout the management of the concern. Staff must use approved Health Board communication channels and must not provide personal telephone numbers, personal email addresses or personal social media details. Subsequent or unrelated concerns must be redirected into the Health Board's published concerns arrangements and recorded appropriately.
- Staff involved in concerns, incidents, investigations and claims are treated fairly and supported appropriately to promote wellbeing, accessible communication, effective information sharing, reflective learning and psychological safety.
- Learning and improvement actions are identified, implemented, monitored, shared and evaluated to ensure meaningful and sustainable change.
- Information from concerns is triangulated with patient safety, quality, safeguarding, workforce and legal intelligence to support organisational learning and system-wide improvement.
- Consideration is given to the offer of redress, in accordance with the Regulations, where review of the facts identifies a qualifying liability in tort.
- All concerns are managed in accordance with the Listening to People Regulations, the Public Services Ombudsman for Wales Complaint Handling Standards and relevant Welsh Government guidance.

Definitions

Concern

A concern is any expression of dissatisfaction, worry or issue raised about NHS-funded care, treatment or services, or any patient safety incident, near miss, adverse event or other matter that indicates actual or potential harm, poor experience, service failure, risk, unresolved dissatisfaction or an opportunity for learning and improvement. A concern may be raised by a patient, family member, carer, representative, member of staff, partner organisation, Medical Examiner, coroner, regulator, commissioner, independent contractor or other route. Concerns must be triaged and managed through the most appropriate pathway, including Listening to People, patient safety incident management, safeguarding, Duty of Candour, redress, claims, inquest, mortality review, external scrutiny or other governance arrangements.

Enquiry

A request for information, clarification, assistance, signposting or resolution of a simple issue that does not require the formal Listening to People process and where there is no allegation of service failure, harm or unresolved dissatisfaction. It is generally managed through routine service response or patient support functions.

Acknowledgement

A formal written confirmation issued by the responsible body not later than 5 working days after it receives notification of a concern, including the offer of a Listening Discussion and communication support information. The acknowledgement may be made in writing or electronically, depending upon how the concern was notified. Where a concern was notified verbally, the acknowledgement must be in writing.

Stage 1 – Early Resolution
Stage 1, also described as “Listen and Act”, is a rapid and proportionate process for resolving straightforward concerns within 10 working days from acknowledgement. It should involve listening, discussion, explanation, apology and immediate action where appropriate, with the aim of resolving the concern without the need for a formal investigation or written response. The receiving service or Clinical Care Group is responsible for undertaking Stage 1, supported by the Patient Support Team where required. An accountable lead and named contact must be identified. Where the concern cannot be resolved within Stage 1, is not suitable for early resolution, indicates actual or potential harm, raises Duty of Candour, safeguarding or redress considerations, involves disputed facts or significant learning, or the person remains dissatisfied, it must be escalated promptly for integrated triage and consideration under Stage 2. The escalation decision and rationale must be recorded and communicated.

Stage 2 – Complaint / Formal Investigation
Stage 2, also described as “Investigate, Respond and Learn”, is the formal investigation stage for concerns that are unsuitable for early resolution or where early resolution has been unsuccessful.

Stage 2 applies where the issues are more complex, involve actual or potential harm, significant service failure, disputed facts, unresolved dissatisfaction, safeguarding considerations, Duty of Candour issues, qualifying liability considerations or significant learning opportunities. The investigation will culminate in a formal written outcome and learning response, communicated in the manner agreed with the person raising the concern wherever possible.

Listening Discussion
A mandatory offer, made at the point of acknowledgement, of an in-person discussion, which may take place by telephone, video or face-to-face conversation, to understand the concern, communication needs, desired outcomes and suitability for early resolution.

Patient Safety Incident
A patient safety incident is an unintended or unexpected incident that could have or did lead to harm for one or more patients or service users receiving NHS-funded healthcare Note: the term “patient safety incident” refers to an incident occurring during the delivery of healthcare. It is recognised that this may not always be to a patient but can also affect other service users in receipt of NHS-funded healthcare. The language throughout this document has been updated where possible to reflect this but for the avoidance of doubt, the definition of a patient safety incident applies equally to a service user in receipt of NHS funded healthcare even if they are not classified as a patient (NHS Executive 2023).

Never Events
The current never event list can be found on the attached link:
du.nhs.wales/files/incidents/supporting-section-1-never-events-list-pdf/ - opens in new tab

Occurrence of a never event, triggers the Management of Patient Safety Incidents and Serious Concerns Procedure. Advice can be sought from the Quality, Assurance and Safety Team, if there is any doubt as to whether an incident is a never event.

Adverse Event
Any event that has given or may give rise to actual or possible personal injury, patient dissatisfaction, or to property loss or damage.

Near Miss
Any event or omission that could have potentially caused harm, but due to prompt action by a member of staff, or simply because of good fortune was prevented.

Qualifying Liability (QL)
Where there is proven personal injury or loss arising out of, or in connection with, the care or treatment of a patient due to the service provided by the responsible body.

Redress
Redress relates to situations where a patient may have been harmed and that harm was caused by NHS care. It may include:

- A written apology;
- An explanation;
- A report detailing actions taken to prevent recurrence;
- Financial compensation and/or remedial treatment, subject to the requirements of the Regulations.

Where redress is being considered or a claim for compensation made the Health Board's Policy for Claims Management will be followed.

Vexatious or Frivolous Concern
A concern that may be excluded under the Regulations where it is deemed vexatious or frivolous. Any decision to apply this provision must be exceptional, justified, recorded, proportionate and communicated clearly to the person raising the concern.

Safeguarding Concern
A concern indicating actual, suspected or potential abuse, neglect, exploitation, deliberate harm, ongoing risk or risk to a child or adult at risk. Safeguarding concerns must be managed in accordance with the All Wales Safeguarding Procedures and relevant Health Board safeguarding policies. Safeguarding requirements take precedence over the Listening to People process. Where a concern raises safeguarding issues, it must be referred immediately through the appropriate safeguarding pathway and may not be suitable for management under Listening to People, or may require the Listening to People process to be paused, adapted or progressed only where this does not compromise safeguarding enquiries, statutory duties, police involvement or multi-agency protection arrangements.

Public Services Ombudsman for Wales (PSOW)
The independent organisation that can review complaints about public services in Wales, including the NHS, where an individual remains dissatisfied following the NHS investigation.

Medical Examiner Service
A statutory service providing independent scrutiny of deaths prior to registration and which interfaces with Listening to People processes via specific communication duties

Llais
The independent citizen voice body in Wales that provides free advocacy and support to people using health and social care services.

Advocacy
Independent support offered to people raising concerns; must be actively offered during the Listening Discussion

Integrated Patient Safety Triage
The process used to assess, prioritise and determine the most appropriate management pathway for concerns, incidents, complaints, claims and feedback.

Concern Management Group (CMG)
A multidisciplinary forum established to oversee and coordinate the management of complex, high-risk or significant concerns.

Learning Review
A structured review undertaken to understand what happened, why it happened and what can be learned to improve future care and services.

Formal Investigation
A proportionate investigation undertaken where concerns require detailed review, analysis and formal response.

Systems-Based Investigation
An approach that examines the wider systems, processes, environments and human factors that contribute to an event rather than focusing solely on individuals.

Just Culture
An approach that promotes openness, fairness and learning by balancing accountability with understanding of human and system factors.

Psychological Safety
An environment where people feel able to speak up, ask questions, report concerns and contribute to learning without fear of blame, punishment or negative consequences.

Professional Curiosity
The willingness to explore, question and understand circumstances fully rather than accepting information at face value.

Human Factors
The environmental, organisational and individual factors that influence human performance, safety and outcomes.

Patient Safety Event
Any unintended or unexpected event that resulted in, or could have resulted in, harm to a patient.

Patient Experience Feedback
Information provided by patients, families or carers regarding their experiences of care and services, including compliments, concerns and suggestions for improvement.

Primary considerations of practice

The Listening to People framework is founded upon the principles of accessibility, compassion, openness, proportionality, learning and continuous improvement. Every concern should be managed in a manner that ensures people feel heard, respected and supported, while enabling the Health Board to learn and improve from their experiences.

Who Can Raise a Concern

A concern may be raised by a patient or service user, a person affected by the actions or decisions of a responsible body, a member of staff, a representative acting on behalf of another individual, or a representative acting on behalf of someone who has died. The Health Board will seek to ensure that individuals are supported to raise concerns and will consider the suitability of representatives where appropriate.

Accessible Ways of Raising a Concern

The Health Board is committed to ensuring concerns can be raised in a way that is accessible and convenient for individuals. Concerns may be raised verbally, in writing or electronically and can be made through the Health Board's published concerns arrangements, available via its website and other communication channels. Patient support services (complaints & feedback) - Hywel Dda University Health Board (opens in a new tab).

Individuals will be offered reasonable adjustments, language support and advocacy where required to ensure equitable access to the concerns process. Concerns may be raised with any member of staff, who has responsibility for ensuring the concern is directed into the appropriate process.

Barriers to Raising Concerns

The Health Board recognises that some individuals and communities may experience additional barriers to raising concerns due to disability, language, culture, literacy, socio-economic circumstances, digital exclusion or concerns about discrimination. Staff must take proactive steps to reduce these barriers, identify and record communication and information needs, make reasonable adjustments, offer advocacy and language support, and support equitable access to the concerns process.

Concerns received directly by staff

Where a concern is received directly by a member of staff, including by email, telephone, text, letter or in person, the member of staff must listen respectfully, address any immediate safety or safeguarding issue and ensure the concern is recorded and directed into the appropriate Health Board pathway. Staff should use approved organisational contact details and systems. If an individual later raises a new or unrelated concern with a staff member who previously supported them, the concern should be acknowledged and redirected through the published concerns arrangements so that it can be recorded, triaged and managed consistently. Staff should seek managerial or Patient Support Team advice where boundaries, communication arrangements or staff wellbeing may be affected.

Acknowledgement and Early Engagement

All concerns will be acknowledged within five working days of receipt. As part of the acknowledgement process, individuals will be advised of the support available to them, including advocacy services, opportunities for a listening meeting, and will receive information about the next steps in managing their concern.

Right to a Listening Discussion
Every person raising a concern will be offered a Listening Discussion. This provides an opportunity to explain their concerns, discuss the impact on them, identify the outcomes they hope to achieve and determine the most appropriate approach to resolution. Listening Discussions may take place face-to-face, by telephone or virtually and are intended to support understanding, compassion, early resolution and person-centred decision making.

The Importance of Listening Discussions
The Listening Discussion is a foundational element of the Health Board's approach to concerns management and represents the first and most important opportunity to understand a person's experience, address their concerns and identify opportunities for early resolution. It is not simply a procedural requirement, but a person-centred conversation designed to ensure that individuals feel heard, respected and supported.

Listening Discussions provide an opportunity to understand the impact that events have had on patients, families, unpaid carers and staff, explore what matters most to them and agree realistic expectations regarding what can be achieved through the concerns process. They support openness, trust, compassion and shared understanding and help ensure that the Health Board responds to concerns in a manner that reflects individual needs, preferences and desired outcomes.

The Health Board expects Listening Discussions to be undertaken using active listening, compassionate communication and trauma-informed principles. Individuals should be provided with sufficient time to explain their experience, access appropriate advocacy or support where required, and receive clear information about the options available to them.

Listening Discussions also support the Health Board's objectives of preventing future harm, promoting early resolution, improving experiences and reducing the need for formal investigation where appropriate. Evidence indicates that meaningful early engagement improves satisfaction, strengthens relationships, supports learning and reduces escalation to more formal stages of the process.

The quality of a Listening Discussion may influence trust in the organisation more than the eventual outcome of the concern itself.

Matters Excluded from the Concerns Process
Certain matters fall outside the scope of the Listening to People arrangements. These include matters already investigated by the Public Services Ombudsman for Wales, Freedom of Information requests, staff employment matters, safeguarding matters, concerns that are subject to civil proceedings, duplicate concerns, concerns deemed vexatious or frivolous, Individual Patient Funding Request decisions and concerns raised outside the applicable time limits, unless exceptional circumstances apply. Where concerns fall outside the Regulations, individuals will be advised of the reason and directed to the most appropriate process where possible.

Enquiries will not be managed in accordance with this policy and individuals will be appropriately supported to the correct teams to ensure timely information and support is provided.

Proportionate and Risk-Based Approach
The Health Board will apply a proportionate approach to the management of concerns. The level of review or investigation undertaken will be informed by the nature of the concern, actual or potential harm, complexity, risk, safeguarding considerations, learning potential and any requirement to consider

qualifying liability. Not all concerns require the same level of review, and the approach taken should be thorough, timely and appropriate to the circumstances.

Level of Harm Grading Framework
The new Listening to People Organisational Guidance adopts a 5-level harm grading framework aligned to the NHS Wales Patient Safety Incident Reporting and Management Framework and Duty of Candour guidance. The framework is intended to support proportionality, escalation, investigation and consideration of Duty of Candour and Redress.

Harm Grade	Description	Examples
Grade 1 – No Harm	An event occurred but resulted in no harm to the patient.	Delay without clinical impact; fall with no injury; administrative error corrected before affecting care.
Grade 2 – Low Harm	Minor temporary harm requiring minimal intervention or resulting in limited impact.	Minor treatment delays; short increase in length of stay (1–3 days); minor injury requiring simple treatment.
Grade 3 – Moderate Harm	Harm requiring clinical intervention, additional treatment or escalation of care.	Avoidable injury requiring intervention; readmission; return to theatre; transfer to higher acuity care; RIDDOR-reportable incident.
Grade 4 – Severe Harm	Significant permanent harm, disability or major loss of function.	Permanent harm or disability; extended hospital stay (>15 days) with permanent sequelae; significant breach of national standards.
Grade 5 – Death	Death where healthcare may have contributed or where significant failures in care are identified.	Avoidable death or care contributing to death; maternal, perinatal or infant death; gross failure to meet standards; irreversible health effects resulting in death.

Application of Harm Grading
The Health Board will utilise the NHS Wales Harm Grading Framework to support the initial assessment and ongoing review of concerns. Harm grading assists in determining the most appropriate and proportionate response, including escalation requirements, safeguarding actions, Duty of Candour considerations, investigation methodology, governance oversight and assessment of potential qualifying liability. Harm assessments will remain dynamic throughout the management of a concern and may be revised as additional information becomes available.

Integrated Management of Concerns
The Integrated Patient Safety Triage Model (appendix 1) provides a single, coordinated approach to the assessment, management and oversight of concerns raised about care, treatment and services provided or commissioned by Hywel Dda University Health Board.

The model brings together concerns, complaints, incidents, claims, patient experience feedback, safeguarding concerns, Duty of Candour notifications, inquests, Prevention of Future Death reports and other sources of quality intelligence into a single process for assessment, review, investigation and learning. This approach supports the Listening to People requirement for an integrated system of concern management that is person-centred, proportionate, responsive and focused on learning and improvement.

The Integrated Patient Safety Triage Model will:

- Place patients, families, unpaid carers and staff at the centre of decision making.
- Ensure concerns are assessed consistently regardless of how they enter the organisation.
- Apply a proportionate response based upon harm, risk, complexity and learning potential.
- Promote early resolution wherever appropriate.
- Support timely identification of Duty of Candour, safeguarding, legal and patient safety requirements.
- Ensure learning is shared across services and organisational boundaries.
- Facilitate a single investigation wherever possible ("Investigate Once, Investigate Well").
- Support a Just Culture approach that prioritises learning, improvement and psychological safety.

All concerns entering the Health Board will undergo an initial triage assessment to determine:

- The nature of the concern
- Actual or potential harm
- Immediate safety risks
- Safeguarding requirements
- Duty of Candour considerations
- Potential qualifying liability
- Complexity and number of organisations involved
- Potential for system learning
- Appropriate resolution pathway

Where safeguarding indicators are identified at triage, safeguarding action must take precedence over Listening to People. The case must be referred through the appropriate safeguarding pathway and advice sought from safeguarding leads. The triage decision must record whether the Listening to People process is suitable, unsuitable, paused, adapted or able to run in parallel with safeguarding processes.

Medical Examiner and Mortality-Related Concerns

Concerns arising from Medical Examiner scrutiny, mortality review, bereavement feedback, inquests or Prevention of Future Death reports are within the scope of this policy where they indicate potential care, treatment, communication, patient safety, safeguarding, Duty of Candour, redress or learning issues. Such concerns must be referred into the integrated triage arrangements and managed through the most appropriate pathway.

Triage must determine whether the matter requires a Listening Discussion, Early Resolution, Stage 2 investigation, patient safety incident reporting, safeguarding referral, Duty of Candour review, redress consideration, legal or inquest input, mortality review action, Clinical Care Group review or escalation to a Concern Management Group. The decision, rationale, accountable lead, communication plan and learning route must be documented.

The outcome of this assessment will determine the most proportionate management route as supported by the integrated triage tool located on our Listening To People page (opens in a new tab).

The integrated triage decision must identify the accountable Clinical Care Group or service lead, nominated case coordinator, required specialist input, proposed investigation or review methodology, communication arrangements, timescales, escalation route and learning/action tracking requirements.

Concern Management Groups

Concern Management Groups (CMGs) may be convened where concerns involve:

- Moderate, severe or catastrophic harm
- Death
- Complex multi-agency involvement
- Significant organisational risk
- Potential qualifying liability
- Matters attracting significant external scrutiny
- Concerns requiring coordinated oversight and decision making

The purpose of the CMG is to ensure appropriate governance, consistency of approach, timely decision-making, investigation sign-off, escalation, communication alignment and oversight of learning and improvement actions. The CMG will agree the investigation scope, accountable investigation lead, required specialist membership, communication plan, response sign-off route, risk escalation requirements and arrangements for monitoring actions to completion and impact.

CMGs must operate in accordance with the Health Board's agreed terms of reference and integrated concerns governance arrangements.

Investigation Approach

Investigations undertaken within the model will:

- Consider whether equality, diversity, inclusion, language, culture, accessibility or discrimination-related factors contributed to the incident, concern or outcome, and identify any learning or improvement actions arising from this.
- Focus on understanding why events occurred.
- Apply systems thinking and human factors principles.
- Consider organisational, environmental and human contributory factors.
- Seek involvement from patients, families and staff.
- Utilise the most appropriate review methodology.
- Avoid unnecessary duplication of investigations.
- Consider the need for independent clinical review where appropriate.

Investigate Once, Investigate Well

The Health Board is committed to the principle of "Investigate Once, Investigate Well", recognising that concerns often involve multiple reporting, governance and assurance requirements arising from the same event or circumstances.

Where concerns relate to incidents, complaints, claims, safeguarding concerns, Duty of Candour reviews, inquests, Prevention of Future Death reports, Ombudsman investigations or other forms of external scrutiny, the Health Board will seek to undertake a single coordinated review wherever possible.

The purpose of this approach is to avoid duplication, minimise burden on patients, families, unpaid carers and staff, ensure consistency of findings and maximise opportunities for learning and improvement. The Health Board will seek to gather information once, use proportionate review methodologies and ensure that learning generated from a concern meets the requirements of all relevant governance processes.

In applying this principle, the Health Board will:

- Undertake a single integrated triage assessment to determine review, investigation and governance requirements.

- Adopt a proportionate investigation methodology based upon harm, complexity, risk, learning potential and statutory requirements.
- Coordinate reviews across complaints, patient safety, legal, safeguarding, quality and operational functions wherever appropriate.
- Avoid requesting the same information repeatedly from patients, families, unpaid carers or staff unless additional clarification is required.
- Ensure investigation findings, learning and improvement actions are shared across all relevant governance processes.
- Seek to produce a single, coherent understanding of what happened, why it happened and what actions are required to reduce the likelihood of recurrence.
- Promote transparency, compassion and partnership with patients, families, unpaid carers and staff throughout the review process.

The Health Board recognises that different statutory and regulatory processes may, on occasion, require separate consideration. However, wherever possible, these processes will be aligned and informed by a common evidence base to ensure a consistent approach, reduce duplication and support organisational learning.

The aim is not to conduct multiple investigations into the same event, but to develop a single, comprehensive understanding that supports learning, improvement and safer care.

Learning and Improvement

Learning is a fundamental outcome of the Listening to People process and a core component of the Health Board's Quality Management System. Learning must be captured, shared, implemented and evaluated through the Health Board's agreed organisational learning arrangements.

The objective of learning is not simply to understand what went wrong, but to continuously improve what happens next. The Health Board is committed to ensuring that concerns result in meaningful learning, improvement and safer care rather than simply the completion of a process or closure of a case.

Learning identified through complaints, incidents, claims, patient feedback, safeguarding concerns, Duty of Candour reviews, inquests and external scrutiny will be managed in accordance with the Health Board's Organisational Learning Framework.

This ensures that learning is identified, documented, implemented, monitored and evaluated to determine whether meaningful and sustainable improvements have been achieved.

The Health Board adopts the principle that every concern should generate learning, whether the concern is upheld. Learning may relate to patient safety, clinical practice, communication, systems and processes, service delivery, workforce wellbeing, organisational culture or opportunities to share and replicate good practice.

Learning will be co-produced wherever possible with patients, families, unpaid carers and staff. Learning analysis will consider whether themes emerge in relation to protected characteristics, accessibility, discrimination, inequitable access to services or differential outcomes. Where identified, these themes will inform service improvement actions, targeted engagement and organisational learning priorities.

Learning arising from concerns will be captured through agreed mechanisms including Learning Summaries, thematic reviews, 7-minute briefings, after action reviews, quality improvement initiatives and service action plans. Learning will be recorded within the Health Board's learning systems and disseminated through established governance arrangements, including the Learning Library, Clinical Care Groups, professional forums, quality and safety meetings, and the Listening and Learning Sub-Committee.

The effectiveness of improvement actions will be monitored through the Health Board's governance arrangements to ensure that identified actions are implemented, embedded and deliver the intended benefits. Where appropriate, learning will be shared across organisational and professional boundaries to support wider system improvement and reduce the risk of avoidable harm.

Where learning actions are identified, the accountable service lead must ensure that actions are specific, measurable, assigned to named owners, time-bound, recorded in the relevant system, monitored through local governance and escalated where delivery is delayed, incomplete or ineffective. Closure must be based on evidence of implementation and, where appropriate, evidence of impact.

The Health Board is committed to creating a learning culture in which patients, families, unpaid carers and staff are recognised as partners in improvement and where concerns are viewed as valuable opportunities to strengthen the quality, safety and experience of care provided to the population we serve.

Learning identified through the Integrated Patient Safety Triage Model will be:

- Recorded within a Learning Summary.
- Assigned to accountable leads.
- Supported by measurable improvement actions.
- Monitored through governance arrangements.
- Shared across services and teams.
- Reported through quality and safety governance structures.

Escalation must occur where risks remain uncontrolled, actions are overdue, themes indicate wider system risk, external scrutiny is likely, or executive/committee oversight is required.

The objective is to ensure that all concerns contribute to improved patient safety, enhanced patient experience, stronger systems and reduced likelihood of future harm.

Being Open / Duty of Candour

Where the Duty of Candour may apply, the Health Board must review the circumstances promptly to determine whether a notifiable adverse outcome has occurred. The duty is triggered where it appears that a service user has suffered, or could suffer, unexpected or unintended harm that is more than minimal and the provision of healthcare was, or may have been, a factor. When triggered, the relevant person must be notified as soon as reasonably practicable by telephone, audio-visual communication or face-to-face meeting, offered a meaningful apology, provided with an explanation of the information known at that time, advised of next steps, offered support and given a named point of contact. Written notification must follow within five working days of the initial notification in accordance with the Duty of Candour Procedure (Wales) Regulations 2023 and Health Board procedure. Saying sorry is not an admission of liability.

The guidance at Appendix 3 provides the process for reviewing whether the Duty of Candour has been triggered, making the initial notification, providing written follow-up, communicating the outcome of further enquiries, offering support and keeping appropriate records.

Multidisciplinary Responsibility
Most healthcare is delivered through multidisciplinary teams. This should be reflected in the way that patients, families and unpaid carers are communicated with when things go wrong.
The Listening to People process recognises that concerns often arise from system, process and communication factors rather than the actions of a single individual. A multidisciplinary approach supports balanced review, shared learning and coordinated improvement. After action reviews and Concern Management Groups help to achieve this shared responsibility.

Continuity of care
Patients are entitled to expect that they will continue to receive all usual treatment and continue to be treated with dignity, respect and compassion. If a patient expresses a preference for their healthcare needs to be taken over by another team, where possible, alternative arrangements should be made.

Nationally Reportable Incidents
As part of the initial assessment process of the incident, the Health Board will need to consider whether an incident requires reporting nationally. Further guidance on this can be found in the Incident Management Procedure or the national policy on patient safety incident reporting: du.nhs.wales/files/incidents/national-policy-on-patient-safety-incident-reporting-2-0-pdf/ (opens in new tab)

Support for Staff Involved in Concerns
Being the subject of a concern or even reporting a concern as a member of staff can be very stressful. In terms of being the subject of a concern, when an issue is raised, whether by a patient or through a report from a member of staff, the details should be shared with the staff member involved wherever appropriate. This should be done supportively, and staff may want to have a member of their professional association or Trade Union representative present in any meetings.

The Directorate Senior Management Team, Redress Team, Patient Support Team and/or Quality Assurance and Safety Team will provide support for those involved with the formal review of a concern in accordance with the 'assist me' good practice model for supporting staff involved in adverse events (see appendix 2).

Consideration should also be given under the workforce and organisational development policies as to whether a staff member may need more proactive support such as counselling. In terms of staff who report concerns, consideration should also be given as to whether they may require specific support. For any member of staff involved in a concern, their line manager should be involved in any decisions that are taken.

Training, Competence and Support
The Health Board recognises that delivering the ambitions of Listening to People requires staff to have the knowledge, skills, confidence and support necessary to listen effectively, manage concerns compassionately and undertake proportionate reviews and investigations.

A comprehensive training, development and support framework will be maintained to support staff involved in all aspects of the concerns process. This will include training and development opportunities

appropriate to role and responsibility, including active listening, compassionate communication, trauma-informed practice, early resolution, investigation skills, systems-based learning, Duty of Candour, Just Culture principles, organisational learning, accessible communication, equality and human rights, unconscious bias, anti-racism and cultural awareness.

The Health Board is equally committed to supporting staff who are involved in concerns, whether they are managing a concern, contributing to a review or are the subject of a concern. Staff will be afforded appropriate guidance, supervision and wellbeing support to promote psychological safety, reflective practice and continuous learning.

Competency requirements, role-specific training pathways and supporting resources will be described within associated procedures, guidance documents and training programmes.

NHS Redress Arrangements

Where a concern includes an allegation that harm has been caused because of NHS care or treatment, the Health Board has a statutory duty to consider whether a qualifying liability may exist and whether redress should be offered.

This assessment can only be undertaken as part of a formal investigation under Stage 2 of the Listening to People process and does not form part of Early Resolution arrangements.

A qualifying liability exists where a patient has suffered injury or loss arising from healthcare provided by the NHS and there is evidence that the care fell below the required standard and caused, or materially contributed to, that harm. The assessment includes consideration of duty of care, breach of duty and causation.

Redress aims to provide a fair, timely and person-centred response when harm has occurred and may include:

- A written apology;
- An explanation of what happened;
- A report describing actions taken to prevent recurrence;
- Remedial treatment or care, where appropriate; and
- Financial compensation where the value falls within the statutory redress arrangements.

The Health Board will consider potential qualifying liability at an early stage of the investigation process to ensure an appropriate and proportionate response. Where there is, or may be, a qualifying liability, individuals will be provided with information about the redress process, access to independent legal advice funded through the arrangements, and ongoing support throughout the investigation.

The Health Board is committed to ensuring that redress arrangements operate alongside the principles of openness, compassion, learning, Duty of Candour and continuous improvement, with the primary objective of understanding what has happened, responding fairly and reducing the likelihood of future harm.

Governance Framework

Through the Quality Management System, the Health Board will provide assurance to the Board, its committees, regulators and the public that concerns are managed effectively, learning is embedded and improvements are implemented and sustained.

Information and learning arising from concerns will form part of the Health Board's Quality Management System and will be used alongside patient safety, audit, mortality, safeguarding, patient experience, workforce and performance intelligence to inform quality planning, quality assurance, quality control and quality improvement activities.

The Health Board will seek to collect and analyse equality information, where appropriate, lawful and proportionate, to understand the experiences of people raising concerns and staff involved in concerns. Analysis will be used to identify disparities, trends, barriers to access, allegations of discrimination and opportunities to improve outcomes for people with protected characteristics and underserved communities. Findings and learning will be reported through relevant governance arrangements to provide assurance that the policy is operating fairly and effectively.

Learning from concerns will be triangulated with other sources of organisational intelligence to identify themes, emerging risks, improvement priorities and opportunities for system-wide learning.

All concerns with significant learning will be reported to the Listening and Learning Sub-Committee and an assurance and escalation report provided to the Quality, Safety, and Experience Committee.

Compliance with stated timescales for acknowledgement, early resolution, investigation, response and learning will be monitored and reported through the Health Board's quality and safety governance arrangements. The Board will be made aware of concerns that may present significant risk to patient safety, public confidence or organisational reputation through the appropriate executive and committee reporting routes.

Measuring Effectiveness

The Health Board is committed to ensuring that the Listening to People framework delivers meaningful improvements in patient safety, quality, experience and organisational learning. The effectiveness of the arrangements described within this policy will be monitored through a combination of statutory performance measures, locally agreed service standards and organisational learning indicators.

Performance will be routinely monitored and reported through the Health Board's **Improving Together Performance Framework** and **My Performance Dashboard**, enabling operational teams, Clinical Care Groups, executive leaders and governance committees to oversee performance, identify emerging risks and monitor improvement over time.

To support consistency across the organisation, a suite of service standards and quality measures will be developed and maintained. These will be reviewed periodically to ensure alignment with national requirements, organisational priorities and emerging learning.

Measures of effectiveness may include:

- Equality monitoring and thematic analysis, including access to the process, communication needs, allegations of discrimination, disparities in experience or outcomes, and evidence that identified inequalities have informed improvement action.
- Compliance with statutory and regulatory requirements, including acknowledgement, early resolution, investigation and response timescales.
- Uptake and timeliness of Listening Discussions.

- Early Resolution rates and escalation rates to Stage 2 investigations.
- Compliance with Duty of Candour requirements.
- The quality, completion and effectiveness of investigation action plans.
- Identification, monitoring and reduction of recurrent themes, contributory factors and avoidable harm.
- Evidence of shared learning, dissemination of learning and implementation of improvement actions across services.
- Evidence of impact and improvement resulting from learning, including demonstrable changes to systems, processes, practice and patient experience.
- Timeliness of implementation and evaluation of learning actions.
- Patient, family and staff feedback regarding the concerns process.
- Number and nature of concerns referred to the Public Services Ombudsman for Wales, together with Ombudsman findings, compliance with recommendations and organisational learning arising from those cases.
- Thematic trends identified from complaints, incidents, claims, safeguarding, Duty of Candour reviews, inquests and other sources of quality intelligence.

Performance information and learning outputs will be reviewed through the Health Board's governance arrangements, including the Listening and Learning Sub-Committee, Quality, Safety and Experience Committee and Board, to provide assurance that concerns are being managed effectively and that learning is leading to measurable improvements in care, safety and experience.

The primary measure of success will not solely be the achievement of timescales, but the extent to which concerns lead to learning, improvement and a reduction in the likelihood of future harm.

Roles and Responsibilities

Chief Executive

The Chief Executive has overall accountability for ensuring that the Health Board has effective arrangements in place for the management of concerns, complaints, incidents and redress in accordance with the Listening to People Regulations, the Duty of Quality, the Duty of Candour and wider statutory duties. Operational responsibility for these arrangements is delegated to the Executive Director of Nursing, Quality and Patient Experience, while overall accountability remains with the Chief Executive.

Independent Member of the Board

The nominated Independent Member maintains strategic oversight of the Health Board’s concerns arrangements and provides independent assurance to the Board that the organisation listens, responds, learns and improves from concerns. This role includes seeking assurance that:

- Ensuring that the organisation complies with the arrangements it has in place for ensuring that the details of concerns received and investigated are considered so that lessons may be learned to seek to avoid such deficiencies recurring;
- Ensuring that an annual report is prepared which summarises the organisation’s activities under the regulations (NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 and subsequent amendments for Listening to People. (Regulation 10.2); and
- Ensuring that arrangements for dealing with concerns are published in a variety of media, formats and languages and that a copy of the arrangements is given free of charge to any person who requests it, in the format requested.

Executive Director of Nursing, Quality and Patient Experience (Responsible Officer)
The Executive Director of Nursing, Quality and Patient Experience is the executive lead and Responsible Officer for the Health Board's Listening to People arrangements. The Executive Director is responsible for ensuring that the Health Board operates an integrated, compliant and learning-focused approach to concerns management, including complaints, incidents, claims, redress, Duty of Candour, Medical Examiner concerns, safeguarding interfaces and other relevant quality intelligence.

- ensuring that concerns are managed in accordance with the Regulations and Listening to People guidance;
- ensuring arrangements are in place to consider qualifying liability and redress where appropriate;
- ensuring complaints, incidents, claims, safeguarding interfaces and patient safety intelligence are managed through a coherent governance framework;
- ensuring assurance is provided to the Board and relevant committees on performance, learning, risk and improvement; and
- ensuring escalation arrangements are in place for significant patient safety, legal, safeguarding, reputational or regulatory risks.

The Executive Director delegates defined operational responsibilities to the Assistant Director of Legal Services and Patient Experience and the Assistant Director of Nursing Assurance and Safeguarding. Delegation does not remove executive accountability, and both delegated leads are required to work together to ensure that legal, patient experience, patient safety, safeguarding and assurance requirements are aligned.

Assistant Director of Legal Services and Patient Experience
The Assistant Director of Legal Services and Patient Experience is responsible for the operational leadership of complaints, concerns, redress and legal services interfaces. This includes ensuring that concerns are acknowledged, coordinated, investigated and responded to in accordance with statutory requirements, and that qualifying liability, redress, claims, inquests, Ombudsman matters and legal risks are considered and escalated appropriately.

Assistant Director of Nursing Assurance and Safeguarding
The Assistant Director of Nursing Assurance and Safeguarding is responsible for the operational leadership of patient safety assurance, safeguarding interface, incident management, organisational learning and quality governance within the integrated arrangements. This includes ensuring that incidents, adverse events, Medical Examiner concerns, safeguarding interfaces, Duty of Candour considerations and wider quality intelligence are triaged, escalated and governed appropriately.

The Assistant Director of Legal Services and Patient Experience and the Assistant Director of Nursing Assurance and Safeguarding will jointly ensure that concerns are managed through an integrated approach, avoiding duplication and supporting the principle of "Investigate Once, Investigate Well".

Executive Directors and Directors
All Executive Directors and Directors are responsible for supporting implementation of this policy within their portfolios. They must ensure that services have effective arrangements to identify, escalate, investigate and learn from concerns, and that risks, themes and improvement actions are reported through the appropriate governance routes.

Quality, Assurance and Safety, Patient Support, Legal Services and Safeguarding Teams
Specialist teams provide advice, coordination and oversight to support services in managing concerns. Their role includes supporting triage, investigation methodology, communication with those raising concerns, Duty of Candour, redress, legal interface, safeguarding advice, learning summaries, action tracking, thematic analysis and escalation. These teams support operational services but do not remove accountability from Clinical Care Groups and service leads for investigation quality, implementation of actions and improvement impact.

Specialist teams will also support integrated triage, CMG coordination, quality assurance of investigation outputs, consistency of response letters, sign-off processes, identification of learning, action tracking, thematic reporting and escalation to the Listening and Learning Sub-Committee, Quality, Safety and Experience Committee or executive leads where required.

Clinical Care Groups
Clinical Care Groups are accountable for responding to concerns relating to their services, ensuring proportionate and timely review, identifying learning, implementing improvement actions and demonstrating impact. They are supported by specialist patient support, quality, patient safety, safeguarding and legal teams, but retain responsibility for the quality and timeliness of operational responses and action delivery.

Clinical Care Groups have responsibility to make sure that the principles outlined within this policy are implemented within their Care Group including fostering a culture for learning from experience and sharing lessons learned.

Clinical Care Groups must ensure that trained staff are available to undertake proportionate reviews and investigations, that investigation leads are clearly identified, and that appropriate clinical, managerial and professional oversight is provided. They must work closely with the nominated coordinator from the relevant concerns, patient safety, safeguarding or legal team.

They are responsible for disseminating lessons learned to colleagues within their area of responsibility, and across the Health Board, providing opportunities for learning through team meetings, shared learning events and with colleagues in other directorates where appropriate. A 7 minute style briefing will be required for every stage 2 complaint to demonstrate learning. These will be stored on the learning library and utilised to identify themes and trends for priority action, and to inform the priorities for the quality improvement process.

Clinical Care Groups must ensure that learning, actions and evidence of implementation are recorded in the appropriate systems, including Datix and AMaT where applicable, and monitored through local and organisational governance arrangements until completed and evaluated for impact.

Clinical Care Groups are responsible for approving investigation findings within their governance arrangements before final response sign-off, ensuring that conclusions are evidence-based, actions are deliverable and learning is shared with affected teams and across the organisation where relevant.

Heads of Service / Departmental Managers
Heads of Service and Departmental Managers are responsible for creating a local culture in which concerns are welcomed, staff feel able to speak up, and learning is used to improve quality, safety and experience.

They must ensure that concerns are identified, acted on and escalated promptly, and that staff have the knowledge, skills, capacity and support required to contribute to early resolution, reviews, investigations, Duty of Candour processes and learning.

Ensuring staff have the knowledge and skills to manage concerns and capacity to undertake the required investigations, receiving appropriate support and guidance throughout.

They are responsible for disseminating lessons learned to colleagues within their area, and across the Health Board where required, providing opportunities for learning through team meetings and with colleagues in other divisions where appropriate.

Safeguarding Leads
Safeguarding leads are responsible for advising on concerns that include actual, suspected or potential abuse, neglect, exploitation, deliberate harm or risk to a child or adult at risk. They will ensure that safeguarding concerns are managed in accordance with the All Wales Safeguarding Procedures and relevant Health Board safeguarding policies. Safeguarding requirements take precedence over Listening to People, and safeguarding leads must advise whether Listening to People activity is suitable, unsuitable, paused, adapted or able to run in parallel without compromising safeguarding enquiries or multi-agency protection arrangements.

Medical Examiner Service Interface
Where concerns arise from Medical Examiner scrutiny, these must be referred into the appropriate integrated triage arrangements. The relevant service, supported by patient safety, patient experience, legal and safeguarding leads as required, must consider whether the concern requires Listening to People, Duty of Candour, patient safety incident reporting, safeguarding referral, redress consideration, inquest preparation or other governance action.

All Staff
All staff are responsible for ensuring that they:

- listen respectfully and respond compassionately when concerns are raised;
- act immediately where there is an urgent safety or safeguarding risk;
- report incidents, concerns, near misses and adverse events through the appropriate route without delay;
- escalate safeguarding concerns through the All Wales Safeguarding Procedures and local safeguarding pathways;
- co-operate fully, openly and honestly with reviews, investigations and Duty of Candour processes;
- support early resolution where appropriate and within their role;
- participate in learning and improvement activity arising from concerns; and
- follow this policy and associated procedures, guidance and written control documents.

Culture
The Health Board is committed to ensuring that the action and learning from all concerns will be incorporated within the whole organisation to ensure the safety of patients and staff.

To promote this philosophy and ensure staff feel confident **whether they are the subject of a concern or are** the reporter or witness of an incident, we will ensure managers take a fair, equitable and consistent approach when they review concerns. Most concerns including serious incidents will not lead to individuals being managed under a workforce policy.

Within the spirit of being open and fair, a workforce process will only be considered where information highlights potential issues of alleged personal or professional misconduct, capability or other matters that require consideration under relevant workforce policies. To support this approach, the Health Board will follow the principles of a Just Culture.

References

National legislation, statutory guidance and national policy

Welsh Government. Listening to People: NHS Wales complaints, incidents and redress process. First published 1 April 2026; last updated 25 June 2026.

Welsh Government. Listening to People: The NHS Wales Complaints, Incidents and Redress Process – People's Guidance. 2026.

The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.

The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) (Amendment) Regulations 2023 and 2025.

Health and Social Care (Quality and Engagement) (Wales) Act 2020.
Welsh Government. Duty of Quality Statutory Guidance 2023 and Health and Care Quality Standards 2023.

The Duty of Candour Procedure (Wales) Regulations 2023.

Welsh Government. Duty of Candour Statutory Guidance 2023.

Public Services Ombudsman for Wales. Complaints Standards Authority: Principles for Complaint Handling.

Welsh Government. Patient safety incident reporting and management (WHC/2023/017). 2023.
NHS Wales Executive. National Policy on Patient Safety Incident Reporting and Management. Version 2.0, 2023.

Wales Safeguarding Procedures. Wales Safeguarding Procedures.

Welsh Government. Safeguarding guidance, including Working Together to Safeguard People statutory guidance.

Social Services and Well-being (Wales) Act 2014.

NHS Improvement. A Just Culture Guide.

World Health Organization. Patient safety fact sheet.

World Health Organization. Global Patient Safety Report 2024.

Putting Things Right – Management of Concerns Guidance. Retained for historic context only for concerns received up to and including 31 March 2026; Listening to People applies to concerns received from 1 April 2026.

Health Board supporting written control documents

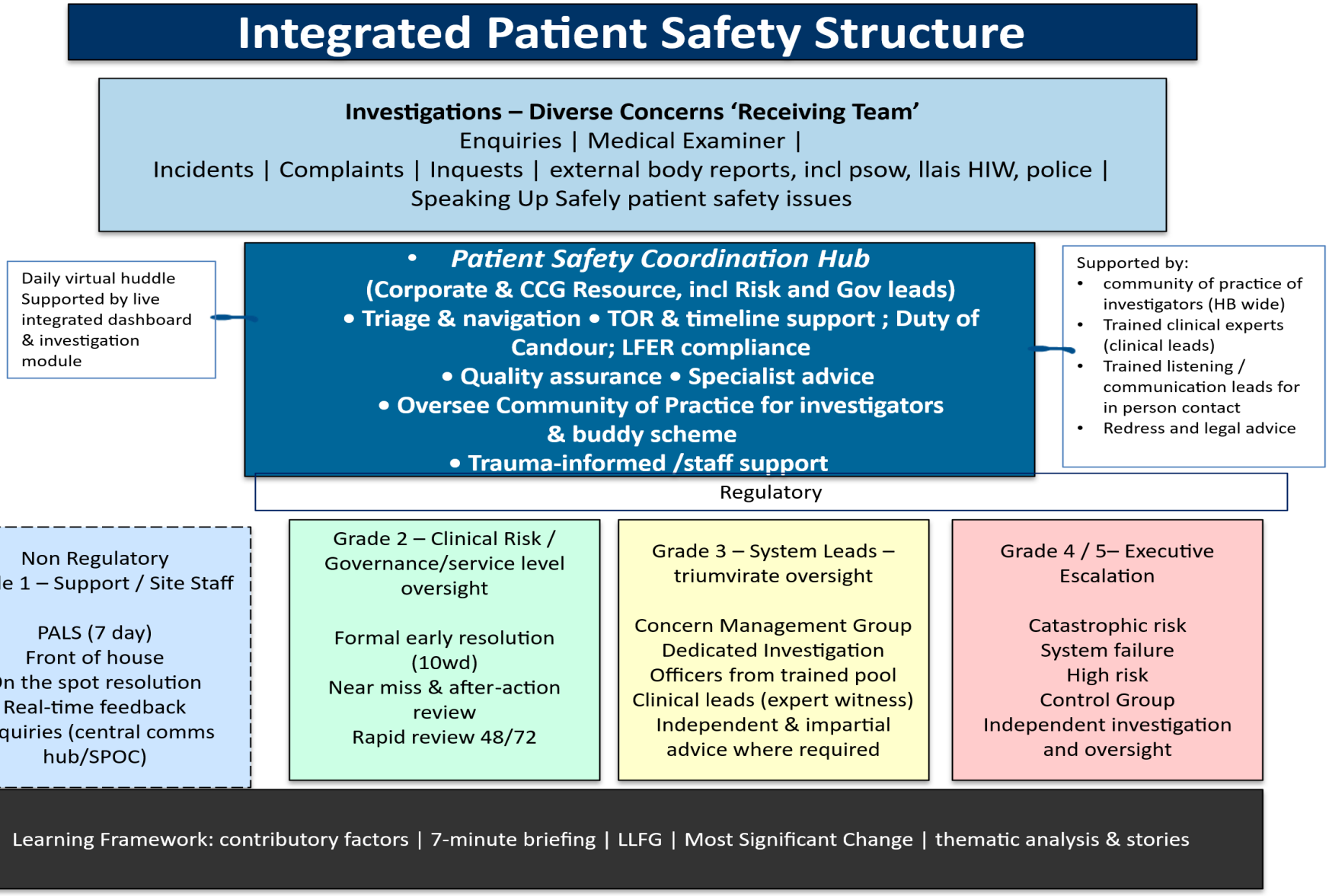
Being Open / Duty of Candour Procedure.
982 – Incident, near Miss and hazard Reporting Policy – opens in a new tab
429 - Management and Distribution of Safety Alerts and Notices Policy – opens in a new tab
004 - Claims Management Policy – opens in new tab
018 - Staff Attending Inquests / Court and Assisting with Police Investigations Guideline – opens in new tab
558 - Management of Nursing and Midwifery Medication Errors / Near Misses Policy – opens in new tab
All Wales Safeguarding Procedures and relevant Health Board safeguarding policies must be followed where a concern includes actual, suspected or potential abuse, neglect, exploitation, deliberate harm or risk to a child or adult at risk.

Safeguarding and workforce supporting written control documents

- Safeguarding Adults at Risk Interim Policy (098)
- All Wales Child Protection Procedures
- Procedural Response for Unexpected Deaths in Childhood Procedure (PRUDIC) (563)
- Safeguarding Children & Young People in Emergency and Out of Hours Service Procedure (405)
- Allegations against Employees of Hywel Dda University Health Board of Harm/Abuse Involving Children or Adults (246)
- All Wales Disciplinary Policy & Procedure (201)
- All Wales Capability Policy (203)
- All Wales NHS Staff to Raise Concerns Procedure (435)

Appendix - Integrated patient safety structure

Integrated Patient Safety Structure



Appendix 2 – Levels of Harm Framework

LEVELS OF HARM FRAMEWORK

The examples listed are meant only to be a guide and not an exhaustive list.

Level of harm	Incidents that <u>would not</u> trigger the duty of candour procedure
None	**Any patient safety incident that had the potential to cause harm but impact resulted in no harm having arisen.** e.g: Appointment delayed, but no consequences in terms of health. e.g: Patient fall – where no harm was suffered or additional interventions required. eg: Near miss – where the potential for harm was noticed and action taken to avoid occurrence of harm.
Low harm/minimal harm	**Any patient safety incident that resulted in a minor increase in treatment and which caused minimal harm to one or more persons receiving NHS-funded care.** Minor increase in treatment could include: e.g: First aid, additional therapy, medication or rehabiliation e.g: Patient fall - requiring one off observations and/or minor treatment. e.g: Increase in length of stay by 1 - 3 days.
	When does the duty of candour apply? **IMPORTANT-** this section sets out the conditions that must be satisfied in order for the duty of candour to apply. These must be worked through when applying the harm framework.1 The duty is triggered in relation to an NHS body if it appears to the body that **both** of the following conditions are met: (1) The first condition is that a person (the "service user") to whom health care is being or has been provided by the body has suffered an adverse outcome. (2) The second condition is that the provision of the health care was or may have been a factor in the service user suffering that outcome. A service user is to be treated as having suffered an adverse outcome if the user experiences, or if the circumstances are such that the user

1 For further guidance on determining whether the duty applies, please see Annex A and Annex H and part 4, page 7 of the Guidance.

	could experience, any unexpected or unintended harm that is moderate or above. The duty may be triggered by an action taken by a NHS body during the provision of health care or by a failure to take action. **The duty is not triggered where harm is related to the natural course of the service user's illness or underlying condition.**
Unexpected or unintended moderate harm	**Examples of unexpected or unintended levels of moderate harm and types of incidents that <u>would</u> trigger the duty of candour procedure include:** **Moderate harm** – (a) **moderate increase in treatment** and (b) Significant but not permanent harm. **Moderate increase in treatment could include:** • An unplanned admission/re-admission, • An unplanned return to surgery, • Increase in length of stay by 4 -15 days, • Cancelling/postponement of treatment, • Transfer to another treatment/care area, such as secondary care or intensive care as a result of the incident. Examples of the type of incidents that would trigger the duty of candour procedure include: **Description of incident** – unplanned admission. Patient was seen by a member of the community MH team; who fails to recognise, or act on evidence of poor medication compliance/failure to adhere to treatment sessions/expression of suicidal thoughts. **Level of harm as a result** - the patient self-harms, causing moderate harm requiring admission to hospital. **Description of incident** - Operation cancelled. **Level of harm as a result** – Leading to deterioration and a longer stay in hospital > 4 days and recovery delayed. **Description of incident** - Patient receives opioids despite this being documented as an allergy. **Level of harm as a result** – Leading to the patient suffering a significant reaction and required emergency treatment. **Description of incident** - A mother had significant post-partum haemorrhage after a difficult delivery, and there was a delay in obtaining blood for transfusion.

	Level of harm as a result – Leading to mother being transferred to the high dependency unit as a result of the post-partum haemorrhage and the delay in obtaining blood for the transfusion meant that her recovery was prolonged. The service user experiencing psychological harm: **Psychological harm** – means a psychiatric condition or the exacerbation of an existing psychiatric condition for a continuous period of at least 28 days. NB: The timeframe above should be used as a measure only. The focus must be on the level of unintended or unexpected harm. **<u>Further detailed case study examples can be found in Annex H.</u>**
Unexpected or unintended severe harm	**Examples of unexpected or unintended levels of severe harm and types of incidents that <u>would</u> trigger the duty of candour procedure include:** **Severe harm would include:** • Avoidable, permanent harm or impairment of health or damage leading to incapacity, disability or the loss of recovery potential. • Avoidable permanent lessening of bodily, sensory, motor, physiologic or intellectual functions, including removal of the wrong limb or organ or brain damage. • Increased length of stay by >15 days **Examples of the type of incidents that would trigger the duty of candour procedure include:** **Description of incident -** loss of recovery potential. Delays in thrombolysis or AHP treatment. **Level of harm as a result -** resulting in loss of recovery of walking or speech, which is permanent. **Description of incident** - Patient suffers an adverse reaction to medication that they are documented to be allergic to. **Level of harm as a result –** Leading to the patient suffering brain damage or other permanent organ damage.

	Description of incident - Patient suffer a perforation of the bowel during surgery. **Level of harm as a result –** Leading to patient requiring a colostomy and/or subsequent operations. **Description of incident -** Patient did not receive a planned follow up x-ray. **Level of harm as a result -** Patient was subsequently found to have lung cancer. The chances of survival had been significantly reduced by the 18 month delay in the follow up x-ray being performed. **Further detailed case study examples can be found in Annex H of the Duty of Candour Guidance**

Unexpected or unintended death	**Examples of unexpected or unintended death and types of incidents that would trigger the duty of candour procedure include:** **Examples of the type of incidents that would trigger the duty of candour procedure include:** **Description of incident** - Wrong blood transfused. **Level of harm as a result -** Leading to multi-organ failure and a fatal cardiac arrest. **Description of incident** - Patient suffers an adverse reaction to medication that they are documented to be allergic to. **Level of harm as a result** - Leading to severe anaphylaxis and subsequent death. **Description of incident -** Patient presents with chest pains and is asked to wait in clinic/practice/emergency department. **Level of harm as a result -** Patient suffers a fatal myocardial infarction in the waiting area, which they then die from.

Appendix 3 – Supporting Staff – Assist me model

The Assist Me model provides a practical framework for supporting staff involved in adverse events and concerns. Managers should ensure timely acknowledgement of the impact on the staff member, clear information about the process, access to appropriate practical and emotional support, regular communication, opportunities for reflection and learning, and follow-up to review wellbeing and any continuing support needs. The model should be applied alongside workforce wellbeing, occupational health, professional support and trade union arrangements as appropriate. A readable version of the model should also be made available through the Listening to People staff resources page.

NATIONAL
OPEN DISCLOSURE
PROGRAMME



THE ASSIST ME MODEL - SUPPORTING STAFF FOLLOWING PATIENT SAFETY INCIDENTS

The importance of support for staff from line managers, colleagues and peers in the aftermath of a patient safety incident should not be underestimated. Being available for staff and hearing/acknowledging their story surrounding the event is crucial. Staff require a safe and confidential space in which to discuss the incident and can find this therapeutic.

A	**ACKNOWLEDGE** with empathy the incident that has occurred and the impact on the member of staff. **ASSESS** the impact of the incident on the member of staff and on their ability to continue normal work.
S	**SORRY** - express regret for what has happened and for their experience.
S	**STORY** – allow time and space for the member of staff to talk about what happened and how they are feeling. Demonstrate understanding. Share experience, as appropriate.
I	**INQUIRE** – encourage questions. **INFORMATION** – provide information.
S	**SUPPORTS AND SOLUTIONS** ♦ **Informal Emotional Support:** Demonstrate empathy and compassion. Be available and accessible to provide support, as required. ♦ **Formal Emotional Support:** Assess any immediate needs and discuss supports available including referral process. e.g. HSE Employee Assistance Programme (EAP), Occupational Health and/or GP. ♦ **Practical Support:** Discuss and agree immediate working arrangements e.g. ability of staff member to continue with normal duties – consider allocation to other duties, as appropriate. Provide contact details for staff liaison person.
T	**TRAVEL** – provide continued support and reassurance going forward and throughout the incident review/open disclosure process.
M	**MAINTAIN** contact and ongoing communication. **MONITOR** progress – check in regularly with the staff member. **MOVE** forward with guidance and support.
E	**END** – close this support process when the staff member feels ready. Remain available. **EVALUATE** the staff members experience of the support process and use learning to benefit other staff.

NOTE: *This model has been adapted from the MPS Assist Model of Communication*

Visit the HSE Open Disclosure website where you can access the full ASSIST Me staff support booklet

www.hse.ie/opendisclosure

Employee Assistance Programme (EAP) is a free, confidential counselling service and offers support for you or your team when required and following a critical incident.

EMPLOYEE ASSISTANCE PROGRAMME (EAP)

CALL 0818 327 327

Go to www.hse.ie/EAPandME to access the online hub of helpful resources.



Appendix 4 – Duty of Candour Trigger Review Process and Candour Procedure

HDUHB Duty of Candour Procedure

Incident has been reported and recorded via DatixCymru and also the patient care record. A review of the incident is undertaken by a member of the Service Management Team. Dependent upon the severity of the incident, based on the information available at that time, the conditions set out in Annex A, have been met and a duty of candour applies.

Notification

On first becoming aware the duty has been triggered, (which is the start date for the duty of candour procedure to be followed), the HB must notify the service user/or person acting on their behalf as soon as possible.

NB: Where the in-person notification is later than 30 working days after the date on when the NHS body first became aware of the notifiable adverse outcome, an explanation of the reason for this delay should be provided and recorded. *This does not mean that the NHS body has one month to make the notification and communicate.*

The initial notification should be **'in person' (telephone, video call, face to face)** by an appropriate senior individual within the service (clinician or manager)

Which method of in person communication is most appropriate will depend on the individual circumstances, including the preference of the service user).

Advice is available from a Duty of Candour Advisor*

Purpose of the in person notification	
• Acknowledge what has happened • Offer an apology • Explain what information is known at that time about what has happened.	• Explain the next steps in relation what will happen next • Offer support • Provide point of contact details.

Once in person notification has been made, the Service should provide **written notification** to the service user/person acting on their behalf within **five working days in accordance with template guide and record the date sent and details of the communication. The letter will also need to be uploaded to datix**

Purpose of the written notification

- Reiterate the verbal apology
- Detail any initial information on what is known about what has happened.
- Explain the intended actions to and further enquiries that the NHS body will undertake

MAKING A MEANINGFUL APOLOGY

It is of fundamental importance that the service user /person acting on their behalf receives a sincere apology in a timely manner that is clear and made in an emphatic way. The objective here is to address the need for information, clarify what has happened and to enable the recipient the opportunity to process what has happened in a supportive environment.

Preparation

It is essential to take the time to prepare for the communication with the service user/person acting on their behalf and any family members. Plan out what you are going to say and discuss this with a senior or peer. Ensure you have adequate time and are not distracted or likely to be interrupted. Being mentally 'present' and able to concentrate is very important part of your preparation. Also think about the needs of the service user/person acting on their behalf – what information do they need and how and what support may they need? (Refer to part 7 of the candour guidance document).

What has happened (be clear what is known and what is not yet known), **Who** is best to deliver this information, **When** is it best to deliver this and **How** you intend to deliver this. It is important to recognise that the '**Why** this has happened' is the purpose of the investigation process and not usually part of the apology at this early stage. Although it is common for Service Users/person acting on their behalf to ask this at this stage. It is acceptable to be honest and say that you are not certain of that at this point in time.

Delivery

You are imparting 'bad news' to a service user/person acting on their behalf, sometimes they are aware of an unexpected or unintended harm but not fully aware of the circumstances or they can be unaware of the unintended or unexpected harm outcome that has occurred. Be clear and factual and avoid jargon. Starting with an introduction of who you are and checking who it is you are talking to and who else is present.

Explain the reason why you are talking to them.
Inform the Service User of the unintended or unexpected harm and what actually is known to have occurred. Show that the circumstances and the impact for the person affected are understood e.g. 'you were left not knowing what was happening'
Accept and acknowledge what should have happened 'We should have explained exactly what was going to occur to you'

Equality Impact Assessment (EqIA) Screening Template

When to complete an EqIA Screening

An EqIA Screening Template must be completed when reviewing, changing and developing procedures/ proposals/ projects/ policies. This is a first step and is used to consider whether there are any negative impacts that may arise.

Purpose of an EqIA Screening Template

The purpose of this short exercise is to ensure that you have shown appropriate due regard when considering the impact for people with protected characteristics in your decision making. The screening process is designed to help you consider the circumstances and to inform evidence-based decisions.

If the proposal is of a significant nature and it is apparent from the outset that a full EqIA will be required, then it is not necessary to complete this Screening Template, you can proceed to complete the full EqIA.

If no negative impacts are identified following completion of the EqIA screening then it is not necessary to undertake a full EqIA however, the decision and justification must be clearly recorded in this document.

On completion of the Screening Template:

- Ensure that all the white boxes within the screening are completed.
- Ensure that the Procedure/ Project/ Proposal/ Policy owner has signed and dated the Screening Template.
- Send a copy of the completed template along with the related policy or project proposal to Inclusion.hdd@wales.nhs.uk for the Diversity & Inclusion Team to review.
- Each Screening Template will be reviewed by the Diversity & Inclusion Team and feedback will be provided to the Procedure/ Project/ Proposal/ Policy owner. This may include recommendations for further action to inform robust decision-making.

Support

For further support please visit the EqIA Sharepoint or contact:
Email: Inclusion.hdd@wales.nhs.uk
Tel: 01554 899055

Director and Directorate	Executive Director of Nursing, Quality and Patient Experience
Service Area	Legal and Patient Support Services

Title of Procedure, Project, Proposal, Policy being screened:	894 'Listening to People' Integrated Patient Safety, Concerns Management and Resolution Policy

Description of the Procedure/ Project/ Proposal/ Policy being screened (including key aims and objectives)

The aim of this policy is to establish a single, integrated and person-centred approach to the management of concerns, ensuring that patients, families, carers and staff are listened to, treated with compassion and respect, and supported throughout the process.
Through timely, proportionate and transparent review of concerns, the Health Board seeks to understand not only what happened, but why it happened, so that learning can be translated into meaningful improvement, safer care, better experiences and improved outcomes for the people and communities we serve.

This policy aims to:

- Promote a culture of openness, compassion, professionalism and continuous improvement, where feedback, concerns and adverse events are welcomed as opportunities to learn.
- Ensure compliance with the Listening to People framework, the Duty of Candour, the Duty of Quality and all relevant statutory and regulatory requirements.
- Create an environment of psychological safety in which patients, families, carers and staff feel confident to speak up, raise concerns, share experiences and contribute to learning without fear of blame or disadvantage.
- Ensure concerns are reviewed in a timely, proportionate and person-centred manner, with the level of review informed by risk, harm, complexity and learning potential.
- Support a Just Culture approach that seeks to understand human, organisational and system factors contributing to events, promoting learning and improvement rather than inappropriate blame.
- Use intelligence from concerns, incidents, complaints, claims, letters from the medical examiner, patient feedback and staff experiences to identify themes, reduce avoidable harm and drive service improvement.
- Ensure learning is translated into demonstrable improvements in patient safety, quality of care, patient experience and workforce wellbeing.
- Support staff involved in incidents, complaints, investigations and claims, recognising the importance of wellbeing, reflective practice and compassionate leadership.

Evidence considered (including staff and population data, relevant research, expert and community knowledge etc.)

This policy replaces the previous Putting Things Right approach with an integrated Listening to People framework. It brings together concerns, complaints, patient safety incidents, claims and redress, alongside related interfaces such as Medical Examiner cases, inquests, safeguarding referrals and external reviews, within a unified patient safety and learning system.

The purpose is to establish a single integrated framework for listening, responding, resolving, learning and improving from concerns, patient safety events and feedback.

This policy applies to all staff who have a responsibility to identify, receive, report, acknowledge, triage, manage, investigate, review, respond to, learn from or provide assurance in relation to concerns. It applies regardless of how the concern enters the organisation, including concerns raised directly by patients, families, carers or representatives; complaints; incidents; near misses; adverse events; staff-reported patient safety issues; Medical Examiner communications; mortality review findings; inquests; Prevention of Future Death reports; claims; redress considerations; safeguarding concerns; commissioned service concerns; independent contractor issues; Ombudsman matters; regulator feedback; external scrutiny; or other quality, safety, experience or governance intelligence.

The policy covers concerns relating to NHS-funded care, treatment, support, communication, access, experience, safety, quality, professional practice, systems, processes and outcomes where Hywel Dda University Health Board is the responsible body, provider or commissioner.

In terms of the effective management, formal review and resolution of concerns, with an approach that is person centred, the Health Board is committed to the principles of openness, accessibility, transparency, responsiveness, fairness and confidentiality. In line with national equality and diversity legislation, the Board takes all reasonable steps to enable patients, their representatives and our staff to raise a concern in the most appropriate format to them. It also offers the support of advocacy services where necessary, working collaboratively with Hywel Dda Community Health Council. This policy provides an objectives framework to govern the procedures for addressing complaints and concerns. It will be the responsibility of staff involved in addressing concerns to ensure that the principles and guidance within this policy is duly followed and that consideration is given to the protected characteristics, where relevant, when following due process.

The policy is intended to make the concerns management process as quick and as fair as possible, with concerns being assessed on the basis of facts and in accordance with the Regulations. It is therefore considered that the impact is primarily positive.

No potential adverse impacts in relation to any protected characteristics have been identified at this stage. A search of similar policies elsewhere indicated similar results.

Whilst no potential adverse impacts in relation to any protected characteristics have been identified at this stage, staff involved in addressing concerns will need to be sensitive to issues in relation to sharing sensitive personal information where required e.g. Transgender status, sexual orientation etc. Each concern is assessed on the basis of facts and in accordance with the law. The Health Board has a legal obligation to provide all information it holds relating to the concern in accordance with the Putting Things Right Regulations. Sharing of personal identifiable information risks have been mitigated by following the Health Board's Information Governance policies and procedures and national guidance/legislation regarding confidentiality and data protection

Associated policies and references can be found on pages 28/29 of the policy.

Assess which protected characteristics will potentially be affected by the proposal in the table below (please ✓ the relevant box to confirm positive, negative or no impact)**.**

If at any point a negative impact has been identified (actual or potential), you do not need to proceed with the completion of this form, as a full EqIA must be undertaken: Equality Impact Assessments (EqIAs) (sharepoint.com)

Age Is it likely to affect older and younger people in different ways or affect one age group and not another?					
Positive Impact	✓	Negative Impact		No Impact	
Justification of impact identified: This is an administrative body of work that will be positively used to support patient, family member, carer or advocate who wishes to raise their concerns with the Health Board and will not have any impact due to age.					
Disability Is it likely to affect those with a physical disability, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes?					
Positive Impact	✓	Negative Impact		No Impact	
Justification of impact identified: The Health Board is committed to ensuring concerns can be raised in a way that is accessible and convenient for individuals. Concerns may be raised verbally, in writing or electronically and can be made through the Health Board's published concerns arrangements, available via its website and other communication channels. Patient support services (complaints & feedback) - Hywel Dda University Health Board Individuals will be offered reasonable adjustments, language support and advocacy where required to ensure equitable access to the concerns process. Concerns may be raised with any member of staff, who has responsibility for ensuring the concern is directed into the appropriate process.					
Gender Reassignment Is it likely to affect those who either: • Have undergone, intend to undergo or are currently undergoing gender reassignment.					

• Do not intend to undergo medical treatment but wish to live in a different gender from their gender at birth					
Positive Impact	✓	Negative Impact		No Impact	
Justification of impact identified: This is an administrative body of work that will be used to support patient, family member, carer or advocate who wishes to raise their concerns with the Health Board the LTP process will have a positive impact due to and gender reassignment.					
Marriage / Civil Partnership Under the Equality Act, the characteristic of Marriage and Civil Partnerships is only protected in the workplace/ employment. Is it likely to affect those who are married or in a Civil Partnership? This means someone who is legally married or in a civil partnership.					
Positive Impact		Negative Impact		No Impact	✓
Justification of impact identified: This is an administrative body of work that will be used to support patient, family member, carer or advocate who wishes to raise their concerns with the Health Board and will not have any impact due to their marriage or civil partnership status.					
Pregnancy and Maternity Is it likely to affect those who are pregnant or have recently had a baby? Maternity covers the period of 26 weeks after having a baby, whether or not they are on Maternity Leave.					
Positive Impact	✓	Negative Impact		No Impact	
Justification of impact identified: This is an administrative body of work that will be used to support patient, family member, carer or advocate who wishes to raise their concerns with the Health Board the LTP policy will primarily have a positive impact for people raising concerns that might be pregnant or recently had a baby.					
Race / Ethnicity Is it likely to affect people of a different race, nationality, colour, culture or ethnic origin including non-English / Welsh speakers, Gypsies/Travellers, asylum seekers and migrant workers?					
Positive Impact	✓	Negative Impact		No Impact	
Justification of impact identified: This is an administrative body of work that will be used to support patient, family member, carer or advocate who wishes to raise their concerns with the Health Board. The LTP policy will have a positive impact due to race or ethnicity.					
Religion or Belief Is it likely to affect people who have a religion or belief? The term 'religion' includes a religious or philosophical belief.					
Positive Impact	✓	Negative Impact		No Impact	
Justification of impact identified: This is an administrative body of work that will be used to support patient, family member, carer or advocate who wishes to raise their concerns with the Health Board and will primarily have a positive impact due to religion or beliefs.					
Sex Is it likely to affect people who are mostly male or female. Where it applies to both equally does it affect one differently to the other?					
Positive Impact	✓	Negative Impact		No Impact	
Justification of impact identified: This is an administrative body of work that will be used to support patient, family member, carer or advocate who wishes to raise their concerns with the Health Board. The LTP policy will have a positive impact it applies equally and does not affect one differently that the other.					

Sexual Orientation
Whether a person's sexual attraction is towards their own sex, the opposite sex or either.

Positive Impact	✓	Negative Impact		No Impact	

Justification of impact identified: This is an administrative body of work that will be used to support patient, family member, carer or advocate who wishes to raise their concerns with the Health Board the LTP policy will have a positive impact regardless of a person's sexual attraction is towards their own sex, the opposite sex or either.

Armed Forces Community
Consider whether this impacts on members of the Armed Forces and their families, whose health needs may be impacted long after they have left the Armed Forces and returned to civilian life. Also consider their unique experiences when accessing and using day-to-day public and private services compared to the general population. It could be through 'unfamiliarity with civilian life, or frequent moves around the country and the subsequent difficulties in maintaining support networks, for example, members of the Armed Forces can find accessing such goods and services challenging.'

For a comprehensive guide to the Armed Forces Covenant Duty and supporting resource please see:
Armed-Forces-Covenant-duty-statutory-guidance

Positive Impact	✓	Negative Impact		No Impact	

Justification of impact identified: This is an administrative body of work that will be used to support patient, family member, carer or advocate who wishes to raise their concerns with the Health Board and will have a positive impact to the armed forces community.

Socio Economic Duty
Consider those on low income, economically inactive, unemployed or unable to work due to ill-health. Also consider people living in areas known to exhibit poor economic and/or health indicators and individuals who are unable to access services and facilities. Food / fuel poverty and personal or household debt should also be considered.

For a comprehensive guide to the Socio-Economic Duty in Wales and supporting resources please see:
more-equal-wales-socio-economic-duty

Positive Impact	✓	Negative Impact		No Impact	

Justification of impact identified: This is an administrative body of work that will be used to support patient, family member, carer or advocate who wishes to raise their concerns with the Health Board the LTP policy will have a positive impact due to their socio economic position.

Welsh Language
Is it likely to impact on opportunities for people to use the Welsh language? The Welsh language should be treated no less favourably than the English language.

Positive Impact		Negative Impact		No Impact	✓

Justification of impact identified: This is an administrative body of work that will be used to support patient, family member, carer or advocate who wishes to raise their concerns with the Health Board and will not have any impact on the use of the Welsh language.

If a negative impact has been identified, you are not required to complete this form as a full EqIA must be undertaken. A full EqIA template and guidance can be found on the following link: Equality Impact Assessments (EqIAs) (sharepoint.com)

Screening Completed by:	Name	Clare Dix
	Title	(Hywel Dda UHB - Team Administrator)
	Contact details	Clare.dix@wales.nhs.uk
	Date	26/08/2026
Screening Authorised by: (Directorate level owner of the procedures/ proposals/ projects/ policy)	Name	Louise O'Connor
	Title	Hywel Dda UHB Assistant Director (Legal and Patient Support Services)
	Contact details	louise.oconnor@wales.nhs.uk
	Date	08/09/2026
Guidance has been provided by Diversity & Inclusion Team:	Name	Alan Winter
	Title	Senior Diversity & Inclusion Officer
	Contact details	Alan.winter@wales.nhs.uk
	Date	29/9/2026
Diversity and Inclusion Team additional Comments:		

Please note: The D&I team will save a copy of the completed form for reference. If any changes are made after the date of review, it is the directorate's responsibility to update the EqIA and inform the D&I team.

10

10 - For Information

10.1

10.1 - QSEC Work Plan 2026-27

For information

Attachments

Draft QSEC Work Programme 2026 27.pdf

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

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

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

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

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

AGENDA ITEM/ ISSUE	LEAD	PURPOSE	RESPONSIBLE OFFICER	9 April 2026	11 June 2026	11 August 2026	9 October 2026	3 December 2026	9 February 2027
Duty of Candour Annual Report 2025/26	SD	FOR APPROVAL	CS		✓				
Duty of Quality Annual Report 2025/26	SD	FOR APPROVAL	CS			✓			
Nurse Staffing Levels (Wales) Act: Assurance Reports (as required) –Annual Report and Spring Calculation Cycle	SD	ASSURANCE	HH		✓				
Cleanliness Standards Audit report and Action Plan	JS	ASSURANCE	SC/ EB			✓			
A review of the implementation of the community Mental Health referral pathway	AC	ASSURANCE	AD		✓				
Fuller Inquiry assurance of progress of recommendations	JS	ASSURANCE	CB	✓					
First Contact Physiotherapist Report	JS	ASSURANCE	JB	✓				Learning from investigation to be shared via LLSC report	
Epilepsy in Learning Disabilities Update	AC	FOR ASSURANCE	OM			✓			
Ceredigion Community Mental Health Referral Pathway (included in the CCG report)	AC	FOR ASSURANCE	LC		✓				

AGENDA ITEM/ ISSUE	LEAD	PURPOSE	RESPONSIBLE OFFICER	9 April 2026	11 June 2026	11 August 2026	9 October 2026	3 December 2026	9 February 2027
Quality Assurance Report for Commissioned Services	**LD**	**FOR ASSURANCE**	**AS**					✓	
Listening to People Initiative (*Inc in the Quality Assurance Report)*	**SD**	**FOR ASSURANCE**	**LOC**		✓				
Insourcing 52 week first consultant appointment quality issues	**AC**	**FOR ASSURANCE**	**KJ**				✓		
Management of outpatients	**AC**	**FOR ASSURANCE**	**PG**			✓			✓ progress against the outpatient transformation programme and associated workplan
Sleep Apnoea Closure Report and Lessons Learnt	**JS**	**FOR ASSURANCE**	**JB**						✓
Patient Safety Plan 2026- 2031	**SD**	**FOR ASSURANCE**	**CS**				✓		
Deep Dives Clinical Services									
Ophthalmology	**AC**	**ASSURANCE**	**PG/ AJ**		✓				
Urology	**AC**	**ASSURANCE**	**PG/NG**			✓			✓ Improvement plan
Orthopaedics	**AC**	**ASSURANCE**	**PG/ LG**				✓		
Radiology	**AC**	**ASSURANCE**	**PG / SP**					✓	
Dermatology	**AC**	**ASSURANCE**	**PG/CW**				✓		
Endoscopy	**AC**	**ASSURANCE**	**PG/ SJ**					✓	

AGENDA ITEM/ ISSUE	LEAD	PURPOSE	RESPONSIBLE OFFICER	9 April 2026	11 June 2026	11 August 2026	9 October 2026	3 December 2026	9 February 2027
Clinical Care Group Updates									
Mental Health and Learning Disabilities	**AC**	**FOR ASSURANCE**	**RTP**		✓		✓		
Community and Integrated Medicine	**AC**	**FOR ASSURANCE**	**ACh**		✓			✓	
Allied Health Services	**AC**	**FOR ASSURANCE**	**SQ**			✓			✓
Planned and Specialist Care	**AC**	**FOR ASSURANCE**	**PG**	✓			✓		
Estates and Facilities	**JS**	**FOR ASSURANCE**	**EB/ SC**			✓			✓
Public Health	**AG**	**ASSURANCE**	**BL**		✓			✓	
Listening and Learning Sub Committee Update Report	**MH**	**ASSURANCE**	**LOC**	✓	✓	✓	✓	✓	✓ TOR for review
Policies				**Expiry**					
1133 Service User Access Policy Psychological Therapies	**AC**	**FOR APPROVAL**	**Andrew Homfray**	5-Mar-26 Extended whilst full review is finalised	✓				
429 Management and Distribution of Safety Alerts and Notices Policy	**SD**	**FOR APPROVAL**	**Cathie Steele**	13-Jun-26					
004 Claims Management Policy	**SD**	**FOR**	**Louise**	8-Oct-26					

AGENDA ITEM/ ISSUE	LEAD	PURPOSE	RESPONSIBLE OFFICER	9 April 2026	11 June 2026	11 August 2026	9 October 2026	3 December 2026	9 February 2027
		APPROVAL	**O'Connor**						
894 Putting Things Right Management and Resolution of Concerns Policy (Incidents, Complaints and Claims)	**SD**	**FOR APPROVAL**	**Louise O'Connor**	8-Oct-26					
1561 - 'Listening to People' Integrated Patient Safety, Concerns Management and Resolution Policy which will replace the 894 'Putting Things Right Management Policy	**SD**	**FOR APPROVAL**	**Louise O'Connor**	8- Oct-26					
63 Use of Patient and Carers Stories Guideline	**SD**	**FOR APPROVAL**	**Louise O'Connor**	13-Feb-27					
307 Production of Patient and Carer Information Policy	**SD**	**FOR APPROVAL**	**Louise O'Connor**	21-Mar-27					
892 Incidents Near Miss and Hazard Reporting procedure	**SD**	**FOR APPROVAL**	**Cathie Steele**	31-Jul-27					
18 Inquest guidance	**SD**	**FOR APPROVAL**	**Louise O'Connor**	15-Aug-27		**Deferred**			
309 - Continuing NHS Healthcare Operational Policy to Support Framework for Implementation	**AC**	**FOR APPROVAL**	**Tracy Devantier**	15-Aug-27					
568 Production and Use of Surveys Guideline	**SD**	**FOR APPROVAL**	**Louise O'Connor**	4-Dec-28					
1097 Corporate Safeguarding Policy	**SD**	**FOR APPROVAL**	**Charlotte Westacott**	11-Aug-26					
For Information									
HIW Annual Report	**N/A**	**FOR INFORMATION**	**N/A**				✓		

AGENDA ITEM/ ISSUE	LEAD	PURPOSE	RESPONSIBLE OFFICER	9 April 2026	11 June 2026	11 August 2026	9 October 2026	3 December 2026	9 February 2027
Joint Commissioning (JCC) Quality Safety Outcomes Sub Committee Highlight Report	**Helen Tyler JCC**	**FOR ASSURANCE**	**N/A**	✓	✓	✓	✓	✓	✓
Work plan 2026/27	**N/A**	**FOR INFORMATION**	**N/A**	✓	✓	✓	✓	✓	✓
Patient Experience Report	**N/A**	**FOR INFORMATION**	**N/A**	✓	✓	✓	✓	✓	✓
Agenda setting meeting with Chair and Exec Lead to include discussion on deep dives on new risks (at least 6 weeks before the meeting)	**CSO**		**CSO**	✓	✓	✓	✓	✓	✓
Draft agenda to go to Executive Team prior to being issued.	**CSO**		**CSO**	✓	✓	✓	✓	✓	✓
Call for papers (at least 4 weeks before the meeting to receive papers at least 14 days before the meeting)	**CSO**		**CSO**	✓	✓	✓	✓	✓	✓
Disseminate agenda and papers 7 days prior to the meeting	**CSO**		**CSO**	✓	✓	✓	✓	✓	✓
Type up minutes and TOA within 7 days of the meeting	**CSO**		**CSO**	✓	✓	✓	✓	✓	✓
Circulate minutes and TOA to Committee for comments, points of accuracy and matters arising within 10 days of the meeting	**CSO**		**CSO**	✓	✓	✓	✓	✓	✓
Check and send final version of minutes to the Committee Chair following comments received.	**CSO**		**CSO**	✓	✓	✓	✓	✓	✓
Chase updates on TOA before the next meeting and RAG rate	**CSO**		**CSO**	✓	✓	✓	✓	✓	✓
Record and track the TOA as	**CSO**		**CSO**	✓	✓	✓	✓	✓	✓

AGENDA ITEM/ ISSUE	LEAD	PURPOSE	RESPONSIBLE OFFICER	9 April 2026	11 June 2026	11 August 2026	9 October 2026	3 December 2026	9 February 2027
part of the decision tracker									
Produce written update report for Board	**CSO**		**CSO**	✓	✓	✓	✓	✓	✓
Prepare schedule of meetings	**CSO**		**CSO**					✓	

Initials

SD- Sharon Daniel	CSO-Katie Lewis	MP- Marilize Preez	LOC- Louise O'Connor	MH- Mark Henwood
AC- Andrew Carruthers	BL- Bethan Lewis	CS- Cathie Steele	AG- Ardiana Gjini	JS- James Severs
HH- Helen Humphreys	SA- Shaun Ayres	MD- Mandy Davies	RW- Rachel Williams	IB- Ian Bebb
RTP- Rebecca Temple Purcell	ACh- Anna Chiffi	SC- Simon Chiffi	AS- Ann Simpson	LD- Lee Davies
EB- Elin Brocke				

10.2

10.2 - Joint Commissioning Committee Highlight Report

For information

Attachments

2.2.1 QSOC Highlight Report 24 August 2026.pdf

Cyd-bwyllgor Comisiynu
Joint Commissioning Committee

Joint Commissioning Committee

Highlight Report from the Quality, Safety and Outcomes Sub-Committee

Dyddiad y Cyfarfod / Date of Meeting	22/09/2026
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Gareth Mitchell, Corporate Governance Manager, NWJCC
Cyflwynydd yr Adroddiad / Report Presenter	Aaron Fowler, Committee Secretary, NWJCC
Noddwr yr Adroddiad / Report Sponsor	Carole Bell, Director of Nursing and Quality, NWJCC

Pwrpas yr Adroddiad / Report Purpose	For Assurance

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Health Boards	Various	Noted
Senior Leadership Team (SLT)	16/09/2026	Noted

1. SITUATION/BACKGROUND

This report had been prepared to provide NWJCC Joint Committee (JC) Members with a summary of the key issues considered by the Quality, Safety and Outcomes (QSOC) Sub-Committee at its public meeting on 24 August 2026.

Key highlights from the meeting are reported in **Section 2**.

2. HIGHLIGHT REPORT

(Links to reports highlighted – August 2026)

Status	Update
Alert / Escalate	**Joint Accreditation Committee of the International Society for Cellular Therapy ISCT and the European Group for Blood and Marrow Transplant EBMT (JACIE) Accreditation Risks** – Members noted the continued critical risk relating to JACIE certification for Bone Marrow Transplant and CAR-T services. The Committee noted the action plan submitted by Cardiff and Vale University Health Board and the work underway to understand mitigating actions and future planning implications through the Integrated Medium-Term Plan (IMTP) and clinical review processes.
Advise	Reports from each of the Directors of Commissioning were received. The following items were discussed. **Director of Commissioning for Specialised Services** • Members discussed quality, safety and outcome risks across the specialised services portfolio, including **JACIE** accreditation risk which is highlighted above. • **Cardiac Surgery** – Cardiac surgical services had been escalated to Level 2, with an initial action plan received and further detail requested to address gaps in data, reporting and assurance. • **Plastic Surgery and Paediatric Endoscopy** – Members noted ongoing waiting list and service sustainability pressures in plastic surgery services in South and North Wales, as well as an emerging risk in paediatric gastroenterology relating mainly to endoscopy waiting lists. Further work was being undertaken to understand the pathways and ensure that patients were prioritised appropriately. • Members noted that **thrombectomy** remained on the organisational risk register and that further consideration would take place through the Joint Committee. **Welsh Kidney Network (WKN) Report** • Members received assurance on four nationally reportable incidents that had closed through the Quality and Patient Safety process. • The Committee noted one risk scored at 16 relating to renal dialysis capacity. Members also noted the forthcoming October Renal Network Conference and that information would be shared with Lay Members should they wish to attend. **WKN: Welsh Language Patient Story - Chronic Renal Disease and Home Dialysis** • The Committee welcomed the open and transparent approach taken by the network, including the sharing of learning across Wales. Members also received a follow-up update on the

Status	Update
	previous Welsh language patient story, noting assurance on patient travel times, transport performance, patient experience at Neath Port Talbot dialysis site and mechanisms for patients to raise concerns. **Director of Commissioning for Ambulance Services and National Programmes** • Members noted improvement in ambulance **handover hours**, while recognising that performance remained above commissioned capacity. • Updates were received on **NHS 111** digital developments. • **Non-Emergency Patient Transport Services (NEPTS) and WAST Call-Taking Processes** – Members requested further assurance on non-emergency patient transport cancellations, quality and equity implications, and WAST call-taking processes, including algorithms, modelling and the framework in place. • Members noted an emerging issue relating to adult critical care transfer service vehicle availability, with work underway with the provider to seek assurance on delivery. • NWJCC and Police colleagues were progressing an 18-month programme to streamline SARC commissioning across Wales, covering the future service model, specification, finance, governance and performance arrangements. • **Major Trauma Network -** The Committee noted that interim overnight coordination arrangements remained in place, supported by EMRTS, while discussions continued with WAST and the network to agree a sustainable 24-hour model. The issue would be kept under review and escalated if the risk increased or a long-term solution was not identified. **Director of Commissioning for MHLDVG** • Members noted the position regarding St Andrew's Healthcare, independent sector performance improvement plans and the positive de-escalation of Caswell Clinic from Level 3 to Level 2. The Committee received assurance that patient safety risks and issues within commissioned services were being managed and monitored. Incident and Concerns Report • Members noted 14 new nationally reportable incidents, three early warning notifications and 16 new complaints, with no new referrals to the Ombudsman. Further work was requested to strengthen the presentation of outcomes, learning and wider sharing of Regulation 28 learning across health boards.
Assure	The Committee received the QSOC Sub-Committee's assigned risks from the **NWJCC Operational Risk Register** as of 31 July 2026. The Committee noted that the risk picture remains stagnant, with a number of long-standing risks that had not moved for a considerable period. AF confirmed that this has been reflected at JC. A **Consolidated Neurosciences Risk Report** was also included for noting.

Status	Update
	The **Escalation Trajectories Report** was received and is attached at **Appendix 1.** The Committee received assurance regarding services currently in escalation. Members noted that one services was in escalation level 3 and that detail had been considered through the relevant Director reports. An update on auditory implant services will be included in the next report to provide further assurance on staff morale. The **Regulator Report** (Healthcare Inspectorate Wales (HIW)/Care Quality Commission (CQC) was received. The Committee received assurance that the report would be considered as part of the forthcoming QSOC development session to strengthen how regulatory information is presented and used to support assurance. **All Wales Individual Patient Funding (IPFR) Report** The Committee noted that the deep dive was underway and that a review of the IPFR form would be undertaken in due course.
Inform	**Patient Story** – QSOC received a patient story relating to specialist spinal rehabilitation. Members welcomed the strongly positive account of person-centred, coordinated and compassionate care, recognising the role of the multidisciplinary team, specialist expertise, continuity of care and psychological support in achieving positive outcomes. **QSOC Development Day** – Members noted that the development day agenda had been updated and would include an item on EQIA and prioritisation. **Forward Plan of Business** – The Committee reviewed and noted the 2026–27 Forward Plan of Business.
Appendices	Appendix 1 - Escalation Trajectories.

3. ASSESSMENT

Objectives / Strategy	
Dolen i Amcan (au) Strategol CBC Link to JCC Strategic Objectives(s)	Maximise Value
	Ensure Quality; Reduce Duplication; Improve Equity & Population Health; Facilitate Integration
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	A Resilient Wales
	A Healthier Wales
Dolen i Hwyluswyr Ansawdd	Leadership

(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / **Link to Enablers of Quality** (Duty of Quality Statutory Guidance (gov.wales))	Culture and Valuing People; Learning, Improvement and Research; Whole-systems Perspective
Dolen i Feysydd Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / **Link to Domains of Quality** (Duty of Quality Statutory Guidance (gov.wales))	Effective
	Efficient; Equitable; Person-centred; Timely; Safe
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: This is a summary of the latest meeting of the JCC
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☒	No: ☒
	Outcome for Equality (delete as appropriate): ~~POSITIVE~~/NEUTRAL/~~NEGATIVE~~ Outcome for Welsh Language (delete as appropriate): ~~POSITIVE~~/NEUTRAL/~~NEGATIVE~~	If no, please include rationale below: This is a summary of the latest meeting of the JCC
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Joint Committee as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	The performance of the services will be used to develop the Plan and identify the areas where resources may be required.	

4. RECOMMENDATIONS

The Joint Commissioning Committee is asked to:

- **Note** the highlights outlined in Section 2 of this report; and
- **Receive** the **report** as assurance

Director Lead: Melanie Wilkey
Commissioning Lead: Krysta Hallewell
Commissioning Team: Neuro-Sciences

Date of Escalation Meetings: 05/08/2026
Date Last Reviewed by Quality & Patient Safety Committee: 24/08/2026

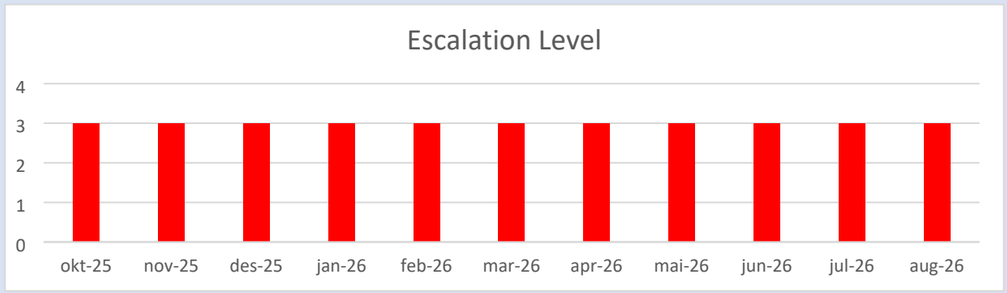
Service in Escalation: Specialist Auditory Implant Device Service

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ August 26
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
October 2025	**3**

Rationale for Escalation Status: Due to insufficient progress against agreed improvement actions monitored through the quarterly Service Performance Management meetings since January 2024, and continued underperformance against the RTT position relative to the specific ministerial target for this patient cohort, the Neurosciences, Long Term Conditions and Rare Conditions Commissioning Team recommends escalation to **Level 3 – Escalated Measures**.

The service now requires significant and sustained improvement, with Executive-level oversight and intervention necessary to address performance risks and secure recovery against agreed standards.

Background Information:

The escalation of the Cardiff and Vale Specialist Auditory Implant Device Service to Level 3 of the NWJCC Escalation Framework was initiated in October 2025 and endorsed by the NWJCC Senior Leadership Team.

The NWJCC assurance and confidence rating remains Low. A formal escalation letter was issued to Cardiff and Vale UHB on 6 October 2025. However, delays in confirming a named Executive Lead and Health Board availability resulted in a postponement of the initial escalation meeting.

The first formal escalation meeting was subsequently held on 22 January 2026.

Action (NWJCC Lead: Director of Commissioning):	Action Due Date	Completion Date
Escalation endorsed by SLT	Oct 25	Oct 25
Escalation letter sent to CVUHB	Oct 25	Oct 25
Escalation meeting to discuss detail and progress against action plan (every 4 weeks)	Ongoing	Ongoing

Issues/Risks:
February 2026 Update – Commissioning and provider teams to jointly clarify: Historic and current commissioning expectations for CT scans, where clinical interpretation of scans should take place and whether pathway changes created unintended delays.
April 2026 update the pre-surgical CT scan pathway remains an open action. Progress has been made on the Long Term Agreement (LTA), and the service will share the draft in due course. The service has highlighted the impact of additional activity undertaken to reduce backlog pressures, noting a decline in staff morale. There is a recognised risk that ongoing pressures on staff wellbeing may contribute to increased sickness absence. Escalation meeting planned for the 16th April has been moved to the 28th April at the request of the service.
June 2026 – There has been significant progress in addressing the 52 week waits in the service and there are no patients currently at 52 weeks working towards a 36 week target. Work ongoing with the review and rebasing of the LTA. The pre surgical scan pathway is still an open action with an SOP in draft. An operational

manager has been moved into the service for support but there are still some concerns around stress wellbeing with the service being stretched due to increased activity to reduce the longest waiters.

August 2026 – Escalation meeting held 5th August. The service has addressed the longest waiters and by August will be working to a 36-week target. The service are modelling against the BCUHB service and have the data and optimal pathways and are in the process of arranging a visit. The SOP for pre surgical scan pathway has been embedded into Audiology service operating procedure. At present the service do not feel they can meet a 26-week target. Sickness has decreased and the morale of the team has improved. There continues to be ongoing discussions around LTA and sustainability of the service

Director Lead: Sue O'Leary
Commissioning Lead: Sue O'Leary
Commissioning Team: Mental Health

Date of Escalation Meetings: 03/08/2026
Date Last Reviewed by Quality & Patient Safety Committee: 24/08/26

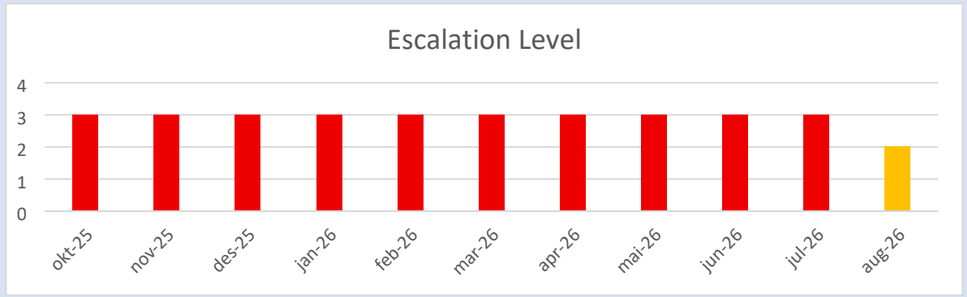
Service in Escalation: Caswell

Current Escalation Level 2

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↓ August 2026
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
January 25	**3**

Rationale for Escalation Status: The service has been placed under formal escalation due to sustained concerns relating to safety and quality within the facility. A site visit by NWJCC representatives in July 2025 identified significant safety and quality concerns. These were reported to the JC in September 2025, which commissioned a full-service review.

The review, undertaken between 15 September and 3 October 2025, assessed compliance with recognised Medium Secure Unit standards and included patient-level review. It identified serious safety and quality issues requiring urgent action.

Similar concerns had been raised in a 2022 NCCU review and were echoed in a June 2025 independent report on Swansea Bay University Health Board's Mental Health and Learning Disability services, which highlighted compromised care standards and weaknesses in leadership and oversight.

The findings indicate systemic governance and safety risks requiring immediate improvement action and strengthened executive oversight.

Background Information:
The escalation of the Caswell Clinic Service to Level 3 of the NWJCC Escalation Framework was initiated and endorsed by the NWJCC Senior Leadership Team in October 2025, following significant safety and governance concerns.

Following engagement with the Swansea Bay Executive Team, the service was placed in Level 3 escalation, with weekly improvement meetings established with Caswell senior leaders and monthly oversight meetings with the Health Board Executive. A detailed improvement plan aligned to recognised standards was developed, with a number of urgent actions identified. Admissions were paused pending assurance that immediate safety risks had been addressed.

Action (NWJCC Lead- Director of Mental Health AC)	Action Due Date	Completion Date
In Committee update to JCC members	October 2025	October 2025
Letter to SBUHB Executive team	October 2025	October 2025
JCC to meet with Caswell SLT on a weekly basis	Complete	Complete

August 2026 Update

Admissions were suspended in September 2025 due to significant staff and patient safety concerns. Immediate risk mitigation actions were implemented over a three-month period. Assurance was received in January 2026, and admissions recommenced on 9 January 2026.

Robust oversight remains in place, including:

- **Weekly meetings between MHLDVG and Caswell senior leadership to monitor delivery of the action plan, with independent verification of completed actions.**
- **Fortnightly meetings between the MHLDVG Director and Swansea Bay Executive Team to seek further assurance and address delivery risks.**

Whilst the service has been de-escalated to Level 2 (see below) the JCC continues to meet with Caswell on a fortnightly basis to continue ongoing assurance processes.

Suspension for new admissions to the clinic	Complete	Complete
JCC to meet with Caswell SLT on a fortnightly basis	Ongoing	Complete
Clinic reopen to admissions	January 2026	January 2026
JCC to meet with Caswell on a fortnightly basis to continue ongoing assurance processes	August 2026	Ongoing
Letter to SBUHB exec team informing of de-escalation to Level 2	August 2026	Complete

Issues/Risks:

The service remains in Level 3 escalation. Decisions regarding de-escalation will be taken jointly by the MHLDVG and NWJCC Nursing and Quality teams once sustained improvement and compliance are demonstrated.

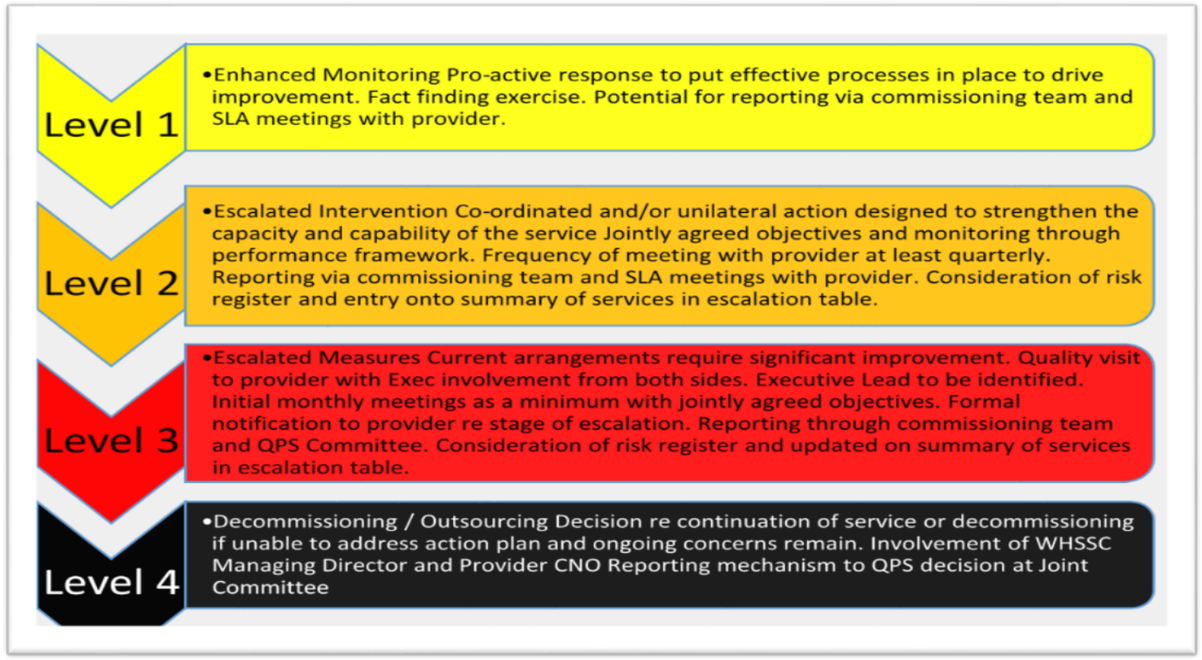
Caswell Clinic remain in Level 3 escalation. Discussions have been held within JCC to establish what needs to be done in order to reduce the level of escalation in the future. Caswell Clinic have been asked to complete the evidence section of the MHLDVG action plan. This will give the JCC a description of what the service has done in order to resolve or mitigate the issues raised at the time of the initial review. Once that has been received by the MHLDVG division, each action will be reviewed against the evidence supplied with a view to understanding what level of progress has been made and what the ongoing escalation level will be. The current series of meetings between the MHLDVG and SBUHB have been suspended and will be rearranged following receipt of the updated action plan from the service in order to ensure that the ongoing meetings are relevant, with the appropriate personnel, and discuss relevant points of the action plan".

June 2026 – Following receipt of a consolidated report in late April 2026 evidencing significant progress against the original review findings, commissioning, quality safety and medical teams have undertaken a detailed assessment to identify the remaining actions required for de-escalation to level 2 monitoring. More integrated oversight arrangements are in place, via monthly escalation meetings from April 2026, with ongoing engagement with the service to support delivery. A clear set of outstanding actions are in place with the health board, with a commitment to review and sign off evidence on a rolling basis.

August 2026 – Following an escalation meeting with the service the JCC recognised the considerable progress that has been made by staff across Caswell Clinic and SBUHB in addressing the issues identified within the Improvement plan since late 2025. It also acknowledges the work undertaken across the service to strengthen quality, safety and operational arrangements. A review undertaken in July by colleagues from the NWJCC Quality & Safety, Medical and Mental Health teams, working in collaboration with SBUHB and Caswell Clinic teams, confirmed that all immediate concerns have now been mitigated and that most actions within the de-escalation plan have been achieved. Continued focus will be required to ensure that these improvements are sustained and fully embedded across the service. Several areas will remain subject to ongoing monitoring in line with level 2 escalation and assurance to support the maintenance of progress achieved to date and to ensure that improvements continue to be embedded. The JCC will continue to work with the service to support and assure further improvement in care planning, clinical risk assessments and the wider governance programme.

Level 1 ENHANCED MONITORING	Any quality or performance concern will be reviewed by the Commissioning Team. Enhanced monitoring is a pro-active response to put effective processes in place to drive improvement. It is an initial fact finding exercise which should ideally be led by the provider and closely monitored and reviewed by the commissioning team. The enquiry will lead to one of the following possible outcomes: • No further action is required routine monitoring will continue. The concern which raised the indication for inquiry will be logged and referred to during the routine monitoring process to ensure this has not developed any further. • Continued intervention is required at level 1 and a review date agreed. • Escalation to Level 2 if further intervention is required There is the potential for reporting via commissioning team report to Quality Patient Safety Committee and through SLA meetings with provider
Level 2 ESCALATED INTERVENTION	Escalated intervention will be initiated if Level I Enhanced Monitoring identifies the need for further investigation/intervention. There should be a Co-ordinated and/or unilateral action designed to strengthen the capacity and capability of the service. At this stage there should be jointly agreed objectives between the provider and commissioner and monitored through the relevant commissioning team. Frequency of meeting with provider should be at least quarterly and possible interventions will include • Provider performance meetings • Triangulation of data with other quality indicators • Advice from external advisors • Monitoring of any action plans A risk assessment should be undertaken, and logged on the Commissioning Team Risk Register. Where appropriate the risk will be included on the JCC Risk Management Framework. Reporting is via commissioning team report to Quality Patient Safety Committee report and SLA meetings with provider. The investigation will lead to on to the following possible outcomes: • Action plan and monitoring are completed within the allocated timeframe, evidence of progress and assurance the concern has been addressed. De-escalation to Level 1 for ongoing monitoring. • If the action plan is not adhered to and further concerns are raised by the Commissioning team or by the provider team or further concerns are identified it may be necessary to move to Level 3 Escalated Measures
Level 3 ESCALATED MEASURES	Where there is evidence that the Action Plan developed following Level 2 has failed to meet the required outcomes or a serious concern is identified a service will be placed in escalated Level 3. At this stage the quality of the service requires significant action/improvement and will require Executive input. In addition to routine reporting through QPS a formal paper will be considered by the JCC Corporate Directors Group (CDG) and an Executive Lead nominated. Formal notification will be sent to the provider re the Level of escalation and a request made for an Executive lead from the provider to be identified. An initial meeting will be set up as soon as possible dependant on the severity of the concern. Meetings should take place at least monthly thereafter or more frequently if determined necessary with jointly agreed objectives. Provider representation will depend on the nature of the issue but the meetings should ideally comprise of the following personnel as a minimum: • Chair (JCC Executive Lead) • Associate Medical Director - Commissioning Team • Senior Planning Lead – Commissioning Team • JCC Head of Quality • Executive Lead from provider Health Board/Trust • Clinical representative from provider Health Board/Trust • Management representative from provider Health Board/Trust An agreed agenda should be shared prior to the meeting with a request for evidence as necessary. At the conclusion of the meeting a clear timeline for agreed actions will be identified for future monitoring and confirmed in writing if appropriate. Reporting will be through commissioning team to QPS Committee. Consideration of entry on the risk register and summary of services in escalation table for Chairs report to Joint Committee. Consideration to involve and have a discussion with Welsh Government may be considered appropriate at this stage. If there is ongoing concern relating patient care and safety with no clear progress then further escalation will be required to Level 4. On the other hand if progress is made through the escalation Level 3 evidence of this should be presented to CDG/QPS and a formal decision made with the provider to de-escalate to Level 2.

Level 4 **DECOMISSIONING/OUTSOURCING**	Where services have been unable to meet specific targets or demonstrate evidence of improvement a number of actions need to be considered at this stage. This stage will require notification and involvement of the JCC Managing Director and CEO from the provider organisation. Both Quality Patient Safety Committee and Joint Committee should be cited on the level of escalation. The following areas will need to be considered and the most appropriate sanction applied to help resolve the issue: 1. De-commissioning of the service 2. Outsourcing from an alternative provider. This may be permanent or temporary 3. Contractual realignment to take into account the potential need to maintain and agree an alternative provider. Involvement with Welsh Government and the Community Health Council is critical at this stage as often there are political drivers and levers that need to be considered and articulated as part of the decision making. Moving in and out of escalation and between Levels In addition to the Levels described above the process has introduced a traffic light guide within each level. The purpose of this is to help demonstrate the direction of travel within the level. It sets out an approach to help identify progress within the level and lays out the steps required for movement either upwards (escalation) or downwards (de-escalation) through the level. At every stage a red, amber or green colour will be applied to the level to illustrate whether more or less intervention is in place. Red being a higher level of intervention moving down to green. It will also help determine the easing of the escalated measures described and inform movement within the stages of escalation. As the evidence and understanding of the risks from a provider and commissioner become evident decisions can be made to reduce the level of intervention or there may be a need to reintroduce intervention should conditions worsen and trigger the re-introduction of measures if progress is unacceptable. In this way organisations will be able to understand what is being asked of them, progress will be easily identified and it will help avoid any confusion. It will also help in the reporting to provide assurance that action is being taken to meet the agreed timescales.



SERVICES IN ESCALATION

Level of escalation reducing / improving position

Level of escalation unchanged from previous report/month

Level of escalation increasing / worsening position

11

11 - Date of Next Meeting : 3 December 2026