Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	09 April 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	First Contact Practitioner (FCP) Physiotherapist Investigation Outcome Report (HDD49221)
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Sharon Daniel, Executive Director of Nursing, Quality, Safety and Experience
SWYDDOG ADRODD: REPORTING OFFICER:	Jo Bradburn, Deputy Director of Allied Health Professions

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 details of the conclusion to the patient safety review following identification of record keeping concerns relating to a First Contact Practitioner (FCP) Physiotherapist. The report provides assurance to the Quality, Safety and Experience Committee on the process followed to investigate the incident, identify learning from this incident, the immediate actions taken and further actions required to mitigate recurrence.

Cefndir / Background

In April 2023, a patient raised a concern that a First Contact Practitioner (FCP) Physiotherapist had not acted on clinical decisions to arrange radiological investigations and onward referrals to therapy specialties. A local investigation took place to establish the nature of this concern. During the local investigation, further concerns were identified relating to the practice and record keeping of the same FCP Physiotherapist. There was evidence to suggest this practice extended beyond the original scope of the initial concern.

The Head of Physiotherapy escalated these concerns to the Clinical Director of Therapies, prompting escalation to the Executive Director of Allied Health Professions and Health Science in November 2023.

It was considered appropriate to review all patient consultations (including assessment and treatment) which had been undertaken by the FCP Physiotherapist from the date of their three-year employment as a FCP Physiotherapist from 2020 to 2023. Due to the potential number of patients impacted by this practice, an executive led investigation process was commissioned by the Executive Team to investigate the breadth and scale of these concerns.

Initial assessment indicated the number of patients potentially affected was in the region of 4000 patients aligned to 6 General Practice (GP) surgeries within Carmarthenshire and Pembrokeshire. The actual number of patient records reviewed during the process was 3965. The number of patient records reviewed by GP surgery is detailed below:

GP Surgery	Number of Patient Records Reviewed
Argyle	1115
Morfa Lane	672
Nantgaredig	122
Neyland	770
Narberth	733
Furnace House	553
Total	**3965**

In February 2024, the Executive Team approved the *Framework for the Review of Harm Following Identification of Record Keeping Not in Line with Professional and Organisational Standards.* This included Terms of Reference for an Incident Control Group to oversee the review.

Asesiad / Assessment

Governance and Oversight of the Investigation Process

Incident Control Group

The Executive Team established an Incident Control Group to oversee this investigation. The Control Group met monthly with weekly progress updates provided to the Executive Director of Nursing, Quality and Patient Experience and the Executive Director of Allied Health Professions and Health Science.

The Control Group initially established two reporting sub-groups: a Scrutiny Panel and a Redress Panel. The function of these two sub-groups was reviewed, and it was determined more valuable to merge the group function, forming one 'Scrutiny and Redress Panel'. A further two sub-groups were established: a Communication Task and Finish Group and a Learning from Events Group.

Scrutiny and Redress Panel

The multiprofessional panel was composed of health care professionals with relevant knowledge, skills and experience to review specific cases of potential or actual harm, thus ensuring appropriate and timely remedial action could be taken.

The panel developed an 'Assessment of HarmTool' to enable the identification of potential or actual harm for each case (Appendix 1). The tool was consistently applied to the review of each case by Patient Safety Officers within the Quality, Assurance and Safety Team.

In cases where harm was identified, a member of the Quality, Safey and Assurance Team and Scrutiny & Redress Panel contacted each individual patient to inform them of the situation. Each individual patient was invited to a meeting to discuss the situation and what this meant for their individual circumstances. Depending on the specific needs of each patient, an individualised treatment plan was developed to ensure timely remedial action, in line with Duty of Candour.

The Scrutiny and Redress Panel categorised patients into one of four categories outlined in the table below:

Category 1	Patients who have suffered pain, suffering or loss of amenity as a direct result of the breach; patients who have a requirement for additional treatment as a result of the breach or whose outcome is affected, patients who have opted for private treatment when otherwise they would have received this treatment within the NHS, and patients where treatment timeframes have now exceeded as a result.
Category 2	Patients who have been identified and placed onto waiting lists for further treatment where they would have been had the action been carried out by the FCP service in 'real time'.
Category 3	Patients who opted for private treatment sooner than the wait within the current NHS wait times.
Category 4	Patients where no harm has been identified.

Each individual patient case was presented to the Scrutiny and Redress Panel following the screening process, except for patient cases identified in category 4.

Communication Task and Finish Group

The Communication Task and Finish Group supported the Scrutiny and Redress Panel to ensure the situation was communicated in a sensitive and timely manner to patients impacted by this situation. The methodology is outlined in the table below:

Category 1	Patients will be prioritised to those requiring urgent care and remedial treatment and receive meeting with Assistant Director of Legal Services and Patient Experience and Consultant Clinical Lead for Trauma and Orthopaedics.
Category 2	Patients will be contacted by the Waiting List Support Service and reassured that they are on the waiting list, where they should be with usual support via the Waiting List Support Service.
Category 3	No further action for these patients as patients chose to opt for treatment sooner than the NHS would provide.
Category 4	No direct communication planned.

The Communication Task and Finish Group provided guidance to staff working within primary care and the FCP physiotherapy service to ensure consistent communication with affected patients who continued to receive care and treatment by the FCP physiotherapy service. Similarly, guidance was provided to the Waiting List Support Service to ensure consistent and clear communication with all affected patients.

In January 2025, the Task and Finish Group engaged with senior leaders from the 6 GP surgeries to seek their feedback from the process, and to understand the impact of this incident on their patients and staff. It was considered important to ensure the learning and experience identified within the GP surgeries was included for wider system learning in the short and longer term.

Learning from Events Group

In December 2024, a Learning from Events Group was established to identify opportunities for learning and mitigate the risk of recurrence which is covered within the main body of this report.

Patient Impact

The total number of patient records reviewed was 3965. From these reviews a small number of patients were identified as requiring escalation of clinical treatment plans and <5 of these remain within the NHS redress scheme.

The number of patients that fall into each category is detailed below:

Patient group	Number of affected patients
Category 1	20
Category 2	31
Category 3	5
Category 4	3899

For those patients in Category 1, an individual incident record has been created on Datix Cymru and Duty of Candour instigated. This ensures that due process has been followed and any outcomes have been formally recorded.

The Assistant Director of Legal Services and Patient Experience and Consultant Clinical Lead for Trauma and Orthopaedics continue to meet with the category 1 patients and will be contacting the remaining patients more recently identified following scrutiny review during April/early May (<10). For patients where urgent treatment is required, these cases are prioritised and arranged via a mix of outsourcing to a private provider or internal provision, depending on the needs and wishes of the patients. All ongoing communication is being managed appropriately via duty of candour and the NHS redress scheme.

Learning From the Events

In December 2024, a Learning from Events Group was established to identify opportunities for learning and mitigate the risk of recurrence. On reflection, the membership of the group did not reflect the experience and learning from staff impacted through this incident and process. To capture the richness and value of their contribution, specific one to one meetings and focus groups were led by the Deputy Director of Allied Health Professions.
Using the information obtained through the investigation and the stakeholder engagement outlined above, key themes were identified to inform opportunity for future learning from this incident. There were 7 key themes identified including clinical, operational, governance, professional, digital, investigation and leadership across the Health Board. These 7 key themes have been outlined within this paper as recommendations 1 to 7 outlined below:

Recommendation 1: Embed clinical governance and assurance

Rationale:

- There was no service level or directorate level governance structure in place to monitor compliance with policy and audit.
- There was no service level or directorate level governance process in place to scrutinise patient safety incidents and the learning from these incidents.
- There was no process or precedent for how to upscale an investigation involving such a significant number patients, at pace.

Recommendation 2: Strengthen supervision and accountability

Rationale:

- There was no supervision policy or procedure in place which determined the standards of supervision for Allied Health Professionals.
- The GP surgeries with the strongest models of clinical supervision in place reported less patient harm.
- There was no national framework for enhanced, advanced and consultant level practice at the time of the incident. There was a Health Board developed EAGLE framework to support advanced practice roles but this was not consistently applied across all professional groups.
- There was variable knowledge and understanding of professional accountability which restricted physiotherapy professional lead access to primary care digital record keeping system and delayed the investigation process.
- There was no formal tool to ensure robust caseload management within the service.
- There were variable induction processes for FCP physiotherapists working in primary care which impacted on knowledge and understanding of the local operating model.

Recommendation 3: Optimise clinical pathways and service design

Rationale:

- There was a variation in the service delivery model of FCP physiotherapy in primary care, for example, the triage process was not consistent across all GP surgeries, leading to duplication of work by General Practitioners and FCP Physiotherapists.

Recommendation 4: Strengthen record keeping policies and processes

Rationale:

- Clinical record keeping audits not routinely undertaken within all the Allied Health Professions.

- Clinical audits that were undertaken did not consider the quality or content of the record and whether actions had been completed.
- Routine clinical audits would have identified this incident earlier.
- The availability and use of an electronic patient record keeping system in primary care was identified as being instrumental to patient safety and aided the efficacy of the investigation. However, the availability of an electronic patient record keeping system is not consistently available across a number of Allied Health Professions which needs to be risk assessed across the Health Board.
- There were examples of excellent record keeping with clear decision making that could be used as exemplars across the Health Board.

Recommendation 5: Establish professional governance and promote professionalism

Rationale:

- There was a need to ensure a standard approach to incident management which relates to the clinical workforce (registered and non-registered), particularly when concerning patient safety incidents across the directorate, that aligned to Health Board process.
- There was a need to improve the process of review of job planning across the service.

Recommendation 6: Strengthen leadership culture

Rationale:

- There was variable understanding and application of incident reporting and management processes, including application of the duty of candour within the directorate.
- There were missed opportunities to address workforce concerns at the time.
- There is a need to promote and embed mechanisms for staff to raise concerns such as the 'Speak Up' framework across the directorate.
- There is a need to ensure appropriate support is available for staff when dealing with an incident of this scale and complexity, in addition to their day-to-day role.

Recommendation 7: Improve communication both internally and externally

Rationale:

- There is a need to ensure timely sharing of patient information as routine practice between primary care, community services and secondary care to uphold continuity of patient care and safety.

It is imperative that action is taken to reduce the risk of incidents of a similar nature occurring within the Health Board. There are examples of learning which must be undertaken to mitigate this risk which range from individuals to wider system learning.

Actions to Mitigate Recurrence

Following the identification of this incident some immediate actions were taken by the physiotherapy service to prevent recurrence. These are outlined below and highlight the immediate impacts of these actions.

Immediate Actions Undertaken	Impact of Action
Refresh of physiotherapy record	Audit tool amended to reflect need to identify missing clinical records and timeliness of actions

keeping audit tool and process	Compliance percentage increased (>90% no areas of concern, 75-90% compliance showed moderate concern, <75% compliance significant concerns)
Review of record keeping audits on annual cycle and in line with record keeping policy	Service wide audits undertaken on an annual basis since 2024 Findings reported to Physiotherapy Quality, Safety and Risk Group Further actions identified as a result of learning from audits e.g. The need to refine guidance re: us of abbreviations Individual action plans developed where concerns raised about individual registrants Early identification of concerns about record keeping with immediate and timely support provided
Monthly physiotherapy governance meeting established which review incidents and identify learning.	Established governance meetings within Physiotherapy service held monthly Physiotherapy governance meeting reports into Clinical Care Group Integrated Governance Meeting Evidence of improved incident management with no open incidents in service over 60 days and an improving trend of incident management between 2023 and 2026 Increased reporting of incidents across physiotherapy service reflecting increased awareness of incident management process Physiotherapy service in Level 1 escalation for management of incidents
Reinforce the importance of incident reporting to include suspected missing records across physiotherapy service	Physiotherapy staff report increased confidence in understanding importance of reporting record keeping incidents >85% of physiotherapists have confirmed they understand the importance of this when surveyed Physiotherapy service has seen further incidents related to record keeping reported as a result of improved governance and awareness raising across the department
Learning shared with Therapies Directorate (prior to introduction of Clinical Care Groups structures).	Services within the Therapies Directorate have all reviewed clinical record keeping audit processes because of this incident. This has resulted in identification of other record keeping incidents and allowed for themes to be identified which have further supported identification of learning/actions related to this incident and reinforced the need for system wide approach to the sharing of learning
Individualised support to directly impacted staff.	Support tailored to individual needs has been provided by Senior Leadership in Physiotherapy, Workforce Teams and Wellbeing Services available across the Health Board.
Culture review undertaken within Physiotherapy Service with accompanying action plan.	Workforce and Organisation Development Team have supported Senior Leadership in Physiotherapy to develop an action plan Impact to be evaluated alongside analysis of staff survey results for 2025
Development of 'Accountability Arrangements for Registered Allied Health Professions' Policy	Accountability Arrangements for Allied Health Professions Policy has been published following wide engagement with professional and operational stakeholders. This clarifies the minimum standards required to provide assurance to the organisation that accountability arrangements are clear. This policy underpins the development of other procedures and processes for the Allied Health Professions including supervision, management of professional concerns and job planning.

Implementation of 'Accountability Arrangements for Registered Allied Health Professions' Policy.	The implementation of the Accountability Arrangements for Allied Health Professions Policy is underway with additional procedures to be established to ensure the full impact of the policy can be evaluated and monitored

A 'Management of Professional Concerns Process for Allied Health Professions' has been drafted and is currently with workforce and trade unions for consideration before going out for wider consultation. This will ensure equity when managing professional concerns and ensure that patient safety is considered as part of this process.

A 'Supervision Framework for Allied Health Professions' has been developed which will outline minimum standards of professional, clinical and line management supervision for the Allied Health Professions (registrant and non-registrant) workforce.

The Incident Learning Action Plan (Appendix 2) has been developed which outlines the actions necessary to mitigate the risk of similar incidents.

A 'Learning from Experience – Good Practice/ Self-Assessment' (Appendix 3) has been developed to further mitigate the risk of similar incidents across the wider Health Board.
The Incident Control Group was stood down on 13th November 2025.

On 19th November 2025 the Executive Team received and endorsed the incident closure report which includes the learning from this incident and the associated action plan to mitigate the risk of recurrence across the Health Board.

Following a further detailed review, the original action plan has been refined to strengthen clarity, proportionality and assurance, resulting in the removal or consolidation of 22 proposed actions. This refinement does not reduce accountability or learning from the incident; rather, it ensures the action set is tightly aligned to the investigation findings and addresses both immediate causes and underlying system factors through high-impact, sustainable actions.

Actions were removed only where they duplicated existing controls, were more appropriately delivered through Health Board-wide policies or governance arrangements or were not directly causally linked to the incident. All investigation findings have been explicitly mapped to retained actions or strengthened organisational processes, providing assurance that learning has been fully captured and embedded in line with Duty of Quality and Duty of Candour expectations. A fuller narrative and findings-to-actions mapping are provided in 'Incident Learning Action Plan' (Appendix 2).

Next Steps

The report and associated action plan to be considered by the Quality, Safety and Experience Committee on 09 April 2026 for assurance of the process and learning from the incident. Recommendation for Quality, Safety and Experience Committee to delegate oversight of the action plan to the relevant executive lead to ensure compliance and completion of the action plan, ensuring Health Board wide learning in line with the report recommendations.

Argymhelliad / Recommendation

The Quality, Safety and Experience Committee are requested to:

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

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.18 Provide assurance that a review process to receive and act upon clinical outcome indicators suggesting harm or unwarranted variation is in place and operating effectively at operational level, with concerns escalated to the Board.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	1. Safe 6. Person-Centred
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	5. Whole systems persepctive
Amcanion Strategol y BIP: UHB Strategic Objectives:	
Amcanion Cynllunio Planning Objectives	
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	

Gwybodaeth Ychwanegol:

Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	AHP – Allied Health Professions FCP – First Contact Practitioner GP – General Practitioner
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	Formal Executive Team – 13/11/25 Executive Director of Nursing, Quality and Patient Experience Executive Director of Allied Health Professions and Health Science Interim Assistant Director of Nursing, Assurance and Safeguarding Service Director for Allied Health Professions and Health Science First Contact Practitioner Incident Control 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:**	Contained within the report
Risg: **Risk:**	Contained within the report
Cyfreithiol: **Legal:**	Contained within the report
Enw Da: **Reputational:**	Contained within the report

Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	Not Applicable

Appendix 1: Assessment of Harm Tool

First Contact Practitioner (FCP) Physiotherapy Incident Investigation Form			
Patient name:		Date of Birth:	
EMIS Number:		NHS number:	
Date of initial MSK FCP Consultation:		GP Practice	
Where there further MSK FCP consultations?		If yes, what dates	
Reason for referral to MSK FCP			
Timeline of FCP and Other Consultations			
Other relevant medical history			
Details of MSK FCP Consultation			
Were notes completed in a timely manner and on the GP record for the FCP consultation?		If yes, what date were the notes made?	
In the electronic record, were notes made retrospectively?		If yes, what date were the notes made?	
Were the electronic notes satisfactory		If not, why were the notes deemed not satisfactory?	
Are there handwritten notes for the FCP consultation?		If yes, what date were the notes made?	
If notes of the FCP consultation are available, was there a plan for further investigation or onwards referral or FCP review?		If yes, was this completed ?	
Reviewers comments			
Further contact following MSK FCP Consultation			
Has the patient been seen by a GP for the same problem (since the MSK FCP contact)?		If yes, what was the date of the consultation?	
If yes, did the GP request further investigation or make an onward referral?			
Has the patient been seen elsewhere (not including the GP practice) since the MSK FCP consultation for the same or related issue?		If yes, please provide further detail	
Other notes			
Conclusion			
In your opinion, what is the level of harm to the patient?		Do you consider further investigation to be required?	
Administration			
Investigation undertaken by:		Date:	

Screening for Scrutiny Panel			
Does the incident meet the requirements to present to Scrutiny Panel		Additional notes	
Incident for this patient reported through Datix Cymru		If yes, what is the incident reference number	
Date screening for panel undertaken		Name and designation of person making decision	
Scrutiny Panel			
Is further investigation required?		If yes, please provide further detail	
Is involvement / advice from Legal Services required?		If yes, please provide further detail	
What was the panel's decision regarding level of harm?		Notes of discussion at Scrutiny Panel	
Outcome of panel		Date of Scrutiny Panel:	

Appendix 2: Incident Learning Action Plan

Purpose of this Action Plan

This action plan has been developed in response to the findings of a Control Group–led investigation. Its purpose is to ensure that learning from the incident is fully captured and translated into meaningful, proportionate, and sustainable improvement actions that reduce the risk of recurrence and strengthen patient safety, quality, and experience.

Approach to Action Development and Refinement

The original action plan deliberately adopted a wide and exploratory scope, identifying actions across governance, supervision, accountability, induction, record keeping, incident management, and organisational culture. This breadth was intentionally used to ensure that no potential area of learning was overlooked at the outset.

Following further review with service leads, professional leadership, and quality governance colleagues, the action plan has been refined and rationalised. This refinement has resulted in the removal or consolidation of 22 proposed actions. This decision was taken to improve clarity, deliverability, and assurance, not to reduce learning or diminish the seriousness of the incident.

Rationale for Removal or Consolidation of Actions

Actions were removed or merged only where one or more of the following criteria were met:

1. *Duplication of Assurance*

Several actions addressed the same underlying risk through different mechanisms (e.g. multiple actions focused on promotion of existing policies or reiteration of existing governance processes). In these cases, actions were consolidated into single, stronger system-level actions supported by audit, monitoring, and reporting through established governance structures.

2. *Learning Already Embedded via System-Level Actions*

Where learning from the incident is more effectively addressed through Health Board–wide policy, governance, or process improvement, service-specific actions were removed to avoid fragmentation. Examples include supervision policy development, large-scale incident management processes, and record-keeping oversight mechanisms, which are now addressed at organisational rather than service level.

3. *Actions Not Causally Linked to Investigation Findings*

Some actions were identified as general areas for service improvement but were not directly linked to the investigation’s causative or contributory factors. While acknowledged as legitimate improvement opportunities, inclusion in this action plan would risk diluting focus on the specific safety learning arising from the incident.

4. *Existing Controls Requiring Strengthening Rather Than Replication*

Actions proposing the re-creation of guidance, standards, or training already in place were removed where the issue was identified as compliance, assurance, or oversight, rather than absence or where the remaining action set focuses instead on audit, governance scrutiny, accountability, and learning loops to ensure existing controls are effective in practice.

5. *Deliverability and Proportionality*

Actions that could not be made SMART, were dependent on significant national or long-term system changes or would not deliver timely risk reduction were removed. This ensures the final plan is achievable, risk-focused, and capable of being assured within agreed timescales.

Assurance That Learning Has Not Been Lost

Importantly, the removal of actions does not equate to removal of learning. All investigation findings have been mapped explicitly to retained actions and addressed either through service-level improvement actions or organisation wide policy, process and governance changes. The retained actions address both active failures (documentation quality, missed escalation, delayed identification) and latent system issues (governance visibility, audit effectiveness, supervision standards, incident management processes). Additionally, actions strengthen multiple layers of defence, including policy, practice, oversight, and culture and align with Duty of Candour and Duty of Quality principles.

Transparency and Ongoing Oversight

To support transparency and assurance a clear mapping of investigation findings to retained actions has been maintained and is available for scrutiny. Progress against actions will be monitored through established governance routes and reported to the appropriate committees. The effectiveness of the reduced action set will be reviewed after implementation to confirm that learning has been fully embedded and risks mitigated. Further actions will be introduced if evidence suggests residual or emerging risk.

Conclusion

The refinement of this action plan represents a maturation rather than a dilution of learning. By focusing on high-impact, system-level, and auditable actions, the organisation is better positioned to demonstrate that it has learned from the incident, acted proportionately, and strengthened assurance in a way that meaningfully improves patient safety and quality.

Ref	Action	By When?	Executive Lead	Status	Recommendations Action Addresses (1=yes, 0=no)						
					1 - Embed clinical governance and assurance	2 - Strengthen supervision and accountability	3 - Optimise clinical pathways and service design	4 - Strengthen record keeping policies and processes	5 - Establish professional governance and promote professionalism	6 - Strengthen leadership culture	7 - Improve communication both internally and externally
1	Review existing SLAs to include process for the escalation of concerns inc. professional, clinical and defines responsibilities of physiotherapy service. Must also include how feedback provided to commissioner and access arrangements to digital systems	31/3/27	Executive Director of Strategy and Planning	On track	1	1	1	1	1	1	1
2	Write a supervision policy for Allied Health Professions that includes standards for frequency of supervision, defines clinical, professional, and line management supervision, sets standards for clinical and professionals supervision, determines the frequency with which caseload review needs to be undertaken for registrants working independently ensuring there is an audit process to evaluate the effectiveness of the policy	30/9/26	Executive Director of Allied Health Professions and Health Science	On track	0	1	0	0	0	0	0
3	Establish a governance structure and process for the employment of enhanced, advanced and consultant practice which must include governance arrangements, use of job descriptions, scope of practice documents and guidance, design of roles, monitoring and maintenance of skills and competencies	30/6/26	Executive Director of Allied Health Professions and Health Science/ Executive Director of Nursing, Quality, and Patient Experience	On track	0	1	0	0	0	0	0
4	Develop policy for the Accountability Arrangements for Allied Health Professions (including physiotherapy) that clearly outlines professional responsibilities, responsibilities of operational managers and demonstrate it has been approved through the appropriate governance structures.	31/3/26	Executive Director of Allied Health Professions and Health Science	Complete	0	1	0	0	0	0	0
5	Establish an Allied Health Professions (including physiotherapy), Health Sciences, Medicines, Nursing Governance process to monitor professional concerns and monitor and manage compliance with professional standards	30/6/26	Executive Director of Allied Health Professions and Health Science/ Executive Director of Nursing, Quality, and Patient Experience/ Executive Medical Director / Executive Director of Workforce and Organisation Development	On track	0	1	0	0	0	0	0
6	Promote, encourage and embed the physiotherapy staff's understanding of the HCPC code of conduct and professional standards and their roles and responsibilities in relation to this	31/3/26	Executive Director of Allied Health Professions and Health Science	Complete	0	1	0	0	0	0	0
7	Embed and communicate Accountability Arrangements Policy for AHP within physiotherapy	30/9/26	Chief Operating Officer	On track	0	1	0	0	0	0	0
8	Develop induction checklist that is local to physiotherapy services that includes specific requirements for those working in primary care, documentation standards, records of policies read and reviewed during induction, supervision arrangements, key contacts for day-to-day management, professional accountability, role specific training, timetable for induction period	30/6/26	Chief Operating Officer	On track	0	1	0	0	0	0	0
9	Embed and implement the Supervision Policy for Allied Health Professions across the Health Board	31/12/26	Chief Operating Officer	Dependent on action 2	0	1	0	0	0	0	0
10	Develop and implement procedure for supporting staff affected by large scale investigation which includes availability of general wellbeing, clinical, professional support as well as more specialised support as required	31/12/25	Executive Director of Nursing, Quality, and Patient Experience	Complete	1	0	0	0	1	1	0
11	Ensure a process is in place to respond to large scale incidents	31/12/25	Executive Director of Nursing, Quality, and Patient Experience	Complete	1	0	0	0	1	1	0

Ref	Action	By When?	Executive Lead	Status	Recommendations Action Addresses (1=yes, 0=no)						
					1 - Embed clinical governance and assurance	2 - Strengthen supervision and accountability	3 - Optimise clinical pathways and service design	4 - Strengthen record keeping policies and processes	5 - Establish professional governance and promote professionalism	6 - Strengthen leadership culture	7 - Improve communication both internally and externally
12	Primary care services to ensure that governance meetings include the monitoring of incidents and lessons learned from incidents	1/3/25	Chief Operating Officer	Complete	1	0	0	0	0	0	0
13	Contribute to the review Health Board Clinical Record Keeping Policy to ensure that it incorporates the learning from this incident, specifically there is a mechanism to ensure the quality of clinical records	20/4/26	Executive Director of Allied Health Professions and Health Science / Executive Director of Nursing, Quality, and Patient Experience / Executive Medical Director	On track	1	0	0	1	0	0	0
14	Review and develop physiotherapy governance and assurance frameworks that demonstrates how quality, safety and experience are monitored and managed, how workforce processes are monitored and managed, how learning is shared across services and clinical care groups, how actions are developed and implemented from the learning identified	1/3/25	Chief Operating Officer	Complete	1	0	0	0	0	0	0
15	Develop and embed an audit tool to audit the effectiveness of local physiotherapy induction process	31/3/27	Chief Operating Officer	Dependent on action 8	1	0	0	0	0	0	0
16	Physiotherapy staff to achieve >85% compliance with duty of candour training	30/6/26	Chief Operating Officer	On track	1	0	0	0	1	1	0
17	Undertake a cultural review of the physiotherapy service	1/3/25	Chief Operating Officer	Complete	0	0	0	0	0	1	0
18	Develop and deliver a bespoke programme of organisational and leadership development for the physiotherapy leadership team	30/6/26	Executive Director of Workforce and Organisation Development / Chief Operating Officer	On track	0	0	0	0	0	1	0
19	Develop an action plan for the physiotherapy service based on the culture review which is to be monitored through the care group governance structures	30/6/25	Executive Director of Workforce and Organisation Development / Chief Operating Officer	Complete	0	0	0	0	0	1	0
20	Primary Care Clinical Care Group to include record keeping audits and relevant findings as standard agenda items within governance meetings to ensure that services are undertaking audits of compliance with clinical record keeping, discussing the findings and identifying areas of improvement	31/12/26	Chief Operating Officer	On track	0	0	0	1	0	0	0
21	Review and amend policy and best practice guidance for the delivery of commissioned services across the HB that outlines best practice when developing service level agreements that ensures inclusion of key deliverables, monitoring arrangements and escalation of concerns and the governance arrangements required for approving the delivery of commissioned services	31/3/27	Executive Director of Strategy and Planning	Interdependency with action 1	0	0	1	0	0	0	1
22	Assess the opportunities for integrated patient records across primary care and Allied Health Professions	30/12/25	Executive Director of Allied Health Professions and Health Science / Executive Director of Finance	Complete	0	0	0	1	0	0	0
23	Develop policy for the development, implementation and monitoring of job plans for Allied Health Professions (including physiotherapy), Health Sciences, Nursing (especially advanced practice) and Pharmacy which must include how job plans are developed equitably and realistically, how job plans are reviewed for effectiveness and compliance and escalation where there is drift from a job plan	31/12/26	Executive Director of Allied Health Professions and Health Science / Executive Director of Nursing, Quality, and Patient Experience	Interdependency with actions 2,3,4	0	0	0	0	1	0	0
24	Commission the National MSK Network to undertake a review of all MSK physiotherapy services including CMATs, FCP and MSK outpatients in order to provide an independent, comprehensive peer review of the MSK Physiotherapy Services delivered by Hywel Dda University Health Board. The review must evaluate clinical effectiveness, accessibility, patient outcomes, compliance with clinical guidelines and alignment with best practice, local and national strategic objectives and inform the service development, quality improvement and strategic planning for MSK services.	31/8/25	Executive Director of Allied Health Professions and Health Science	Complete	0	0	1	0	0	0	0
		31/3/27		Dependent on action 23	0	0	0	0	1	0	0

Ref	Action	By When?	Executive Lead	Status	Recommendations Action Addresses (1=yes, 0=no)						
					1 - Embed clinical governance and assurance	2 - Strengthen supervision and accountability	3 - Optimise clinical pathways and service design	4 - Strengthen record keeping policies and processes	5 - Establish professional governance and promote professionalism	6 - Strengthen leadership culture	7 - Improve communication both internally and externally
25	Embed and communicate process for development of job plans for AHPs within physiotherapy service		Chief Operating Officer								
26	Promote, encourage and embed physiotherapy staff's understanding of the duty of candour and their roles and responsibilities in relation to this	30/9/25	Chief Operating Officer	Complete	0	0	0	0	0	1	0
27	Ensure mechanism to share speaking up safely framework are promoted across professional and operational groups at intervals appropriate to the framework.	30/9/25	Executive Director of Workforce and Organisation Development	Complete	0	0	0	0	0	1	0
28	Promote, encourage and embed the non-punitive and learning focused culture of incident reporting and management process as set out in the Incident, Near Miss and Hazard Reporting and Management Procedure across Clinical Care Groups.	30/6/25	Chief Operating Officer	Complete	0	0	0	0	1	1	0
29	Develop a physio specific audit tool of clinical records that must consider: • Time of written record (in working hours and contemporaneous) • Time of patient communication • Whether action plans have been completed • Whether action plan was completed in clinically appropriate timescale • Adherence to standards as defined by HCPC and/or relevant professional body	1/4/24	Chief Operating Officer	Complete	0	0	0	1	0	0	0
30	Develop and implement a schedule for clinical record keeping in line with best practice standards to be reported via local physiotherapy governance	1/4/24	Chief Operating Officer	Complete	0	0	0	1	0	0	0
31	Commission bespoke support for the affected FCP therapy team to facilitate professional reflection and recovery from the incident based on feedback from FCP team	31/12/25	Chief Operating Officer	Complete	0	0	0	0	0	1	1
32	Facilitate all leaders, registrants and support workers affected by this incident to reflect on this incident to inform personal development plans	30/6/26	Chief Operating Officer / Executive Director of Allied Health Professions and Health Science / Executive Director of Nursing, Quality, and Patient Experience	On track	0	0	0	0	0	1	0

Appendix 3: Learning from Experience Good Practice/ Self-Assessment

Operational – LfE Good Practice/ Self-Assessment	Yes	No	Partially	N/A	Actions Needed
Does your service have a local induction checklist that includes specific requirements for the setting, documentation standards, records of policies read and reviewed during induction, supervision arrangements, key contacts for day-to-day management, professional accountability, role specific training, timetable for induction period?					
Does you service have a tool to evaluate the effectiveness of local induction process?					
Does your service have annually reviewed organisation charts that clearly identifies operational and professional accountability?					
Do all job descriptions used within your service specify operational and professional accountability?					
Does your service have job plans in place?					
Does your service have a process to review and monitor job plans?					

Does your service have a service specification that defines the standards of care for the provision of your service and includes aims, objectives, scope of service, clinical standards, qualifications and competencies, referral criteria and pathways, service delivery (inc. location, scheduling, communication with patients), outcome measures, mechanisms for quality assurance, patient experience?					
Does your service have a schedule for clinical record keeping audits?					
Are clinical records in your service area audited?					
Do you monitor compliance with the Clinical Record Keeping audit?					
Do you have report templates for your service area to communicate to the referrer and/or GP/senior clinician of the outcome of intervention?					
Does your service include the following into service governance meetings: monitoring of incidents (including learning), demonstration of compliance with mandatory training and action plans where compliance is less than 85%?					
Do your teams know how to raise concerns via the Speaking Up Safely platform?					

Do your teams know how and when to raise incidents via Datix/Civica?					

Professional LfE Good Practice/ Self-Assessment	Yes	No	Partially	N/A	Actions Needed
Do you have a process in place to monitor and manage concerns raised about a registrant health care professional?					
Are there clearly defined and documented accountability arrangements in place for registrants within your professional group that clearly outlines professional responsibilities, responsibilities of operational managers and demonstrate it has been approved through the appropriate governance structures?					
Are the accountability arrangements understood and embedded across your professional group?					
Is there a process for the development, implementation and monitoring of job plans for your professional group which include how job plans are developed equitably and realistically, how job plans are reviewed for effectiveness and compliance and escalation where there is drift from a job plan?					
Are job plans embedded within your professional group?					

Do you have a documented process in place to monitor the compliance of your professional group in line with both the Clinical Record Keeping Policy and the Clinical Audit Policy?					
Do you have a supervision policy for your professional group that includes standards for frequency of supervision, defines clinical, professional, and line management supervision, sets standards for clinical and professionals' supervision, determines the frequency with which caseload review needs to be undertaken for registrants, particularly those working independently?					
Is there a process in place for communicating with other professionals (particularly those in primary care) following an intervention for your professional group?					
Does your professional group have a governance structure and process for the employment of enhanced, advanced and consultant practice which must include governance arrangements, use of job descriptions, scope of practice documents and guidance, design of roles, monitoring and maintenance of skills and competencies?					
Do advanced practitioners within your profession have scope of practice documents in place?					

Do you have a process in place to monitor your professions compliance against professional standards?					
Is there a culture of professional curiosity and reflective practice across your professional group as evidence through a professional forum, peer review process and clinical audit cycle?					
Do you have an audit tool for the audit of supervision across your professional group?					
Does your professional group have a documented Professional Governance process to monitor professional concerns and monitor and manage compliance with professional standards?					