Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report
(Unannounced)
Caswell Clinic, Swansea Bay University Health Board

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our values

We place people at the heart of what 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 goal

To be a trusted voice which influences and drives improvement in healthcare

Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.

Contents

1. What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection at Caswell Clinic, Swansea Bay University Health Board on 23, 24 and 25 February 2026. Caswell clinic is a regional medium secure forensic mental health unit based at Glanrhyd Hospital, Bridgend. The clinic provides inpatient care for adults with mental illness who present a risk to others and who may have offended or be at risk of offending. The following wards were reviewed during this inspection:

- Penarth Ward - an eight-bed male Psychiatric Intensive Care Unit (PICU)
- Tenby Ward – a 14-bed male acute assessment and treatment ward
- Newton – an 11-bed female admission, treatment and rehabilitation ward
- Cardigan Ward - a 14-bed male acute assessment and treatment ward.

Our team, for the inspection comprised of two HIW healthcare inspectors, four clinical peer reviewers (one of whom was the nominated Mental Health Act reviewer) and one patient experience reviewer.

During the inspection we spoke with patients or their families/carers to find out about their experiences of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of six questionnaires were completed by staff. Feedback and some of the comments we received appear throughout the report.

Where present, quotes in this publication may have been translated from their original language.

Note the inspection findings relate to the point in time that the inspection was undertaken.

2. Summary of inspection

Quality of Patient Experience

Overall summary:
Patients at Caswell Clinic generally reported positive experiences of care and felt supported by staff who treated them with dignity, kindness and respect. Staff appeared knowledgeable and we observed staff responding to individual needs in a timely manner. Patients reported feeling safe on the wards and were aware of how to raise concerns or provide feedback.

Patients were involved in decisions about their care and aspects of daily living, promoting autonomy and recovery-focused practice where possible.

Patients spoke positively about the range of therapeutic activities available, including occupational therapy sessions, access to gym facilities and opportunities to access the community. These activities were viewed as supporting recovery, structure and wellbeing. Food provision was also viewed favourably, with patients reporting satisfaction with the choice and quality of meals available.

There was also a clear focus on supporting patients' physical health and wellbeing, with access to routine health assessments, GP and nursing support and preventative screening.

However, the inspection identified issues that affected the overall quality and consistency of care. Ongoing environmental challenges, although managed by staff, detracted from the therapeutic setting. In addition, the inspection identified inconsistency in observation practices, including the obscuring of bedroom door observation panels, which reduced staff visibility of patients and assurance that observations were applied consistently and safely across wards.

This is what we recommend the service can improve:

- Develop guidance to clarify safe and consistent observation practices which do not compromise patient safety
- Ensure timely repair and restoration of adapted facilities, including the communal bathroom on Cardigan Ward, to maintain appropriate access for patients who require mobility support and to support dignity and independence
- Review restrictions, such as mobile phone access, to ensure they are proportionate and tailored to individual need.

This is what the service did well:

- The on-site dental suite provided a high-quality and timely service
- Good access to advocacy services and clear information about patient rights which supported patient involvement and safeguarded individual rights.

Delivery of Safe and Effective Care

Overall summary:
The inspection found that the physical environment at Caswell Clinic is not of an acceptable standard for a medium secure mental health service. Despite sustained efforts by staff to manage and mitigate risk, the environment did not reliably support safe, dignified and therapeutic care. Environmental deterioration, both internally and externally, continued to limit therapeutic activity, increase infection prevention risks and place additional pressure on staff. This must be addressed as a priority to restore a safe, dignified and therapeutic environment.

The condition of the estate required ongoing risk-management measures, including restricted access to unsafe areas and escorted access to outdoor spaces. These arrangements increased workload for staff and reduced assurance that risks were being managed in a sustainable way. It is not acceptable that several of these long-standing issues have persisted since our previous inspection and continued to be identified through other external reviews.

Since the inspection, there has been improved clarity of roles and responsibilities between Swansea Bay University Health Board, which operates the clinic, and Cwm Taf Morgannwg University Health Board, which owns the estate. This clarification, along with confirmation of secured capital funding for a planned programme of remedial works, provided some reassurance; however, timely delivery and sustained joint oversight remain essential.

We identified inconsistencies in the application of security and risk management arrangements, particularly out of hours. While checks were undertaken during staffed daytime hours, they were not consistently applied at night, reducing assurance that expected controls in a medium secure setting were maintained at all times.

Areas of good practice were also identified. Care and treatment planning was generally comprehensive and aligned with the requirements of the Mental Health (Wales) Measure 2010, supported by multidisciplinary input and regular review. Nutritional and hydration needs were comprehensively assessed and recorded, with clear care plans in place when patients required additional support or intervention. Mental Health Act monitoring arrangements were robust, supported

by clear documentation, effective administrative oversight and appropriate access to advocacy.

Medicines management was well overseen, with secure storage, appropriate governance arrangements and strong pharmacy integration supporting safe prescribing and administration. Restrictive practices were used infrequently and as a last resort, with a clear emphasis on prevention, de-escalation and least-restrictive approaches.

This is what we recommend the service can improve:

- Improve the reliability and assurance of routine safety, security and monitoring processes
- Address environmental and infrastructure issues that impact infection prevention and control, including laundry provision and the condition of ward areas
- Strengthen medicines governance arrangements by ensuring monitoring practices are consistent and contemporaneous across all wards
- Improve efficiency and support staff workload by reviewing reliance on paper-based records and reducing unnecessary duplication
- Ensure care and treatment planning clearly identifies and reviews unmet needs, in line with the requirements of the Mental Health (Wales) Measure 2010.

Quality of Management and Leadership

Overall summary:
Staff described positive working relationships with their immediate line managers and reported that ward-level leadership was approachable, supportive and accessible. Local management arrangements supported day-to-day oversight, decision-making and escalation of concerns.

However, staff feedback highlighted less positive experiences in relation to senior leadership and organisational culture. Staff described limited visibility of senior leaders and inconsistent communication, which contributed to uncertainty during periods of service change. This was particularly evident following the repurposing of Ogmore Ward after the fire at Taith Newydd in November 2024, with staff reporting a lack of clarity about longer-term plans and the future direction of the service.

Staff reported feeling encouraged to raise concerns, including through incident reporting systems, and described an open culture at local level. However, concerns raised did not always appear to be followed by clear communication about

outcomes, learning or actions taken. This reduced staff confidence that issues raised would consistently lead to visible improvement at service level.

Quality improvement activity was evident through audit processes, safety forums and clinical oversight meetings. The introduction of the All-Wales Audit Management Tool (AMAT) was a positive development, with the potential to improve coordination and oversight of audit activity. Workforce arrangements demonstrated high compliance with mandatory training and performance development reviews. Partnership working with external organisations also supported patient pathways, despite wider system pressures.

This is what we recommend the service can improve:

- Strengthen senior leadership visibility and communication to provide clearer direction and reassurance to staff during periods of service change
- Ensure that learning from incidents, reviews and service changes is clearly communicated to staff
- Strengthen access to role-specific training, structured local induction and protected learning time.

This is what the service did well:

- Ward-level leadership was accessible and supportive, enabling effective day-to-day management and escalation.

3. What we found

Quality of Patient Experience

Patient feedback

The patients we spoke with during the inspection generally reported positive experiences of care at Caswell Clinic. They described staff as kind, approachable and knowledgeable about their individual needs, and this was supported by direct observation of respectful and meaningful interactions throughout the wards.

Patients reported feeling safe and well supported, with clear routes available to raise concerns or provide feedback. Weekly community meetings, access to advocacy services and feedback boxes were well understood by patients and seen as effective ways of having their voices heard.

Patients spoke positively about the range of therapeutic activities available, including occupational therapy sessions, gym facilities and opportunities to access the community, which supported recovery and wellbeing. Food provision was also viewed favourably, with patients reporting satisfaction with choice and quality.

However, patients highlighted frustrations related to the physical environment, particularly the outdoor areas and laundry facilities, which were seen as detracting from their overall experience.

Person-centred

Health promotion

We found that the service demonstrated a strong commitment to promoting and supporting patients' physical health and wellbeing. Patients had received full and comprehensive physical healthcare assessments, alongside more specific assessments tailored to individual need, including nutrition, falls risk and mobility. These assessments supported the early identification of physical health needs and informed ongoing care planning.

Patients also received regular physical health observations and benefited from timely support from healthcare nurses and GP input where required. We saw evidence that patients were supported to attend screening programmes and other external physical health appointments, which contributed to preventative care and early intervention.

Patients had access to a wide range of health-promoting activities, including occupational therapy sessions, access to gym facilities and opportunities to develop daily living skills such as cooking and laundry, all of which supported independence and overall wellbeing.

A notable area of good practice was the on-site dental suite, which was observed to be of a very high standard. The facilities, equipment and governance arrangements were robust and supported timely access to essential dental care for patients.

Dignified and respectful care

We found that patients were generally treated with dignity and respect across the service. During our observations and conversations, staff interacted with patients in a calm, kind and professional manner, and patients confirmed that they felt respected and listened to.

Privacy was well supported, with patients having access to individual, lockable en-suite bedrooms, with arrangements in place for staff access where required for safety. Patients were able to personalise their bedrooms within agreed guidance, which supported individuality and a sense of ownership. Staff were observed knocking before entering bedrooms, and a range of private spaces were available for confidential discussions, visits and therapeutic work.

Arrangements to support dignity in relation to gender were generally appropriate, with access to single-sex accommodation and facilities across the service. Staff reported that there were occasions, particularly during night shifts, where the mix of gendered staff could be challenging. It is important that the service remains mindful of maintaining an appropriate gender mix when planning staffing to support safe and dignified care. Patients reported feeling safe and respected within communal areas, and segregated spaces were available where required.

However, during the inspection we observed instances where material had been used by patients to cover bedroom observation panels. Staff provided differing explanations for the use of the material, including reducing light disturbance or supporting patients during periods of alone time; however, there was no documented policy, guidance or agreed practice to support this approach. It was also unclear how the use of the material was linked to individual risk assessments or agreed care planning. We considered the practice of covering observation panels presented a potential risk to patient safety, as it reduced staff's ability to observe patients and identify signs of deterioration or emerging risk in a timely manner. Senior staff confirmed that observation panels should not be covered under any circumstances. Staff were advised during the inspection to take immediate action to stop this practice.

The health board must ensure there is clear governance, policy direction and staff guidance to clarify safe observation practices which do not compromise patient safety, are appropriately risk-assessed and are applied consistently across the service.

Individualised care

We found that patient care was delivered in a personalised and individualised manner, with patients supported to make day-to-day decisions about their care, routines and activities, which helped promote independence and autonomy. Patients described being involved in decisions about their care and reported that their preferences were respected. This included flexibility around clothing, daily routines and engagement in activities, which supported dignity and self-identity.

Our review of care and treatment plans evidenced that patients had up-to-date and individualised plans in place that reflected their assessed needs and supported their safety. Care and treatment plans were person-centred and outcome-focused, with clear identification of goals, interventions and responsibility for delivery. Plans reflected the requirements of the Mental Health (Wales) Measure 2010, with appropriate coverage of the required domains, and a named Care Coordinator was identified. Planned review dates were in place and, although some timescales were recorded as ongoing, this was considered proportionate given the longer-term nature of patients' treatment and planned discharge pathways. Interventions identified within plans included a range of therapeutic, physical health and social activities, which were appropriate to meet individual needs.

Timely

Timely care

Staff described systems in place to ensure patients could access help promptly when required, including timely responses to requests for support and the appropriate administration of medication. Patients reported that when they asked for help, staff responded appropriately and within a reasonable timeframe. Staff confirmed that care and support were prioritised based on clinical need, and we did not identify any recurring themes from patient feedback to suggest delays in care delivery.

Equitable

Communication and language

The service demonstrated a clear commitment to effective communication and supporting patients' language choice. Information was available in both Welsh and English across wards, and 'Iaith Gwaith' badges were used to clearly identify Welsh-speaking staff. Staff were able to explain how translation services could be

accessed, and patients confirmed that information relating to their care was accessible, clearly presented and easy to understand.

We found that Newton ward demonstrated particularly strong practice in the presentation and communication of patient information, with clear organisation, good visibility and clarity. Practice on other wards was more variable, and the service should consider how learning from Newton ward could be shared more widely to support greater consistency across the clinic.

Patients were supported to communicate with families, advocates and professionals through available telephone facilities, with restrictions applied appropriately based on individual risk assessment.

Our review of care and treatment plans evidenced that patients' social, cultural and spiritual needs were considered as part of care planning. Language choice was clearly recorded, and patients were supported to engage or re-engage with religious or spiritual practices of their choice where appropriate. This helped ensure communication and support were tailored to individual needs and preferences.

Rights and equality

Patients reported that their rights were respected and that they were treated fairly and without discrimination. Equality, diversity and inclusion principles were embedded through organisational policy, staff training and day-to-day practice. Patients were supported to observe religious or spiritual practices of their choice, and care and treatment planning reflected consideration of social, cultural and spiritual needs.

There was clear evidence that patients were kept informed of their rights under the Mental Health Act. Information about applying for hospital managers' hearings and Mental Health Review Tribunals was provided through rights forms and leaflets. Patients were informed of the section under which they were detained both verbally and in writing, in a format appropriate to individual need. Records demonstrated that patients' rights were revisited regularly, at least annually and sooner where circumstances changed, such as a tribunal application or ward transfer.

Patients confirmed that advocates visited the service regularly and were accessible when needed, which supported patient voice and reassurance. Arrangements were also in place to support private communication with family members, advocates and professionals, including access to telephone facilities. However, some patients reported that access to personal mobile phones was subject to set time

restrictions, generally ending at 10pm, which they felt limited their ability to maintain contact with family and support networks.

The health board should ensure that mobile phone access arrangements and restrictions are tailored to individual need and risk, and reviewed regularly, to support equitable access to family and support networks.

We noted that a communal bathroom on Cardigan Ward had been fitted with mobility aids but had been out of service for a prolonged period, reported to be approximately 18 months. As a result, access to appropriate facilities for patients who may require mobility support was limited.

The health board must ensure that communal bathroom facilities fitted with mobility aids are brought back into use in a timely manner, so that appropriate reasonable adjustments are consistently available for patients who require mobility support.

Delivery of Safe and Effective Care

Safe

Environment

We found that the environment at Caswell Clinic continued to present significant and ongoing challenges, many of which had been identified during our previous inspection in September 2023. We observed clear evidence of environmental deterioration both internally and externally, including water damage, damaged and rotting woodwork, flooring held together with tape as a temporary measure, and outdoor furniture and structures that were unsafe or in poor condition. The condition of gardens and outdoor spaces significantly limited their therapeutic value, with escorted access required due to known hazards.

These environmental concerns were also echoed in staff feedback provided following the inspection. Staff raised concerns about the safety of outdoor areas, including uneven paving near the front entrance, and reported issues with vermin, including the presence of rats linked to waste storage arrangements. While these issues were highlighted through staff feedback rather than direct observation, they further reinforced concerns about environmental conditions and the risks posed to both patients and staff.

These findings reflected long-standing concerns that had also been raised through other external reviews and demonstrated that known environmental risks had not been addressed sufficiently or within an appropriate timeframe. While we recognised that pressures associated with ageing mental health estates are not unique to Caswell Clinic and are evident in other services across Wales, this did not mitigate the impact on people receiving care at this service.

The condition of the environment had a direct and adverse impact on safety, dignity and therapeutic engagement, placed additional demands on staff to manage and mitigate risks, and was not aligned with the expectation of least-restrictive, recovery-focused care within a medium-secure mental health setting. We acknowledged plans to install new seclusion facilities as a positive development; however, at the time of inspection these did not address the wider environmental issues affecting the day-to-day care experience.

Following the inspection, we wrote to Cwm Taf Morgannwg University Health Board seeking assurance regarding its role, accountability and oversight of the estate. The health board confirmed that capital funding had been secured, responsibilities between Swansea Bay University Health Board and Cwm Taf Morgannwg University Health Board had been clarified, and that a programme of remedial works would

shortly begin. While this provided some reassurance, it is clear that timely, sustained improvement is required to ensure the environment consistently supports safe, dignified and therapeutic patient care.

The health board must provide an update on progress against its improvement programme for the environment at Caswell Clinic. This should include clear timescales for delivery and assurance that environmental risks are being actively identified, monitored and managed while remedial works are completed.

Risk management

During the inspection, staff demonstrated a clear understanding of individual patient risks and were able to explain how concerns were identified, reviewed and escalated. Patient risks were supported by structured risk assessments, including WARRN assessments, which were generally detailed and reflected patients' current presentation. Observation levels were clearly recorded within care records, and staff were able to describe how these were set and reviewed when patients' needs changed.

However, concerns were identified about how consistently risk management and security arrangements were being applied when accessing the wards, particularly during out-of-hours and night-time periods for visitors. During the first night visit, the inspection team was not provided with information about prohibited or restricted items, and identity badges were not consistently checked. In contrast, during core daytime hours when the reception desk was staffed, these checks were completed and the inspection team was required to sign to confirm they had reviewed the prohibited or restricted items list. These findings were consistent with issues identified during a recent external review, indicating that further work is required to ensure standards are applied consistently at all times.

In addition, nurses' office doors were observed to be left open on multiple occasions on several wards throughout the inspection. We considered this practice to present an unnecessary risk within a medium secure environment, as it reduced control over access to secure areas and did not align with expected security arrangements. Taken together, these findings indicated that security measures expected within a medium secure setting were not always being applied consistently.

The health board should ensure that security and risk management expectations appropriate to a medium secure environment are clearly reinforced and consistently applied across all wards, including during out-of-hours and night-time periods.

Inconsistencies were also identified in the completion of routine safety and security checks. While some wards demonstrated good oversight, gaps were noted elsewhere, including incomplete ligature alarm checks, emergency equipment records and security checklists.

The health board must strengthen its assurance arrangements to ensure that all routine safety and security checks are completed accurately, at the time they are carried out, and consistently across all wards. Any gaps in compliance should be identified promptly and addressed.

Ligature cutters were available on each ward; however, their accessibility, location and type varied. In some areas, ligature cutters were stored in cluttered drawers, which may have delayed access in an emergency. Other key safety equipment, such as jimmy bars, was not always stored in a clear or easily identifiable location. On one ward, the jimmy bar was stored on the floor alongside guitars and other equipment. One ward demonstrated good practice, with the equipment clearly signed and stored separately, but this approach was not consistent across the service. These issues were discussed and addressed during the inspection; however, the lack of a clear and consistent approach reduced assurance that staff would be able to respond promptly in an emergency.

The health board should develop and implement a clear local standard operating procedure setting out expectations for ligature risk equipment, including the type, number, location and signage of ligature cutters and jimmy bars, to ensure consistent access and staff awareness across the service.

Infection, prevention and control and decontamination
During the inspection, wards were generally observed to be clean and tidy, and staff demonstrated an understanding of their responsibilities in relation to infection prevention and control. Cleaning schedules were in place, and housekeeping staff spoke positively about their role in maintaining ward cleanliness.

However, the inspection identified that the condition of some parts of the environment limited the service's ability to maintain effective infection prevention and control arrangements. Issues such as damaged flooring, peeling skirting boards and evidence of previous water ingress were identified across several areas. While these issues were being managed in the short term, they reduced assurance that all surfaces could be cleaned and maintained effectively to the required standard.

The health board should ensure that environmental maintenance issues which impact on effective infection prevention and control are identified, prioritised

and addressed in a timely manner to support safe and sustainable IPC arrangements.

Concerns were also identified regarding the reliability and resilience of laundry facilities across the site. During the inspection, ongoing issues were reported with washing machines and tumble dryers being out of service for prolonged periods on a number of wards. As a result, staff described having to transport laundry between wards and wait extended periods for repairs to be completed.

Similar issues were identified during a previous Healthcare Inspectorate Wales inspection of Cefn Coed Hospital in October 2025. Taken together, these repeated issues suggest a wider health board challenge in relation to the management and resilience of laundry provision across its mental health inpatient estate. The continued impact of these issues presents ongoing risks in relation to infection prevention and control, staff workload, and patient dignity.

The health board must review the laundry provision at Caswell Clinic and across its wider mental health inpatient estate and implement a more robust and sustainable approach that ensures timely repair or replacement of equipment, reliable access to laundry facilities, and effective infection prevention and control arrangements.

Safeguarding of children and adults

Staff showed an understanding of their safeguarding responsibilities and were able to explain how concerns would be raised and reported, usually through senior colleagues or ward managers, and how local reporting systems were used. Some discussions suggested a reliance on ward managers to coordinate safeguarding responses, with less clarity among some staff about escalation and support arrangements when ward managers were temporarily unavailable during the day, such as when attending meetings or on leave. While this did not present a direct safeguarding risk, the health board may wish to consider strengthening shared understanding of safeguarding processes across staff teams.

Patients told us that they felt safe on the wards and were clear about who they could speak to if they had concerns, including ward staff, patient representatives and advocacy services.

Safeguarding policies and procedures were accessible, and staff spoke positively about safeguarding training. Safeguarding arrangements for managing risks between patients were also discussed. Staff described how risks were managed through the use of separate male and female wards and coordination when patients accessed shared spaces, such as gardens and communal areas. These arrangements required ongoing staff awareness, communication and supervision.

Management of medical devices and equipment
Medical devices and equipment observed during the inspection were generally appropriate for the patient group and available when needed. Staff were able to explain how equipment was accessed and used, and equipment seen on the wards was clean, in useable condition and safely stored. Essential equipment, including emergency trolleys and resuscitation equipment, was available across the service.

Emergency drugs met national guidelines, were stored appropriately and were in date. Logbooks showed that regular checks were carried out and that systems were in place to replace expired items. Staff were able to describe how adverse drug reactions would be reported, including through pharmacy and Yellow Card processes.

Arrangements for oxygen cylinder management were well established. Staff had access to appropriate training and guidance on safe use, oxygen was stored securely in designated areas, and weekly checks were carried out to ensure adequate supply. Incidents involving oxygen were reported and managed through established governance and reporting arrangements.

Medicines management
During the inspection, there was good overall assurance in relation to the management, storage and administration of medicines. The clinic rooms were clean, tidy and appropriately organised, and staff demonstrated a clear understanding of medicines governance and day-to-day practice. Medicines, including controlled drugs, were stored securely with appropriate access controls in place. Controlled drug registers were completed accurately, with evidence of regular stock checks and dual sign-off.

Electronic prescribing was well embedded across the service and supported safer prescribing and administration processes. Staff spoke positively about the system and how it supported audit, reduced the risk of error and improved oversight. Pharmacy staff were well integrated within the multidisciplinary teams, providing regular input, supporting audits and engaging directly with patients to help them understand their medicines. Staff described how medicines-related incidents and errors were reported, investigated and reviewed, with learning shared appropriately.

However, some gaps were identified in medicines fridge temperature monitoring checklists, which reduced assurance that checks were consistently completed accurately and at the time they were undertaken across all wards.

The health board must ensure that medicines fridge temperature monitoring is completed accurately, contemporaneously and consistently across all wards, with clear ward-level oversight to support reliable medicines governance.

The patients we spoke with confirmed that they were involved in discussions about their medicines and felt supported to understand what they were prescribed. Consent to treatment documentation was appropriately completed and readily accessible, both within ward files and through electronic systems. Where patients lacked capacity, relevant legal documentation was available, and staff were able to explain how this was reviewed and applied in practice.

Effective

Effective care

We observed staff delivering care that was appropriate to meet the needs of patients and in line with agreed care plans. The patients we spoke with described positive relationships with staff and felt that their care and treatment were clearly explained. Staff demonstrated good knowledge of the patients they were supporting and were able to describe how care was tailored to individual needs.

Staff told us that staffing levels were generally sufficient to meet patient needs, and inspection observations supported this. Wards appeared calm and organised, and staff were able to spend time engaging with patients through one-to-one interactions, activities and therapeutic engagement.

Care and treatment planning reflected a person-centred and preventative approach. Staff described how care plans included strategies to help reduce escalation, such as meaningful activity, structure and engagement with familiar staff. Where required, care plans also included reactive strategies to support consistent and appropriate responses during periods of increased distress.

Individual behaviour support plans, including positive behaviour support approaches, were used where appropriate. These plans identified known triggers, early warning signs and agreed strategies to support patients and guide staff responses. Staff were able to explain how these plans informed day-to-day care and promoted consistency across teams.

Staff discussions and records demonstrated that restrictive practices were used infrequently and as a last resort. Staff were aware of de-escalation techniques and alternatives to restraint and described prioritising least-restrictive and therapeutic approaches. Where restrictive interventions were required, staff described how these were reviewed through multidisciplinary processes, with a focus on understanding triggers and reducing recurrence.

There was evidence of access to psychology and other therapeutic input to support the management of behaviour that challenged. Staff also described the importance of involving patients, where possible, in understanding their triggers and preferred strategies, supporting a recovery-focused and respectful approach to care.

Nutrition and hydration

During the inspection, patients were supported to meet their nutritional and hydration needs and were generally able to access food and drinks in line with their preferences. Patients told us that they were able to have hot and cold drinks when they wanted, and access to food outside of set mealtimes was available.

Communal kitchen facilities were available on wards, and patients were supported by staff and occupational therapy to prepare food safely where appropriate.

Our review of patient care and treatment plans demonstrated that nutritional and hydration needs were comprehensively assessed, recorded and addressed. Where patients required additional support or intervention, clear plans were in place within care records. Staff were able to explain how nutritional needs were monitored as part of wider physical health care and how any concerns would be escalated for review.

Patients were provided with diets appropriate to their medical needs and were supported to make suitable choices from the available menu options. Staff described how individual dietary requirements, including cultural, vegetarian and other specific needs, were considered through care planning and day-to-day support.

There was access to specialist services when required. While there were no formal service level agreements in place with Speech and Language Therapy (SALT) or dietetic services, staff described how patients were referred on an individual basis when concerns were identified. Evidence indicated that referrals were responded to appropriately. Where swallowing difficulties were identified, patients were fully assessed and modified diets and fluids were provided as required.

Patients were encouraged to be involved in food-related activities as part of promoting independence and rehabilitation, including support with food shopping and meal preparation. An on-site shop was available, and some patients were supported to be involved in its operation. Staff also described how food storage was managed on the wards, including routine checks to ensure food remained in date.

Patient records
Care and treatment plan (CTP) records were being maintained in paper format. Records were stored securely, with appropriate arrangements in place to protect patient confidentiality. Staff were able to access records easily when required.

We found that records were organised in a way that allowed key information to be identified without difficulty. In particular, records on Newton ward demonstrated good practice, with clearly identifiable sections that supported ease of navigation through the file.

All members of the multidisciplinary team recorded in a single patient record, supporting a consistent and joined-up approach to documenting the patient journey.

However, concerns were raised in the HIW staff questionnaires about the reliance on paper records. One staff member wrote:

> *"A huge amount of staff time is being wasted on having to duplicate hand-written notes due to the lack of IT support (I.e. no electronic notes)."*

The health board should consider the concerns raised by staff regarding reliance on paper records and provide assurance on how record-keeping arrangements will be reviewed to support efficient working and reduce unnecessary duplication.

Mental Health Act monitoring
We reviewed the Mental Health Act (MHA) documentation for four detained patients at the clinic. Patients were lawfully detained, and the legal authority for detention was clearly recorded and supported by appropriate documentation. Records were well organised and easy to navigate, supporting effective oversight and review of patients' legal status.

We saw evidence that patients had been informed of their rights under the Mental Health Act. Staff were able to explain how and when this information was provided, and the patients we spoke with confirmed that they were aware of their rights and knew how to access support if they had questions or concerns about their detention.

Consent to treatment arrangements were reviewed and found to be appropriate. Capacity assessments had been completed where required, and consent to treatment certificates were available and up to date. Where patients lacked capacity, the correct legal framework had been applied and documentation clearly reflected this. Records relating to second opinion appointed doctor (SOAD)

involvement were available where relevant and had been completed appropriately.

Section 17 leave was managed in a structured way. Leave decisions were discussed during ward rounds and were supported by risk assessments and clearly documented conditions. Staff were able to describe how leave was authorised, monitored and reviewed in line with patients' individual circumstances.

Mental Health Act administration procedures were supported by experienced administrative input. Staff spoke positively about the availability of MHA administration support, which contributed to the timely completion, monitoring and review of legal documentation and processes.

Monitoring the Mental Health (Wales) Measure 2010: care planning and provision

During the inspection, we reviewed five care and treatment plans and found that they were generally comprehensive, covered the required domains of the Mental Health (Wales) Measure 2010, and were supported by detailed assessments. Plans set out clear goals, interventions and responsibilities, and demonstrated an understanding of patients' individual needs and risks. There was evidence that care planning was informed by multidisciplinary input, with contributions from nursing, medical, psychology and allied health professionals.

We found good evidence of person-centred care planning, with patients' views and preferences clearly reflected. This included the use of patient quotes, pen portraits and descriptions of what a "good day" looked like for individual patients. Where appropriate, care planning reflected recovery-focused goals and progression through treatment and rehabilitation pathways.

Care and treatment plans were generally reviewed appropriately, with documented review dates and evidence of updates in response to changes in patient presentation or need. Given the longer-term and complex nature of care for many patients within a medium secure setting, some plans were recorded as ongoing, which was considered proportionate and consistent with patients' treatment pathways.

However, we did not consistently see clear documentation of unmet needs within the plans reviewed. Although current needs and interventions were clearly described, clearer identification and recording of unmet needs would strengthen assurance that all aspects of the Mental Health (Wales) Measure 2010 are being fully applied and reviewed.

The health board must ensure that care and treatment plans clearly identify and record any unmet needs, and that these are reviewed as part of ongoing care planning in line with the requirements of the Mental Health (Wales) Measure 2010.

Efficient

Efficient

Staff described systems in place to support the efficient delivery of care and day-to-day ward functioning. Care was prioritised based on patient need, and staff were able to respond appropriately to requests for support. Patients told us that staff generally responded in a timely way when assistance was needed, and we did not identify any recurring themes from patient feedback to suggest delays in care delivery.

Staff described how ward routines, handovers and multidisciplinary discussions supported coordination and continuity of care. Documentation, including care and treatment plans and ward records, was readily accessible and supported efficient information sharing between staff. The use of electronic prescribing and integrated pharmacy input also supported efficiency by reducing duplication and supporting timely medicines management.

However, it was clear that the long-standing environmental and infrastructure issues continued to impact on the efficiency of the service. Staff described having to put additional measures in place to manage environmental and infrastructure issues, such as supervising restricted areas and transporting laundry between wards, which increased workload and reduced the efficient use of staff time. While staff demonstrated flexibility and resilience in managing these additional pressures, continued delays in addressing known environmental and infrastructure issues limited the service's ability to operate as efficiently as intended.

Quality of Management and Leadership

Staff feedback

Overall, staff feedback reflected a commitment to providing good quality care to patients, with most respondents expressing satisfaction with the care and support they provide. Staff felt that patients' privacy and dignity were maintained and that patients were informed and involved in decisions about their care. Most staff indicated that they would be happy with the standard of care provided by the service for themselves or their family, and the majority would recommend the setting as a place to work.

While many staff felt they had adequate materials and equipment to carry out their role, views were more divided on whether there were enough staff to do the job properly. Some staff reported difficulties managing competing demands, reflecting the pressures associated with working in a complex medium secure environment.

While most staff felt their working patterns supported work-life balance and were aware of occupational health support, many did not feel the organisation took sufficient positive action to support staff health and wellbeing. Some staff reported low morale and feeling stretched, with limited protected time for reflection, training or support.

> *"Ultimately, staff morale has been incredibly low for a little while, but this does not appear to be held as a priority at any meaningful level"*

Staff reported an open culture in relation to reporting incidents and errors, with most feeling encouraged to report concerns. However, fewer staff were confident that concerns would be addressed consistently or that feedback on learning and change would always be provided.

The health board should review the themes raised through staff feedback and provide clear assurance on the actions it will take to address these concerns, including how feedback will be shared with staff.

Leadership

Governance and leadership

We found that arrangements were in place to support day-to-day operational management at ward level. Staff described positive working relationships with their immediate line managers and reported that ward-level leadership was

approachable, supportive and accessible. Many staff felt able to seek advice, raise concerns and receive feedback from their direct managers, supporting effective day-to-day decision-making and oversight.

However, staff feedback indicated more mixed views in relation to senior leadership and organisational culture. While some respondents felt supported locally, perceptions of senior leadership were less positive overall. Staff reported that senior managers were not consistently visible and that communication from senior leadership was often unclear or inconsistent. This contributed to uncertainty among staff about service changes, including the repurposing of Ogmore Ward to accommodate patients from Taith Newydd following a fire in November 2024, and how these changes affected patients and ward practice. Staff reported a lack of clarity about longer-term plans for Ogmore Ward and its future role within the service. One staff member commented in their questionnaire:

> *"There is poor communication across the service, with many members of staff including myself left confused with regards to changes made in the service and how they impact patients. Top-down communication is incredibly poor, so staff members are left to field questions from patients which we do not have the answers to."*

Staff feedback also suggested that concerns raised through incident reporting, reviews or service changes were not always followed by clear communication about outcomes, actions taken or learning. This reduced staff confidence that issues raised would consistently lead to visible improvement, despite most staff indicating that they felt encouraged to report concerns in the first instance.

The health board must strengthen its arrangements to ensure clear, open and consistent communication with staff, particularly during periods of service change, and in relation to actions taken or learning from incident reporting.

Workforce

Skilled and enabled workforce

Most respondents to the HIW questionnaires felt they had received appropriate mandatory training, and all confirmed that they had received an appraisal or performance development review (PDR) within the last 12 months. The evidence we reviewed supported this, with high levels of compliance demonstrated for mandatory training and completion of PDRs.

However, some staff identified gaps in access to specific role-relevant training, including learning disability awareness, Mental Health Act training and record keeping. Staff also described challenges in accessing training and development

opportunities during periods of high workload, where staffing pressures limited protected time away from the ward.

Some staff described a lack of a structured local induction tailored to the forensic and medium secure setting. Given the complexity of the patient group and the operational demands of the service, this reduced assurance that all staff were consistently supported to develop the necessary role-specific knowledge and confidence.

While staff demonstrated commitment to ongoing professional development, these pressures risked limiting opportunities for reflection, learning and skill development.

The health board should review workforce development arrangements to ensure that role-specific training and local induction processes are consistent and accessible, and that staff are supported with sufficient protected time to engage in training and professional development alongside operational demands.

Culture

People engagement, feedback and learning

During the inspection, staff described an open culture for raising concerns and providing feedback. Most staff reported that they knew how to raise concerns, including through incident reporting systems, and felt encouraged to speak up about issues affecting patient care and ward practice.

Staff were able to describe opportunities for engagement and feedback at ward level, including team meetings, safety huddles and informal discussions with line managers. These mechanisms supported day-to-day engagement, and staff reported feeling able to raise issues within their immediate teams. However, while staff were aware that patient feedback was collected, fewer described receiving regular updates on themes or outcomes arising from this feedback.

The health board should consider how patient feedback and associated learning can be more consistently shared with staff to support engagement and improvement.

Information

Information governance and digital technology

During the inspection, staff demonstrated an awareness of their responsibilities in relation to information governance. Patient records were stored securely, and

appropriate arrangements were in place to protect patient confidentiality. Staff were able to access information when required to support patient care and ward-level decision-making.

Learning, improvement and research

Quality improvement activities

A range of audit activity was evident at local level across the service. Staff were able to describe ongoing clinical and governance audits taking place within wards and teams. Audits were beginning to be uploaded and managed through the All-Wales Audit Management Tool (AMAT), which was expected to support improved oversight and coordination of audit activity.

There was evidence of routine clinical and operational oversight through established forums, including safe staffing meetings, morning huddles, nursing director checks and clinical lead meetings. These meetings supported discussion of staffing, risks and patient-related issues and provided opportunities for issues to be identified and considered at an early stage.

Staff also described future plans for the service, including the development of new high dependency facilities and wider ward reconfiguration, which had the potential to support quality improvement over time.

Whole-systems approach

Partnership working and development

During the inspection, staff described working relationships with partner organisations that supported the delivery of care and treatment. This included engagement with health board services and external agencies involved in supporting patients' care pathways. Staff were able to describe how partnership working helped facilitate access to specialist input when required and contributed to coordinated care planning.

Staff also described working with external organisations to support patient transitions and pathways, including placement planning, leave arrangements and onward care. While these processes were often complex and influenced by wider system pressures, staff reported efforts to work collaboratively with partner organisations to progress patient care where possible.

4. Next steps

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

The improvement plans should:

- Clearly state how the findings identified will be addressed
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

Appendix A - Summary of concerns resolved during the inspection

The table below summarises the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns Identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
During the inspection we observed instances where material had been used by patients to cover bedroom observation panels.	Covering observation panels reduced staff's ability to observe patients effectively, limiting early identification of deterioration, self-harm or emerging risk. This had the potential to compromise patient safety and undermine safe observation practices within a medium-secure setting.	The concern was escalated immediately to senior clinical and managerial staff on site during the inspection. HIW made clear that the practice was not acceptable and posed a potential risk to patient safety.	Senior staff confirmed that observation panels should not be covered under any circumstances. Ward staff were instructed during the inspection to remove any coverings with immediate effect, and the practice ceased at the time of inspection.
During the inspection, inconsistencies were identified in the storage, accessibility and visibility of ligature risk equipment across wards. Ligature cutters and jimmy bars were not stored consistently, with some equipment kept in cluttered drawers or on the floor alongside other non-safety items.	Inconsistent storage and accessibility of ligature risk equipment had the potential to delay staff response during an emergency. This could increase the risk of harm to patients by reducing assurance that staff would be able to access and use essential safety equipment promptly when required.	The concern was raised with senior ward and service leadership during the inspection. HIW highlighted the risks associated with inconsistent storage and accessibility of ligature risk equipment and the need for a clear, standardised approach across all wards.	Immediate action was taken on wards to improve the storage and visibility of ligature risk equipment, with drawers being cleared of clutter. Expectations were also clarified with staff.

Appendix B – Immediate improvement plan

Service: Caswell Clinic

Date of inspection: 23, 24 and 25 February 2026

The table below includes any immediate non-compliance concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

	Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	No immediate assurance issues were identified during the inspection.					

Appendix C - Improvement plan

Service: Caswell Clinic

Date of inspection: 23, 24 and 25 February 2026

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions, they are taking to address these areas.

	Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	During the inspection we observed instances where material had been used by patients to cover bedroom observation panels.	The health board must ensure there is clear governance, policy direction and staff guidance to clarify safe observation practices which do not compromise patient safety, are appropriately risk-assessed and are applied consistently across the service.	Dignified and respectful care	Ward managers have provided assurances that all patient bedroom doors no longer have curtains / material placed over their observations windows. All patients will be risk assessed and a management plan put in place during patient access to private time. Checks to be added to daily security / fire security checks and audited on a weekly basis for compliance	Lead Nurse / Directorate Manager	30/06/2026

				as per SOP for Internal and External Perimeter Checks to be ratified.		
2.	Patients reported that access to personal mobile phones was restricted by set times, generally ending at 10pm, which some felt limited their ability to maintain contact with family and support networks.	The health board should ensure that mobile phone access arrangements and restrictions are tailored to individual need and risk, and reviewed regularly, to support equitable access to family and support networks.	Rights and equality	All patients are risk assessed as per Access to mobile phone policy, which is currently under review. Basic mobile phones are classified as a restricted item and as such are to be handed in at a pre-agreed time based on ward role and function. Individual access outside of these times can be reviewed on an individual basis dependent on their circumstances i.e. family illness etc. Patients also have access to a patient ward phone should this be required.	Lead Nurse / Directorate Manager	30/06/2026

3.	A communal bathroom on Cardigan Ward, fitted with mobility aids, had been out of service for a prolonged period (approximately 18 months), limiting access to appropriate facilities for patients who may require mobility support.	The health board must ensure that communal bathroom facilities fitted with mobility aids are brought back into use in a timely manner, so that appropriate reasonable adjustments are consistently available for patients who require mobility support.	Rights and equality	Estates work complete but due to mobility aids the bathroom presents ligature risks and therefore remains locked. Patients able to access if required following individual risk assessment. Patients have an en-suite with a shower and following risk assessment can be provided with the appropriate mobility aids i.e. shower seat, raised toilet seat. We will liaise with Estates to undertake the necessary further repairs to the communal bathroom by end of September.	Lead nurse / Directorate Manager	30/09/2026
4.	We found that long-standing environmental and estates issues at Caswell	The health board must provide an update on progress against its improvement programme	Environment	Weekly escalation meeting established with Estates Supervisors to review	Directorate Manager / Estates	31/08/2026

	Clinic present ongoing safety and therapeutic risks.	for the environment at Caswell Clinic. This should include clear timescales for delivery and assurance that environmental risks are being actively identified, monitored and managed while remedial works are completed.		and progress outstanding environmental repairs. Central database is held and updated via Divisional / Directorate Manager and Estates. The current list of environmental defects are all targeted for completion by the end of August. Specific concerns highlighted within the improvement plan for Caswell Clinic, related to the environment are: 1. Completion of improvement work to Secure Garden and Courtyard areas. 2. Repair to Penarth Ward		

				roof and internal area of the ward (outstanding from previous review) These will be prioritised for completion by end of July.		
5.	Inconsistent application of security and risk management practices, particularly out of hours, reduced assurance within a medium secure environment.	The health board should ensure that security and risk management expectations appropriate to a medium secure environment are clearly reinforced and consistently applied across all wards, including during out-of-hours and night-time periods.	Risk management	Restricted / prohibited items list has been cascaded to all staff. Email sent to all staff reiterating security measures for all visitors, whereby ID is required and signing of prohibited / restricted items declaration form.	Lead Nurse / Directorate Manager	31/05/2026
6.	Gaps in the timely and accurate completion of routine safety and security checks across	The health board must strengthen its assurance arrangements to ensure that all routine safety and security checks are	Risk management	Ward security and fire checklists have been updated and are due for ratification. This checklist will then be	Directorate manager	30/06/2026

	wards reduced assurance of effective oversight.	completed accurately, at the time they are carried out, and consistently across all wards. Any gaps in compliance should be identified promptly and addressed.		audited on a weekly basis via ward assurance audits. Looking to develop a security compliance audit on AMAT for ward management to complete as part of unit's Key performance indicators.		30/09/2026
7.	Inconsistent arrangements for the storage, accessibility and identification of ligature risk equipment reduced assurance that staff would be able to access and use it promptly in an emergency.	The health board should develop and implement a clear local standard operating procedure setting out expectations for ligature risk equipment, including the type, number, location and signage of ligature cutters and jimmy bars, to ensure consistent access and staff awareness across the service.	Risk management	MH & LD service group are currently developing robust policies and procedures regarding ligature cutters. Documents require ratification. Audit to be conducted to ensure all wards have the same equipment, retained in a similar location, signage available for staff	Directorate Manager / Lead Nurse	30/09/2026 30/06/2026

8.	The condition of some parts of the environment limited assurance that infection prevention and control arrangements could be maintained effectively across the service.	The health board should ensure that environmental maintenance issues which impact on effective infection prevention and control are identified, prioritised and addressed in a timely manner to support safe and sustainable IPC arrangements.	Infection, prevention and control and decontamination	All ward managers are currently undertaking an audit of all ward furniture to establish what is required for replacement. Lead nurse to compile one order form to escalate for possible procurement. For noting: Ward managers complete IPC audits on the Health Board's auditing system AMAT. All outstanding actions relating to environmental concerns needing to be addressed via Estates, are recorded and monitored to completion (see response to R4).	Lead Nurse / Directorate Manager	30/09/2026
9.	Ongoing issues with the reliability and availability of laundry facilities posed risks to	The health board must review the laundry provision at Caswell Clinic and across its	Infection, prevention and control and decontamination	Currently reviewing alternative options and costings for installation. Also	Directorate Manager	30/09/2026

	infection prevention and control, staff workflow and patient dignity.	wider mental health inpatient estate and implement a more robust and sustainable approach that ensures timely repair or replacement of equipment, reliable access to laundry facilities, and effective infection prevention and control arrangements.		enquiring as to what the Health Board's internal provision for laundering services could provide, with aim to develop an SBAR to be escalated to Management team for final sign off by September 2026 Currently all wards have washing machines available within housekeepers store room with allocated machines for specific items. Staff are transferring patient clothing in laundry baskets wearing PPE (Personal Protective Equipment).		
10.	We identified some gaps in the fridge temperature monitoring checklists across the wards.	The health board must ensure that fridge temperature monitoring is completed accurately, contemporaneously and	Medicines management	Lead pharmacist for MH&LD service group has circulated treatment room temperature	Pharmacy	31/07/2026

		consistently across all wards, with clear ward-level oversight to support reliable medicines governance.		monitoring forms. Local pharmacist provides support and awareness to staff regarding the monitoring of min/max temperature levels. Updated security checklist now includes monitoring. Review of checks to be conducted in order to provide assurances.		
11.	Some concerns were raised in the HIW staff questionnaires about the reliance on paper records.	The health board should consider the concerns raised by staff regarding reliance on paper records and provide assurance on how record-keeping arrangements will be reviewed to support efficient working and reduce unnecessary duplication.	Patient records	MH&LD currently rolling out a staged programme for introduction of RIO records system. Caswell Clinic will be part of stage three due to commence in 2027. All wards have updated their clinical notes and all disciplines have been requested to ensure	Lead Nurse / Directorate Manager	31/08/2026

				their clinical entries / interventions/ risk assessments are sent to the wards for filing. Assurance audit to be developed to be completed on a weekly basis choosing random patient notes. Any discrepancies to be escalated to ward manager / head of department.		
12.	We found that unmet needs were not always clearly identified or recorded within the care and treatment plans we reviewed.	The health board must ensure that care and treatment plans clearly identify and record any unmet needs, and that these are reviewed as part of ongoing care planning in line with the requirements of the Mental Health (Wales) Measure 2010.	Monitoring the Mental Health (Wales) Measure 2010: care planning and provision	CTP steering group has undertaken a quality assurance audit of all patient CTP's. Report to be compiled and discussed to identify lessons learned. Where identified, clinical teams to be notified of need to amend care and treatment plans to reflect identified unmet needs.	Lead Nurse	31/09/2026

				Quality assurance audit to be conducted on a 3 monthly basis.		31/08/2026
13.	Staff feedback identified ongoing concerns about workforce pressures, communication, morale and infrastructure, highlighting a need for clearer assurance on how these issues are being addressed and how learning is shared with staff.	The health board should review the themes raised through staff feedback and provide clear assurance on the actions it will take to address these concerns, including how feedback will be shared with staff.	Staff feedback	Question and Answer sessions are to recommence from June 2026. Staff / patient newsletter is currently in development. Members of Senior Management team to attend Q&A sessions on a bi-monthly basis. Quality and safety performance group and clinical lead to discuss, share and cascade learning to all representatives. With significant information being shared universally via email and ward handovers.	Lead nurse / Directorate Manager	31/07/2026 30/09/2026

14.	Staff feedback highlighted inconsistent visibility and communication from senior leadership, particularly during periods of service change, which reduced staff confidence and clarity about future plans and the actions taken in response to concerns raised.	The health board must strengthen its arrangements to ensure clear, open and consistent communication with staff, particularly during periods of service change, and in relation to actions taken or learning from incident reporting.	Governance and leadership	Question and Answer sessions are to recommence from June 2026. Staff / patient newsletter is currently in development. Members of Senior Management team to attend Q&A sessions on a bi-monthly	Lead nurse / Directorate Manager	31/07/2026
15.	Staff feedback highlighted variability in role-specific training, induction and access to protected learning time.	The health board should review workforce development arrangements to ensure that role-specific training and local induction processes are consistent and accessible, and that staff are supported with sufficient protected time to engage in training and professional development alongside operational demands.	Skilled and enabled workforce	Feedback received from Februarys induction – to be reviewed. Steering group to be established to plan an MDT focused induction timetable to align with training needs analysis undertaken in January 2026.	Lead nurse / Directorate Manager	31/07/2026 30/09/2026

16.	Some staff reported that that they did not receive regular updates on themes or outcomes arising from patient feedback.	The health board should consider how patient feedback and associated learning can be more consistently shared with staff to support engagement and improvement.	People engagement, feedback and learning	Patient feedback service provides reports through service groups quality and safety meetings. Reports and additional information to be cascaded through directorate quality and safety meetings and included in staff / patient newsletters. Feedback is also received through compliments and complaints directly to the service which is then reported via quality and safety performance group Information is also contained in the directorate scorecards. Service to explore mediums of sharing and discussing themes and trends identified with all	Lead Nurse	31/08/2026

				staff working within the service, including exploration of a sharepoint page accessible by all within forensic services.		

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative:

Name (print): Dermot Nolan

Job role: Interim Service Group Director, Mental Health and Learning Disabilities **Date: 28 May 2025**