Agenda Item
5.3.1

Quality, Safety & Experience Committee

Unscheduled Care Group Highlight Report from the Quality & Safety Committee.

Dyddiad y Cyfarfod / Date of Meeting	18/11/2025
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Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Quality & Safety Committee	18/11/2025	

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf Morgannwg University Health Board
PCH	Prince Charles Hospital
RGH	Royal Glamorgan Hospital
POW	Princess of Wales Hospital
YGT	Ysbyty George Thomas Hospital
MDU	Medical Day Unit
Q&S	Quality & Safety
HIW	Health Inspectorate Wales
USC	Unscheduled Care Group
ED	Emergency Department
AMaT	Audit Management and Tracking System
IPC	Infection prevention control
UHW	University of Wales Hospital
ANTT	Aseptic Non Touch Technique
AMU	Acute Medical Unit
ANP	Advanced Nursing Practitioner
COTE	Care of the Elderly
ACE	Acute Care of the Elderly Unit
MRI	Magnetic resonance imaging
OCP	Operational Change Policy
TIA	Transient Ischaemic Attack
PALS	Patient Advice and Liaison Service
SSNAP	The Sentinel Stroke National Audit Programme
STAR	Surgical Trauma and Orthopaedic Rehabilitation
SBAR	Situation Background Assessment Recommendations.
QIM	Quality Management System
PACE	Patient Clinical Engagement
IA	Initial Assessment
PALS	Patient Advice and Liaison Service
PPE	Personal Protective Equipment.
HCSW	Health Care Support Worker
SSNAP KPIs	The Sentinel Stroke National Audit Programme - Key Performance Indicators

1. Introduction

1.1 This report had been prepared to provide the Committee with details of the key issues considered by the Quality, Safety, Risk and Experience meeting on 18th November 2025.

1.2 Key highlights from the meeting are reported in section 3.

2. Purpose of this Meeting

2.1 The purpose of the Quality, Safety, Risk and Experience meeting is to provide assurance to the Care Group and the Health Board's Quality, Safety & Experience Committee on the provision of safe and high-quality patient care and experience to the population we serve.

2.2 The Committee is requested to **NOTE** the report

Highlight Report

Alert / Escalate	**<u>Stroke Performance</u>** The Health Board's Stroke Performance is below the expected standard. Key Activities in progress: ○ Key stakeholder meeting with weekly huddles ○ Weekly Action log review with clinical engagement ○ Transformation Action Plan monitoring ○ Data and patient tracking review ○ Pathway mapping to identify digital touch points

Stroke Quality Improvement Measures Current Month stats July 2025		
% of patients who are diagnosed with a stroke who have direct admission to an acute stroke unit (<4 hours)		
Admissions	No within 4 hrs	% compliance
53	1	1.88%
Percentage of eligible stroke patients thrombolysed with a door to need time of <= 45mins		
Eligible patients thrombolysed	Thrombolysed <= 30 mins	% compliance
3	0	0%
% of patients who are diagnosed with a stroke who receive a CT scan within 20 minutes		
Patients diagnosed as stroke	Scanned <= 20 mins	% compliance
53	1	1.88%
% of patients who are diagnosed with a stroke who receive a CT scan within 1 hour		
Patients diagnosed as stroke	Scanned <= 1 hr	% compliance
53	19	35.84%
% of patients who are assessed by SNS within 4 hours		
Assessments	Assessed <= 4 hours	% compliance
53	22	41.50%
% of patients who are assessed by a stroke specialist consultant physician within 14 hours		
Asssessments	Assessed <= 14 hours	% compliance
53	34	64.15%
% of patients who are assessed by OT within 24 hours		
Assessments	Assessed <= 24 hrs	% compliance
53	20	37.73%
% of patients who are assessed by PT within 24 hours		
Assessments	Assessed <= 24 hrs	% compliance
53	19	35.84%

Stroke Quality Improvement Measures Current Month stats August 2025		
% of patients who are diagnosed with a stroke who have direct admission to an acute stroke unit (<4 hours)		
Admissions	No within 4 hrs	% compliance
67	5	7.50%
Percentage of eligible stroke patients thrombolysed with a door to need time of <= 45mins		
Eligible patients thrombolysed	Thrombolysed <= 30 mins	% compliance
4	0	0%
% of patients who are diagnosed with a stroke who receive a CT scan within 20 minutes		
Patients diagnosed as stroke	Scanned <= 20 mins	% compliance
68	10	14.70%
% of patients who are diagnosed with a stroke who receive a CT scan within 1 hour		
Patients diagnosed as stroke	Scanned <= 1 hr	% compliance
68	41	60.29%
% of patients who are assessed by SNS within 4 hours		
Assessments	Assessed <= 4 hours	% compliance
68	25	36.76%
% of patients who are assessed by a stroke specialist consultant physician within 14 hours		
Asssessments	Assessed <= 14 hours	% compliance
68	39	57.35%
% of patients who are assessed by OT within 24 hours		
Assessments	Assessed <= 24 hrs	% compliance
57	20	35.08%
% of patients who are assessed by PT within 24 hours		
Assessments	Assessed <= 24 hrs	% compliance
57	22	38.59%

Data Interpretation (July – August 2025):

- **Overall Improvement** is seen in several key measures, though compliance remains below target in many areas
- **Direct admissions within 4 hours** improved from **1.88%** (July) to **7.5%** (August) showing early signs of recovery
- **Door-to-needle times** for thrombolysis at CT scan within 20 minutes **remains low**, indicating delays in acute stroke pathway response.
- **SNS assessments within 4 hours and Stroke Consultant reviews within 14 hours**, show modest improvement, though **still below compliance target**
- **Therapy assessments** (Occupational Therapy (OT) and Physio within 24 hours) **remain variable,** reflecting workforce and flow pressures.

Summary

The above data indicates performance in Stroke Pathway timeliness is improving but inconsistent, with continued challenges in rapid diagnostics and senior assessments. Focused action is required to enhance stroke response, access to imaging, and early Multi-Disciplinary Team (MDT) review.

September - October 2025 Performance Overview (21/09 – 05/10)

SSTP Performance Summary

Data shows gradual improvement in **time to CT scan** over the three-week period. The proportion of patients scanned within 20 minutes increased modestly, while those scanned within **1 hour rose significantly**, reaching around **65–70%** by early October.

Performance for admission to the **Acute Stroke Unit (ASU) within 4 hours fluctuated** — declining at the end of September but improving again in early October to near **30–35%,** suggesting some recovery in flow and access to stroke beds.

Improvement Trajectory - SSNAP performance Target:

- 40% of all patients having CT within 20 mins
- 100% of all patients transferring to Acute Stroke Unit (ASU) within 4 hours

Summary:

While progress is evident in timely CT access, further consistency is needed in both scanning and ASU admission times to meet national stroke pathway standards.

<u>Training Provision and ESR Compliance</u>

Limited availability of ILS, Violence & Aggression, and Manual Handling training has led to low compliance across the Health Board.

This poses significant risks to patient and staff safety, increases potential for injury, and may lead to regulatory non-compliance.

Service delivery is also affected, with reduced staff readiness for emergencies and safe patient handling. A review of training capacity and recovery plan is required to address the gaps and improve compliance.

USC mandatory compliance average is currently **65.44%.** The Nurse Director will work in conjunction with Senior Nurse leadership teams to support an upward trajectory to achieve the 85% compliance target and will monitor in monthly HB workforce meetings. However, as stated above the current lack of training provision is a risk to achieving this.

POW Clinical Site Team

Significant investment has strengthened Clinical Site teams at both RGH and PCH. However, POW team remains extremely fragile with high sickness levels and limited site manager cover. A Head of Patient Flow has been appointed at POW to support the team, lead workforce remodelling, and drive further investment to stabilise site operations and improve patient flow. This appointment commences on 3rd November 2025.

Ysbyty George Thomas

Concerns have been raised by Therapy team regarding care and deconditioning at YGT. In addition, concerns have been raised following an incident out of hours on the unit in relation to leadership and behaviours.

Senior Leadership team aware and have instigated several meetings with key stakeholders and establishment of a robust action plan to ensure improvement on the unit. Safeguarding colleagues have been engaged to establish whether any trigger for safeguarding following patient review.

An update was provided to Executive Leadership Group (ELG) on the 10th November 2025.

	The formal YGT OCP concluded on 20th October 2025 to progress the transfer of service from Unscheduled Care to Primary and Community Care, date to be confirmed.
Advise	**Optimise Launch POW** On 6th October the launch of the POW phase of the Optimise programme took place as part of a rapid improvement plan being rolled out across the site over the next couple of months. This programme requires a whole system approach to ensure optimal outcomes for population and to build strong foundations that will support the wider transformation programme for Unscheduled Care services on the Princess of Wales site. The programmes key deliverables focus on achieving SAFER board round compliance and embedding the Optimal Hospital Flow Framework. These elements are designed to support improved multi-disciplinary communication, enhance discharge planning, and ensure timely decision-making to promote safe, effective patient flow and improving patient experience and outcomes. Initial feedback from clinical teams has generally been positive, with increased clarity around daily priorities and awareness of 'home first' concept. Ongoing monitoring will focus on measuring compliance against key indicators, evaluating impact on length of stay, and identifying opportunities for further improvement. **Winter Planning** Winter Plans and surge areas temporarily opened on the 3 Acute Sites (non-commissioned areas) early October 2025.

USC Winter Planning Overview
PCH
Extend UTC Hours
Re-set Acute Medicine
Risk assessed surge space x1 ED
Optimise Launch – following POW (date TBC)
RGH
Review further opportunities to divert GP intake pack to POW – Phase 1 complete
Risk assessed surge space x1 ED
Optimise Launch-following POWH implementation (date TBC)
POW
Re-set Acute Medicine AMU/SDEC – realignment of pathway and workforce
Expansion/realignment of ACE

Ambulatory footprint ED
Optimise Launch – 6th October
Discharge Pathways – support from Julia Wilkinson as part of the reset programme
Risk assessed surge space x1 ED
Additional Plans
Review data and bed modelling
Review additional capacity Requirements
Review additional decisions makers
Risks
Clinical Pathways – remaining at RGH due to critical incident Stoke/Medicine
Confirmation of additional funding required
Workforce/Recruitment

Implementation of UNITE (Unscheduled Care Improvement, Transformation and Efficiency)

The UNITE programme provides overall direction and governance for transforming unscheduled care services across Cwm Taf Morgannwg University Health Board (CTM UHB). The programme led by the Care Group will align with the organisations strategic goals and will deliver intended outcomes. It brings together multiple workstreams, under a single, coordinated structure to improve patient flow, reduce variation, and embed sustainable change in acute settings. UNITE builds on the momentum of previous initiatives such as STAMP, TRUE, and Optimise, serving as framework for all Unscheduled Care, Care Groups transformation projects

UNITE is structured around key domains of unscheduled care, each with its own dedicated delivery group. These include:

- STAMP - Responsible for delivering improvements across Acute Medicine and Medical Same Day Emergency Care (SDEC) pathways.
- ACE Programme - Developing a sustainable Acute Frailty provision across the health board.
- ED - Evaluating clinical spaces to optimise patient placement and experience, alongside embedding digital enablers that support modern, efficient care pathways.
- Discharge & Flow - Working with the Optimise programme to improve performance and capability in line with Optimal Hospital Flow Framework
- Enabling Projects - Development of the Urgent Treatment Centre (UTC), Doccla, and other supporting initiatives that contribute to the transformation of front door services.

Each domain will have a weekly meeting to drive delivery, track progress, and escalate issues.

Emergency Departments: Major Trauma Education

ED nurses are required to maintain critical life-saving skills such as Advanced Life Support (or the paediatric equivalent) and achieving Level 1 and 2 competencies as defined by the National Major Trauma Nursing Group (NMTNG) as part of the Trauma Quality Indicators when the South Wales Trauma network was established.

The NMTNG states that Level 1 competencies should be completed within the first 12 months of the Registrant's start in an Emergency Department (in the 12 months after their initial preceptorship for newly registered nurses). Level 2 competencies should be completed within three years of the Registrant's start in the ED.

Current compliance for these levels is as follows (16-10-2025):

	Adult Competencies	Child Competencies
POW – Level 1	48.65%	7%
POW – Level 2	25.00%	0%
PCH – Level 1	65.00%	18.75%
PCH – Level 2	33.33%	50.00%
RGH – Level 1	79.41%	10%
RGH – Level 2	41.18%	0%

Risks of poor compliance:

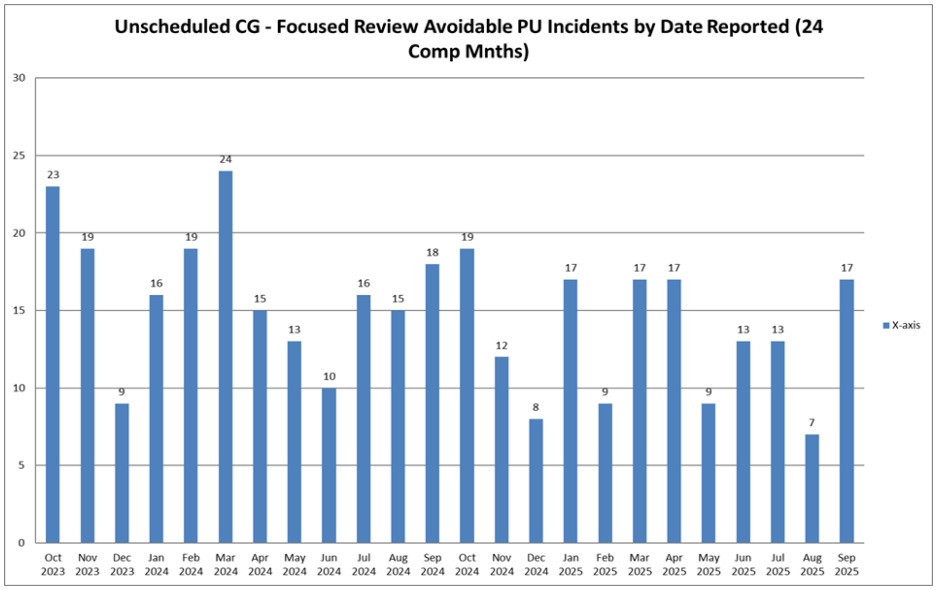
- Non-compliance with Trauma Quality Indicators
- Higher risk of adverse incidents, complaints, and liability
- Reduced staff morale and retention due to lack of advanced training
- Increased risk of clinical errors due to lack of advanced training

Senior Nurse for Professional Development has devised a paper on Major Trauma Level 2 Training as required by NICE and National Major Trauma Nursing Group. These need progressing as an MDT to secure financial investment; to equip our workforce with the required skill set which would develop a gold standard service that supports the needs of our population whilst upholding a positive reputation for the organisation.

Assure

USC Avoidable Pressure Damage Prevalence

Overview of USC reported Hospital Acquired Avoidable Pressure Damage (October 2023 to September 2025) CTMHB wide

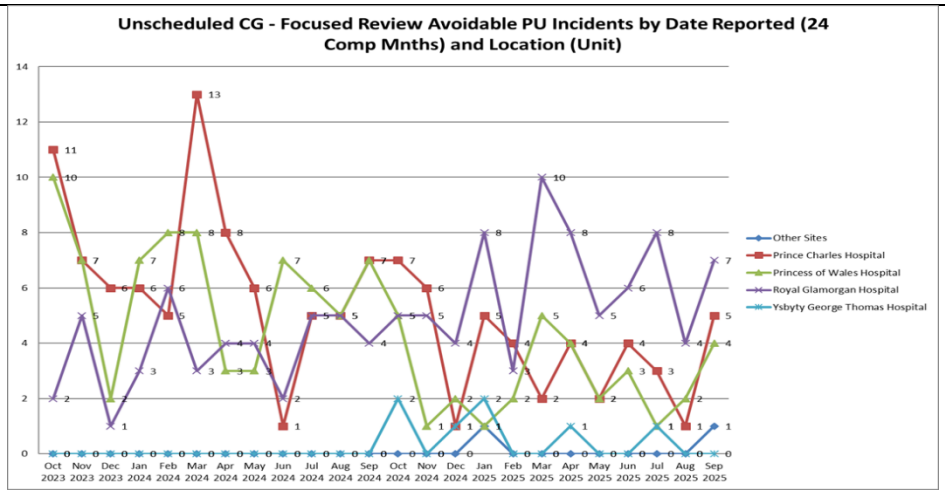


The above graph demonstrates the following key findings:

- During the period of October 2023 – September 2024 a total of 198 avoidable pressure damage incidents were reported
- During the period of October 2024 - September 2025 a total of 161 avoidable pressure damage incidents were reported
- The data illustrates that there were **37 fewer incidents reported in the most recent 12 months** compared to the previous year
- Demonstrating a 19% decrease overall
- The last 12 months show a more stable trend but still fluctuating pattern. However, **September 2025 showed a resurgence (17) which has returned to the higher reporting range.**

Overview of USC reported Hospital Acquired Avoidable Pressure Damage (October 2023 to September 2025) per DGH site

The below graph demonstrates the number of avoidable pressure damage incidents per month for each hospital site over the past 24 months.



During the period October 2024 to September 2025 in comparison to the previous 12 months the data illustrates the following trends for each respective site:

Site	Incident Trend
Royal Glamorgan Hospital	Increase
Prince Charles Hospital	Reduction
Princess of Wales Hospital	Noticeable Reduction

NB: It is important to note that the bed base increased in RGH in October 2024 and significantly reduced in POW due to the Critical Incident. Therefore, there are variables in the data when comparing with the previous 12-month prevalence in both RGH and POW sites.

This increase in avoidable harm has implications for patient outcomes, staff morale, and organisational reputation, and may lead to regulatory scrutiny if not addressed promptly.

HIW Improvement Plan - RGH Emergency Department

Following the unannounced HIW Inspection at RGH Emergency Department on 5-7th August 2025 several areas of improvement were identified during the inspection. In response the service has completed an improvement plan to support the required actions. HIW has commended the comprehensive and robust action plan and will require an update in 3 months (mid-January 2026).

The key areas of improvement have been highlighted by HIW, however, there were no immediate improvements identified. The action plan has been finalised and accepted, and HIW have commended the quality of the report.

In the meantime, progress will be monitored and updated monthly by the CSG and presented at Performance and Assurance meetings.

RGH Ward 3 Respiratory Update

Ward 3 continues to have an improving trajectory in both performance and staff engagement. The recently appointed Band 7, supported by two Band 6 nurses, is providing strong and visible leadership, contributing to the achievement of trajectory targets and the facilitation of ongoing Respiratory training and education for staff.

Infection Prevention and Control (IPC) standards have shown measurable improvement, with enhanced compliance observed during recent audits. Estates colleagues are currently undertaking ward flooring replacement work, which will further support IPC standards and overall ward environment quality.

The Ward Manager is also targeting improved pressure damage training compliance to support a reduction in avoidable pressure damage and harm to patients within this clinical area.

There has been an increase in positive feedback from both patients and staff, reflecting notably improved team cohesion, morale and communication. This progress highlights the effectiveness of targeted support measures provided to the ward.

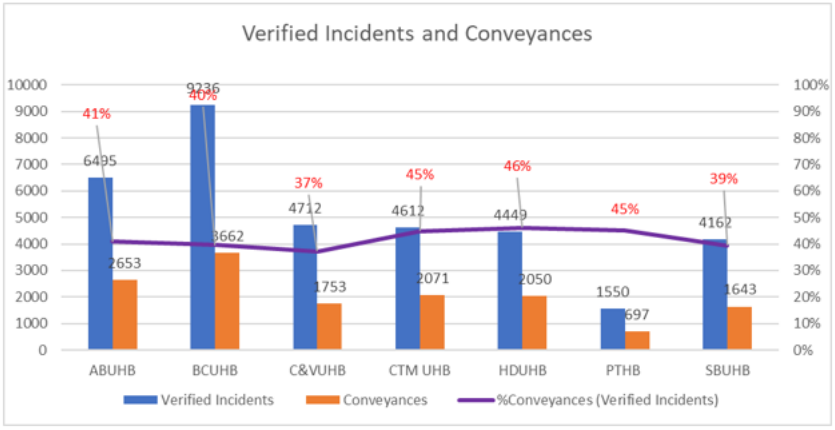
USC Performance and 30-Day Action Plan Update

The **USC Performance and 30-Day Action Plan Update (for September)** CTMUHB outlines significant progress and strategic planning in urgent and emergency care. Key actions include the development and implementation of rapid improvement plans, internal professional standards, and pilot programs such as UTC and UCC. Performance metrics show CTMUHB achieving the fastest ambulance handover times in Wales (average 24 minutes in July), with PCH and RGH leading nationally. Despite challenges like reduced inpatient capacity and a critical incident at POW, CTMUHB maintained low lost hours and improved conveyance rates.

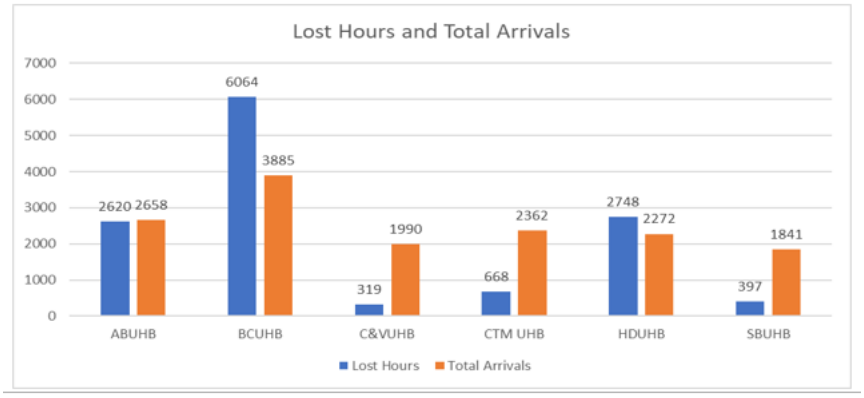
The 30-day deliverables focus on operational enhancements such as defining roles, improving diagnostics access, and refining discharge processes. Transformational goals include discharge protocols and care home admission avoidance. Outcome targets aim for zero tolerance to extended ED waits and improved discharge timings. The 60-day and 90-day plans build on these

foundations, targeting further reductions in wait times, enhanced patient flow, and expanded community care capacity. The overarching goal is to achieve zero tolerance for 12-hour ED waits and 45-minute ambulance handovers by October 2025, supported by trajectory-based planning and system-wide coordination.

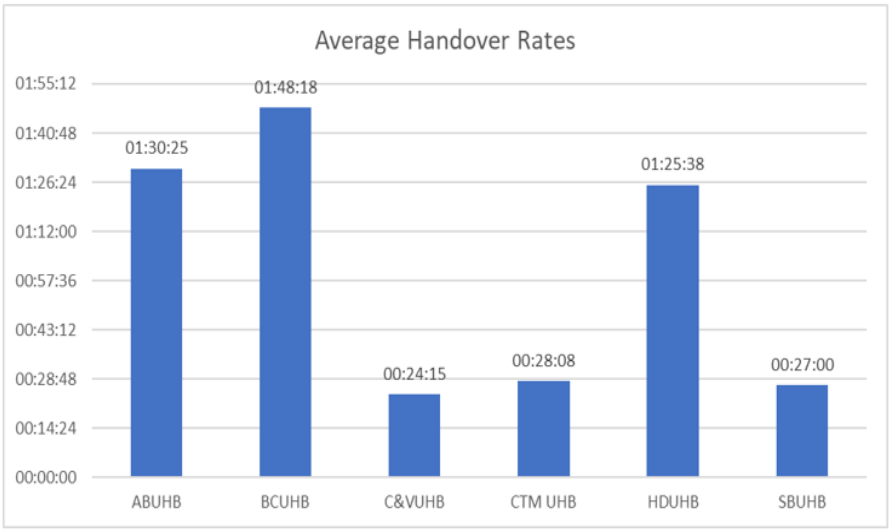
Please see below graphs relating to September's Ambulance performance.



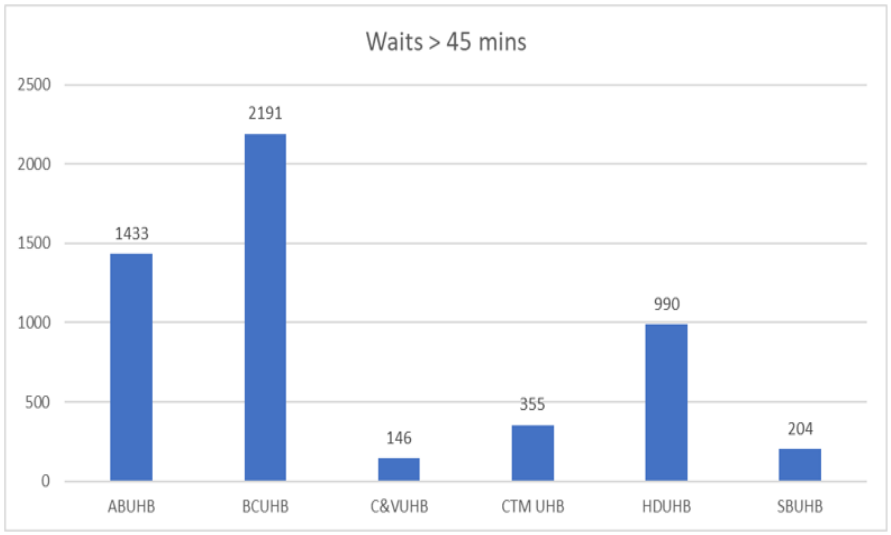
The above graph demonstrates that CTMHB's conveyance rate (46%) is above the midpoint compared to other Health Boards. Overall CTMUHB is showing slightly above average performance in terms on incident verification and conveyance in September.



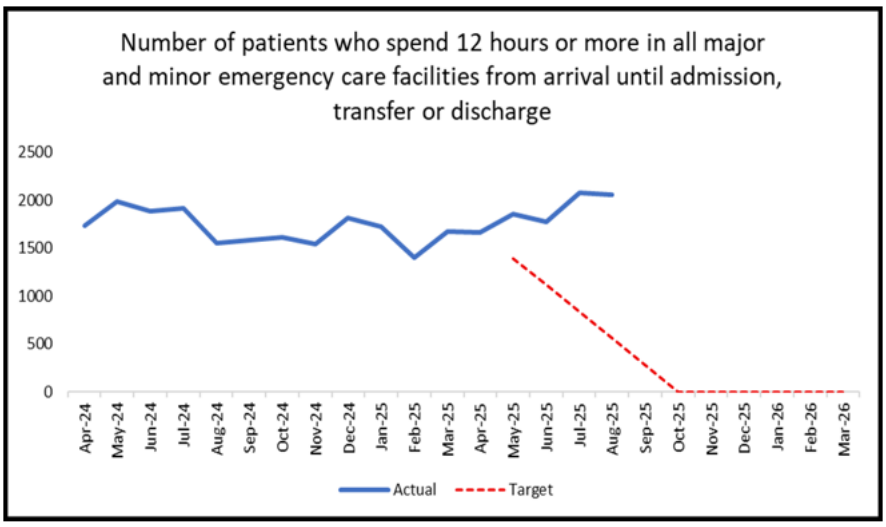
The chart above demonstrates that CTMUHB lost 668 hours with a total of 2,362 arrivals. CTMUHB has relatively low lost hours compared to most other Health Boards in September.



The above graph illustrates CTMUHB had strong performance in handover efficiency in the month of September, with an average handover rate of 28 minutes, it performed significantly better than several other Health Boards.



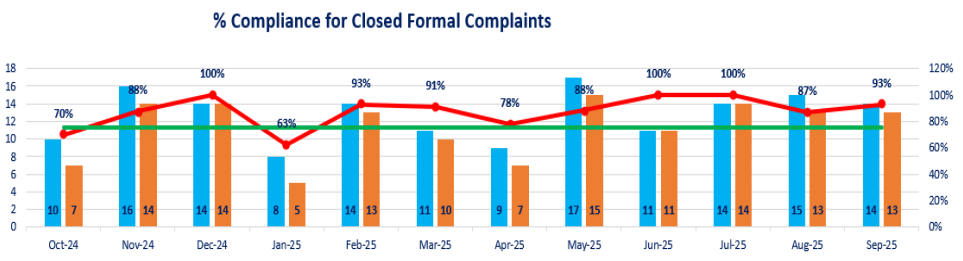
CTMHB records a relatively low number of ambulance waits > 45 mins compared to most other Health Boards in September, indicating strong performance in reducing patient delays.



While earlier data indicates a reduction in ambulance handover delays – meaning ambulances are transferring patients into Emergency Departments more efficiently. This chart reveals a contrasting upward trend in the number of patients waiting over 12 hours inside Emergency Departments.

This pattern suggests that bottlenecks have shifted downstream, likely within the hospital system itself. While ambulance offloads are now quicker, patient flow beyond ED (into wards, diagnostics, discharge pathways) has become constrained, leading to crowding and extended stays in departments. The increase in 12-hour waits highlights internal capacity pressures, suggesting the need for improved inpatient flow and discharge processes to sustain overall system efficiency.

Concerns ED & Medicine



Overall compliance has shown a positive upward trend, increasing from 87% in August to **93%** in September 2025. Ongoing

monitoring will continue to ensure this progress is maintained and embedded across clinical teams.

Since the reintroduction of the Patient Advice and Liaison Service (PALS) presence within the Emergency Department, there has been a notable rise in the number of enquiries received. This increase is being closely monitored to determine underlying themes, particularly around patient experience, communication and waiting time. Early indications suggest that accessibility to PALS within the department has improved visibility and encouraged more real-time feedback from patients and relatives.

There are currently **25 open complaints**. There has been an increase in the number of complaints received compared to previous months. Despite this rise, it is important to note that **all complaints remain within the 30-day response compliance** timeframe, with zero breaches reported. The complaints predominantly relate to diagnosis/treatment, communication, waiting times, unsafe discharges, long ED waits and other aspects of patient experience. These are being monitored through governance processes to identify learning to support the required service improvements.

Professional Standards & Behaviours

There have been several recent incidents where staff behaviours have not aligned with the organisation's expected standards of professionalism, values and behaviours. Such incidents have the potential to impact team culture, patent experience and the overall reputation of the Health Board. These incidents are being addressed through appropriate management processes.

As an immediate response, the Corporate Nursing Team has implemented targeted Professionalism Training sessions for Band 6 & 7 staff groups. These sessions aim to reinforce the Health Board' core values, strengthen leadership accountability and promote consistent professional conduct. This proactive approach supports our ongoing commitment to maintain high standard of care and upholding the reputation of the Health Board.

Designated Nursing Officer (DNO) Training for Medical Gases

Compliance relating to Designated Nursing Officer (DNO) training for medical gases governance remains low across the Health Board. An analysis and co-ordinated response, supported by the Assistant Director of Nursing, to determine the designated

	persons per area, and develop a targeted improvement plan to address gaps and strengthen compliance in underway. **Nutrition and Hydration: Catering Model Pan CTMHB** The digital catering model now needs to be implemented at RGH and POW to align with the successful approach already embedded at PCH that support our populations nutrition and hydration needs safely. Standardising this model across all sites will strengthen governance, improve the consistency and quality of patient care, and reduce variation in practice. Implementation will focus on facilitating patients' dietary requirements safety, thus supporting recovery and improved patient outcomes. **AMaT** AMaT actions for USC as reviewed weekly by the USC Directors. There is a rigorous approach to daily assurance checks by either the HON or Lead Nurse. For all sites, as part of their ward assurance the Lead and Senior Nurses are reviewing AMaT at a minimum of once a week to ensure compliance with the audits and action plans. With support from the outreach team Fluid balance compliance has improved, weekly audits continue and bespoke training by the outreach team has continued. **Risk Register** No new risks greater than 15 have been added to the Risk Register
Inform	**Head of Nursing Vacancies PCH and POWH** Interviews undertaken 27th October 2025 and 2 new Heads of Nursing recruited for PCH and POWH. **Senior Nurse Appointment RGH** A Senior Nurse has been appointed for Integrated Medicine and has now commenced in post. This role will provide enhanced nurse leadership and strengthen governance, support the required service improvement work and quality oversight. **Recruitment & Workforce Stability** Targeted recruitment efforts continue across unscheduled care and medical wards, with several key posts successfully filled. Ongoing campaigns aim to reduce reliance on temporary staffing and improve workforce stability, supporting safer staffing levels and service continuity.

An opportunity has been supported for a Lead Nurse secondment to cover the 3 Emergency Departments pan CTMUHB as a proof of concept for 6 months. The role will provide strategic and operational oversight, promote standardisation of care, and strengthen nursing leadership that has proven effective and efficient in Planned Care. This restructuring will form part of a wider strategic initiative for the senior nursing leadership across Unscheduled Care on the acute sites.

Equality, Diversity and Inclusion

Our newly appointed Senior Nurse in Medicine RGH has been approached by the RCN and has agreed to participate in a photo shoot in University of Cardiff to celebrate diversity within senior positions in the NHS in Wales.

POW Ward Moves

All required ward moves to date have been undertaken on the POW site successfully.

Patient Experience & Well-being

Collaboration with the Daring to Dream charity continues, with several music events scheduled over the coming months across POW COTE wards. These sessions aim to enhance the well-being and engagement of patients within our dementia and elderly population, supporting a more therapeutic and person-centred environment.

MyPorter Task Request Management System

A new digital portering task management system is being launched 1st November pan CTMHB to enhance operational efficiency and patient experience.

MyPorter has been adopted by over 70 NHS Trusts across the UK and has demonstrated measurable improvements in patient flow, especially in Emergency and Radiology departments

The system enables real-time task allocation and tracking, supporting timely patient transfers, reducing delays, and promoting a smoother healthcare journey across hospital sites.

	Recognition and Achievement: CTM Cardiology The CTMHB Cardiology team received national recognition at the **Welsh Health Care Awards 2025**, achieving success in the **Improvement in Cardiology Care** category. This award highlights the teams outstanding commitment to innovation, collaboration, and delivering high quality, patient centred cardiac services across the Health Board. 
Appendices	Not applicable

3. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM /Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM /Link to CTMUHB Strategic Areas	Choose an item.
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Leadership
	If more than one applies please list below:

Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Person Centred
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	Yes - Reuse
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd?* / **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☒	No: ☐
	Outcome:	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg?* / **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☒	No: ☐
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please include rationale below:
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol)* / **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	
	People	

4. Recommendation

4.1 The Quality, Safety & Experience Committee is asked to **NOTE** the highlights outlined in section 3 of this report.