Quality, Safety & Experience Committee

Tue 20 May 2025, 09:00 - 12:00

Virtually via Microsoft Teams

Agenda

09:00 - 09:05
5 min

1. PRELIMINARY MATTERS

1.1. Welcome & Introductions

Information *Carolyn Donoghue, Independent Member/Committee Chair*

1.2. Apologies for Absence

Information *Carolyn Donoghue, Independent Member/Committee Chair*

1.3. Declarations of Interest

Information *Carolyn Donoghue, Independent Member/Committee Chair*

09:05 - 09:10
5 min

2. CONSENT AGENDA BUSINESS

The Committee Chair will ask if there are any items from the Consent Agenda (Section 8) that Committee Members wish to bring forward to the main agenda for discussion

09:10 - 09:15
5 min

3. COMMITTEE GOVERNANCE ARRANGEMENTS

3.1. Action Log

Discussion *Carolyn Donoghue, Independent Member/Committee Chair*

3.1 QSEC Action Log QSEC 20 May 2025.pdf (4 pages)

3.2. Matters Arising not contained within the Action Log

Discussion *Carolyn Donoghue, Independent Member/Committee Chair*

3.3. Committee Annual Report 2024-2025

Decision *Carolyn Donoghue, Independent Member/Committee Chair*

3.3a Cover Report QSE Committee Annual Report 2024 2025 QSEC 20 May 2025.pdf (3 pages)
3.3b Appendix 1 Quality Safety Committee Annual Report 2024 2025 QSEC 20 May 2025.pdf (12 pages)

09:15 - 09:40
25 min

4.
STAFF AND SERVICE USER EXPERIENCE

4.1.
Shared Listening & Learning Story - Maternity Services

Discussion *Bryany Tweedale, Maternity Services*

Listening & Learning Story Presentation.pdf (8 pages)

4.2.
Executive and Independent Member Walkaround Framework Cover Paper

Discussion *Ana Llewellyn, Mental Health & Learning Disabilities Care Group Nurse Director*

4.2a Exec IM Walkaround Cover Paper QSEC 20 May 2025.pdf (4 pages)
4.2b Appendix 1 Board Development Walkarounds QSEC 20 May 2025.pdf (16 pages)
4.2c Appendix 2 Exec IM Walkaround Framework QSEC 20 May 2025.pdf (9 pages)

09:40 - 11:10
90 min

5.
SETTING THE SCENE - SERVICE DELIVERY

5.1.
Spotlight Report Update on cluster of incidents within maternity services at the Princess of Wales Hospital (March – May 2025).

Discussion *Head of Midwifery & Neonates, Children & Families Care Group (Merthyr & Cynon)*

5.1 Spotlight cluster of incidents at PoW QSEC 20 May 2025.pdf (6 pages)

5.2.
Report from the Clinical Executives

Discussion *Clinical Executives*

5.2 Clinical Executive Directors update QSEC 20 May 2025.pdf (12 pages)

5.3.
Care Group Highlight Reports

Discussion *Care Group Nurse Directors/Care Group Medical Directors*

5.3.1.
Children & Families Care Group

Discussion *Suzanne Hardacre, Care Group Nurse Director*

5.3.1 Highlight Report Children & Families Care Group 20 May 2025.pdf (7 pages)

5.3.2.
Unscheduled Care Care Group (to include an update on Stroke Services)

Discussion *Sarah Follows, Operational Director for Unscheduled Care*

5.3.2 USC Highlight Report QSEC 20 May 2025.pdf (8 pages)

5.3.3.
Planned Care Care Group

Discussion *Sharon O Brien, Care Group Nurse Director*

5.3.3 Planned Care Highlight Report QSEC 20 May 2025.pdf (7 pages)

5.3.4.
Mental Health & Learning Disabilities Care Group

Discussion *Ana Llewellyn, Care Group Nurse Director*

5.3.4 MHLD Highlight Report QSEC 20 May 2025.pdf (9 pages)

5.3.5.
Diagnostics, Therapies, Pharmacy & Specialities

Discussion *Hannah Wilton, Director of Pharmacy and Medicines Management*

5.3.5 Highlight Report DTPS QSEC 20 May 2025.pdf (11 pages)

5.3.6.
Primary Care & Communities Care Group - to Include a Progress report on Dental Services

Discussion *Lucie Owen, Primary Care & Communities Care Group Director*

5.3.6a PCC highlight report QSEC 20 May 2025.pdf (9 pages)
5.3.6b Appendix Paediatric Dental GA Service QSEC 20 May 2025.pdf (4 pages)

11:10 - 11:20
10 min

6.
DELIVERING OUR PLAN

6.1.
Patient Safety, Quality & Experience Dashboard

Discussion *Head of Concerns & Business Intelligence*

6.1 Patient Safety and Quality Dashboard Report QSEC 2025-05-20 Draft.pdf (17 pages)

11:20 - 11:45
25 min

7.
GOVERNANCE, RISK AND ASSURANCE

7.1.
Organisational Risk Register – Risks Assigned to Quality & Safety Committee

Discussion *Cally Hamblyn, Assistant Director of Governance & Risk*

7.1a Org Risk Register - May 2025 CP QSEC.pdf (7 pages)
7.1b Appendix 1 - Org RR May 2025 QSEC.pdf (6 pages)

7.2.
Highlight Report from the Harm Free Care Agenda

Discussion *Richard Hughes, Deputy Director of Nursing*

7.2 Highlight Report Harm Free Care May 2025 QSEC 20 May 2025.pdf (9 pages)

7.3.
Annual Assurance Report on Compliance with the Nurse Staffing Level (Wales) Act

Discussion *Greg Dix, Executive Director of Nursing/Deputy CEO*

7.3a Nurse Staffing Report QSEC 20 May 2025.pdf (6 pages)
7.3b Appendix A Nurse Staffing Report template (May report) - Adult Paeds -Final V1.pdf (15 pages)
7.3d Appendix C -SABR on Section 25B ward moves outside of Biannual acuity Audit Final V2.pdf (5 pages)

11:45 - 11:50
5 min

8. CONSENT AGENDA

8.1. FOR APPROVAL

8.1.1. Unconfirmed Minutes of the Meeting held on 25 March 2025

Decision *Carolyn Donoghue, Independent Member/Committee Chair*

8.1.1 Unconfirmed Minutes QSEC 25 March 2025 QSEC 20 May 2025.pdf (17 pages)

8.1.2. Unconfirmed Minutes of the In Committee Meeting held on 25 March 2025

Decision *Carolyn Donoghue, Independent Member/Committee Chair*

8.1.2 Unconfirmed Minutes IC QSEC 25 March 2025 Final QSEC 20 May 2025.pdf (2 pages)

8.1.3. Ratification of Chairs Urgent Action - Medical Gases Management Policy

Decision *Carolyn Donoghue, Committee Chair*

8.1.3a Ratification of Chairs Urgent Action Medical Gas Policy QSEC 20 May 2025.pdf (4 pages)
8.1.3b Medical Gas Policy V4.0 APR 2025 QSEC 20 May 2025.pdf (29 pages)

8.2. FOR NOTING

8.2.1. Non-Routine Committee Business (Forward Plan)

Information *Carolyn Donoghue, Independent Member/Committee Chair*

8.2 1 CTMUHB QSEC Non Routine Bus QSEC 20 May 2025.pdf (3 pages)

8.2.2. Annual Cycle of Business

Information *Carolyn Donoghue, Independent Member/Committee Chair*

8.2.2 CTMUHB QSEC Cycle of Business QSEC 20 May 2025.pdf (5 pages)

8.2.3. Clinical Policies Highlight Report

Information *Dom Hurford, Executive Medical Director*

8.2.3 Clinical Policies Highlight Report QSEC 20 May 2025.pdf (4 pages)

8.2.4. Cancer Services Annual Report

Information *Dom Hurford, Executive Medical Director*

8.2.4 CTMUHB Cancer Services Annual Report QSEC 20 May 2025 TW.pdf (12 pages)

8.2.5. Bi-Annual Report CTM Radiation Safety Committee

Information *Lauren Edwards, Executive Director of Allied Health Professionals and Health Sciences*

8.2.5 Bi Annual Report CTM Radiation Safety Committee May QSEC 20 May 2025.pdf (4 pages)

8.2.6.
Antimicrobial Stewardship Report – May 2025

Information *Hannah Wilton, Director of Pharmacy and Medicines Management*

8.2.6 Antimicrobial Stewardship Report QSEC 20 May 2025.pdf (10 pages)

8.2.7.
Outcome Report: Quality, Safety & Experience Committee Effectiveness Survey

Information *Carolyn Donoghue, Independent Member/Committee Chair*

8.2.7 Quality Safety Committee Effectiveness Survey Themed Action Plan.pdf (6 pages)

8.2.8.
Health Inspectorate Wales (HIW) Improvement Plan Tracker Report

Information *Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director*

8.2.8a - HIW Tracker Inspection Improvement Plans- QSC May 25 - Final Draft.pdf (7 pages)
8.2.8b - App 1 -HIW Inspections Recommendations Tracker_QSEC May 2025 - CH.pdf (5 pages)

8.2.9.
Continuing Healthcare (CHC)

Information *Ana Llewellyn, Care Group Nurse Director*

8.2.9 CHC Annual Report QSEC 20 May 2025 AL tweak.pdf (16 pages)

8.2.10.
Infection Prevention Control

Information *Greg Dix, Executive Director of Nursing/Deputy CEO*

8.2.10a IPC workplan May 25 QSEC 20 May 2025.pdf (5 pages)
8.2.10b IPCAnnual Programme of work 2025-26 QSEC 20 May 2025.pdf (4 pages)

8.2.11.
Health, Safety & Fire Sub Committee Highlight Report from the meeting held on 1 April 2025

Information *Hywel Daniel, Executive Director for People*

8.2.11 Highlight Report HSFSC 1 April 2025 QSEC 20 May 2025.pdf (5 pages)

8.2.12.
Joint Commissioning Committee Quality, Safety & Outcomes Sub Committee Highlight Report

Information *Carolyn Donoghue, Independent Member/Committee Chair*

8.2.12 QSO Highlight Report Feb 25 QSEC 20 May 2025.pdf (6 pages)

11:50 - 11:55
5 min

9. CLOSE OUT BUSINESS

9.1.
Committee Highlight Report to the Board

Discussion *Cally Hamblyn, Assistant Director of Governance & Risk*

9.2.
Meeting Feedback

Discussion *Carolyn Donoghue, Independent Member/Committee Chair*

Is there anything we should do more or less of?
Have we managed our time and allowed open and balanced discussion?
Have we considered our values and acted in a way that supports embedding our values across CTM?
Have we maintained a Strategic Focus?
Have we received sufficient assurance from a range of sources?
Has our discussion allowed us to better understand the risks that we are managing that may affect the achievement of our strategic goals?

9.3.
Any Other Business

Discussion *Carolyn Donoghue, Independent Member/Committee Chair*

11:55 - 11:55
0 min

10.
Private / Closed Session Business

Discussion *Carolyn Donoghue, Independent Member/Committee Chair*

The following items will be discussed at the In Committee session:

- Update on cluster of incidents within maternity services at the Princess of Wales Hospital - Verbal update
- Controlled Drug Accountable Officer (CDAO) Report: April 2024 – March 2025
- Organisational Risk Register - Closed Risks

11:55 - 12:00
5 min

11.
Date & Time of the Next Meeting

Information *Carolyn Donoghue, Independent Member/Committee Chair*

Tuesday 22 July 2025 at 9:00am - This will be held as an in person meeting at the Hub, Royal Glamorgan Hospital, Llantrisant

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Committee Action Log

nmittee
Member

the action originated from	reference	Reference Page Number	m Title / Summary	Nature of Action	Lead Officer	Lead Executive	Timescale for action to be completed	Status of Action	Narrative Progress Update
16.05.2024	7,1	17	Patient Safety, Quality & Experience Dashboard	Lessons learnt and identified themes from Public Services Ombudsman Reviews to be presented to a future meeting.	Assistant Director of Quality & Safety	Executive Director of Nursing/Deputy CEO	18-sep-24	Open	**Proposed for Closure** This was included in March and May's report within the PSOW section - May's report the PSOW section is page 4 to top of page 6. Specifically lessons learned will be identified from any upheld / partially upheld final reports issued. During this period only 1 partially upheld report was received, the learning from this case is included at the bottom of page 5.
19.11.2024	5.2d	9	Mental Health & Learning Disabilities Care Group Highlight Report	Consideration to be given to the most appropriate way of reporting and ensuring visibility of estates issues to the Committee for assurance purposes.	Assistant Director of Governance & Risk	Director of Corporate Governance/ Board Secretary	21.01.2025	Open	**In progress** Discussions remain ongoing amongst the Executive Team on the most appropriate way of reporting estates issues
21.01.2025	6,1	9	Patient Safety, Quality & Experience Dashboard	Internal Audit Review of Patient Experience to be presented to a future meeting of the Committee	Deputy Director of Nursing	Executive Director of Nursing/Deputy CEO	22-jul-25	Open	**In progress** Report to be added to agenda once finalised and presented to the Audit, Risk & Assurance Committee on 22 May 2025
21/01/205	5,1	4	Thematic Spotlight Presentation - WAST joint investigation framework thematic review	WAST produced Quality Report to be shared with Members at future meetings of the Committee to help Independent Members to triangulate data between WAST and the Health Board	Executive Director of Nursing/Deputy CEO	Executive Director of Nursing/Deputy CEO	20/05/2025 **Now 22/07/2025**	Open	**In progress** Agreed that this agenda item is put on hold until the new USC DoN is appointed. Agreed that this item will be deferred until July QSEC with any urgent issues being provided through the USC Care Group highlight report; Matter will be kept under review regarding frequency of reporting and the report requirements will be made to allow for regular updates to be provided by the Care Group in respect of the joint working with WAST looking at the People's Experience and Quality of Care
21.01.2025	5,1	4	Thematic Spotlight Presentation - WAST joint investigation framework thematic review	Consideration to be given outside the meeting on the frequency of reporting on this matter to future Committee meetings. Deputy Director of Nursing to discuss further with Committee Chair to determine the level of information required moving forwards	Committee Chair	Executive Director of Nursing/Deputy CEO	25/03/2025 **Now 22/07/2025**	Open	**In progress** Agreed that this agenda item is put on hold until the new USC DoN is appointed. Agreed that this item will be deferred until July QSEC with any urgent issues being provided through the USC Care Group highlight report; Matter will be kept under review regarding frequency of reporting and the report requirements will be made to allow for regular updates to be provided by the Care Group in respect of the joint working with WAST looking at the People's Experience and Quality of Care

21.01.2025	5.3e	8	Primary & Community Care Group Highlight Report	Progress report on Dental Services to be presented to a future meeting of the Committee. Discussion to be held at next agenda planning session in regards to scheduling the item for discussion	Primary Care & Community Care Group Nurse Director	Executive Director of Nursing/Deputy CEO	20.05.2025	Open	**On agenda** This report is on the agenda for discussion at the May meeting
21.01.2025	2.1 (CLOSED)	2	Listening & Learning Story – Experience of Care received from the Adult Mental Health Service	Update to be presented at a future meeting which demonstrated the impact of the lessons that had been learnt.	Mental Health & Learning Disabilities Care Group Nurse Director	Executive Director of Nursing/Deputy CEO	22.07.2025	Open	**In progress** This will be presented to the July meeting of the Quality, Safety & Experience Committee
25.03.2025	4,1	3	Listening & Learning Story - Care received at the Snowdrop Breast Centre	Positive feedback to be shared with the Team at the Snowdrop Breast Centre along with the concerns identified in regards to communication of histology results	Planned Care - Care Group Nurse Director	Executive Director of Nursing/Deputy CEO	20.05.2025	Open	**Proposed for Closure** Feedback has been shared with the Team at the Snowdrop Breast Centre
25.03.2025	5,1	4	Spotlight Presentation - Stroke Unit Temporary Centralisation	Concerns raised in regard to service inequity and the potential risk to patients to be fed into the Allied Health Professionals Group	Executive Director of Allied Health Professionals and Health Sciences	Executive Director of Allied Health Professionals and Health Sciences	20.05.2025	Open	**In progress** Awaiting status up from Executive Director
25.03.2025	5,1	4	Spotlight Presentation - Stroke Unit Temporary Centralisation	Concerns raised in regard to service inequity and the potential risk to patients to be included in the alert/escalate section of the Highlight Report to Board	Director of Corporate Governance/Board Secretary	Director of Corporate Governance/Board Secretary	29.05.2025	Open	**Proposed for Closure** This has been included in the alert/escalate section of the Highlight Report being presented to the May 2025 Board
25.03.2025	5,1	5	Spotlight Presentation - Stroke Unit Temporary Centralisation	Report to be presented to a future meeting to outline progress made in this area	Executive Director of Allied Health Professionals and Health Sciences	Executive Director of Allied Health Professionals and Health Sciences	20.05.2025	Open	**In progress** Awaiting status up from Executive Director
25.03.2025	5.3a	6	Children & Families Care Group Highlight Report	Next iteration of the report to include a narrative explanation of the data to enable Independent Members to draw conclusions as to how the Health Board were performing in a number of areas	Children & Families Care Group Nurse Director	Children & Families Care Group Nurse Director	20.05.2025	Open	**In progress**
25.03.2025	5.3b	7	Unscheduled Care Group Highlight Report	Spotlight presentation to be presented to a future meeting in relation to the positive experiences that had been achieved in regard to the opening of two wards at Ysbyty George Thomas during the critical incident at the Princess of Wales Hospital	Unscheduled Care Group Nurse Director	Unscheduled Care Group Nurse Director	TBC	Open	**In progress** This item will be discussed at a future agenda planning session to agree scheduling
25.03.2025	5.3c	7	Planned Care Group Highlight Report	Future iterations of the report to not include reference to clinical matters if an explanation was not being provided to make the matters clearer to members of the public	Planned Care - Care Group Nurse Director	Planned Care Group Nurse Director	20.05.2025	Open	**Proposed for Closure** Care Group Nurse Director will ensure future reports do not include reference to clinical matters moving forward

25.03.2025	5.3f	9	Diagnostics, Therapies, Pharmacy & Sciences Care Group Highlight Report	Concerns raised by Members in regard to the prescribing practices for the new weight management drug given that there was currently no screening process in place and the long term implications of the drug were not yet known to be included in the alert/escalate section of the Highlight report to Board	Director of Corporate Governance/Board Secretary	Director of Corporate Governance/Board Secretary	29.05.2025	Open	**Proposed for Closure** This has been included in the alert/escalate section of the Highlight Report being presented to the May 2025 Board
25.03.2025	5.3f	9	Diagnostics, Therapies, Pharmacy & Sciences Care Group Highlight Report	Further clarity to be provided in regard to the discrepancies highlighted in relation to the higher than average number of clinical incidents being reported within stroke services which did not correlate with the update provided on stroke services earlier in the meeting	Executive Director of Allied Health Professionals and Health Sciences	Executive Director of Allied Health Professionals and Health Sciences	20.05.2025	Open	**In progress** Awaiting status up from Executive Director
25.03.2025	6,1	10	Patient Safety, Quality & Experience Dashboard	Update to be provided at the next meeting which identifies whether the locally reportable incidents were now being picked up via the Duty of Candour. Ombudsman report to be shared with Committee Members for information and awareness.	Assistant Director of Quality & Safety	Assistant Director of Quality & Safety	20/05/2025 **Now 22/07/2025**	Open	**In progress** The implementation of Duty of Candour on the 01.04.23 introduced an additional layer of scrutiny which includes a process of corporate review that ensures all incidents previously identified as LRIs would be picked up. Progress needs to be made in relation to adding more detail into the Duty of Candour section of the dashboard, which will be undertaken once the 2024/2025 annual report has been produced.
25.03.2025	7,1	13	Organisational Risk Register - Risks Assigned to the Quality, Safety & Experience Committee	Review to be undertaken of the reduction in the risk score for risk 5462 Adult Weight Management Service and the request made for the risk score to be reverted back to 20	Director of Corporate Governance/Board Secretary	Director of Corporate Governance/Board Secretary	20.05.2025	Open	**Proposed for Closure** Following discussion outside the Committee meeting it was agreed that the risk captured in the Organisational Risk Register (Datix Risk ID 5462) reflected the service delivery risk and was appropriately decreased in risk score in March 2025. It was agreed that the Strategic Risk Owner for this risk should be Gethin Hughes, Chief Operating Officer. In response to the wider strategic risks around Population Health, Philip Daniels has proposed that he will reframe the Strategic Risk on the Board Assurance Framework to reflect the discussions at the Committee

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Committee Action Log

nmittee
Member

the action originated from	reference	Reference Page Number	m Title / Summary	Nature of Action	Lead Officer	Lead Executive	Timescale for action to be completed	Status of Action	Narrative Progress Update
19.11.2024	5.2b	7	Unscheduled Care Group Highlight Report	Spotlight presentation to be presented to a future meeting in regard to the WAST joint investigation framework thematic review that had recently completed. Presentation to highlight the analysis undertaken and associated recommendations	Assistant Director of Quality & Safety	Executive Director of Nursing/Deputy CEO	21.01.2025	Closed	**Proposed for Closure** Presentation shared at the meeting held on 21 January 2025.
21.01.2025	6,1	9	Patient Safety, Quality & Experience Dashboard	Bi-Annual update on the work being undertaken by the Harm Free Care Board to be presented to a future meeting	Deputy Director of Nursing	Executive Director of Nursing/Deputy CEO	11.02.2025	Closed	**Proposed for Closure** Deputy Director of Nursing confirmed at the agenda planning session held on 11 February that the first report will be presented to the May 2025 meeting with bi-annual updates thereafter. Added to cycle of business
21.01.2025	6,1	9	Patient Safety, Quality & Experience Dashboard	Exploration to be given as to whether the Duty of Candour data can be split into Primary and Secondary Care	Assistant Director of Quality & Safety	Executive Director of Nursing/Deputy CEO	25.03.2025	Closed	**Proposed for Closure** Following the Internal Audit review of Duty of Candour, a comprehensive evaluation of all related reports is being conducted. This review aims to ensure alignment with the Once for Wales templates and standards. Additionally, consideration will be given to the feasibility of reporting Primary and Secondary Care cases separately
21.01.2025	5,2	5	Clinical Executives Report	Update to be obtained on the current status of progress being made to address the key priority areas identified in last year's staff survey	Executive Director of Allied Health Professionals and Health Sciences	Executive Director of Allied Health Professionals and Health Sciences	25.03.2025	Closed	**Proposed for Closure** Response received from the Executive Director of Allied Health Professionals and Health Sciences on 4 February 2025 and shared with Members by email on 5 February 2025.
21.01.2025	5,1	4	Thematic Spotlight Presentation - WAST joint investigation framework thematic review	Analysis to be undertaken as to whether the newer more medicalised paramedics were bringing into the hospital more appropriate patients. Understanding required on the level of acuity, in comparison to previous years	Unscheduled Care Group Nurse Director	Executive Director of Nursing/Deputy CEO	25.03.2025	Closed	**Proposed for Closure** Response received from the Unscheduled Care Group Nurse Director on 4 February 2025 and shared with Members by email on 5 February 2025.
21.01.2025	5.3d	8	Mental Health & Learning Disabilities Care Group Highlight Report	Concerns raised in relation to the progress being made in relation to Phase 3 of Right Care Right Person to be highlighted in the Committee Highlight Report to Board	Assistant Director of Governance & Risk	Executive Director of Nursing/Deputy CEO	30-jan-25	Closed	**Proposed for Closure** This was included in the Committee Highlight report presented to the Board at its meeting on 30 January 2025
21.01.2025	7,4	14	Pressure Ulcer Prevalence Audit 2024	Issues highlighted in relation to equipment and data to be included in the Committee Highlight report to Board, given its significance to patient harm, cost and staff time.	Assistant Director of Governance & Risk	Executive Director of Nursing/Deputy CEO	30-jan-25	Closed	**Proposed for Closure** This was included in the Committee Highlight report presented to the Board at its meeting on 30 January 2025

Agenda Item
3.3

Quality, Safety & Experience Committee

QUALITY, SAFETY & EXPERIENCE COMMITTEE ANNUAL REPORT 2024 - 2025

Dyddiad y Cyfarfod / Date of Meeting	20/05/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Emma Walters, Head of Corporate Governance & Board Business
Cyflwynydd yr Adroddiad / Report Presenter	Carolyn Donoghue, Chair of the Quality, Safety & Experience Committee
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	Endorse for Board Approval

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	

1. Situation /Background

1.1 Under Standing Order 10.2.3, each Committee of the Board is required to submit an annual report *"setting out its activities during the year and detailing the results of a review of its performance".*

1.2 This annual report from the Quality, Safety & Experience Committee details the activities and performance for the Committee for the reporting period 2024-2025.

2. Specific Matters for Consideration

2.1 The Committee Annual Report at Appendix 1, summarises the key areas of business activity undertaken by the Committee from April 2024 – March 2025 and highlights activity for further consideration over the next 12 months.

3. Key Risks / Matters for Escalation

3.1 Please refer to Appendix 1 for the full detail contained within the report.

4. 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	Living Well
	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))*	Learning, Improvement & Research
	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))*	Safe
	If more than one applies please list below:

Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable 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: Not applicable for this report
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: Not applicable for this report
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.	

5. Recommendation

5.1 The Committee are being asked to **ENDORSE FOR BOARD APPROVAL** the Committee Annual Report.

6. Next Steps

6.1 Once endorsed, the Annual Report will be submitted to the Board meeting being held on 29 May 2025 for approval.

Appendix 1

Quality, Safety & Experience Committee

Committee Annual Report 2024-2025

QUALITY, SAFETY & EXPERIENCE COMMITTEE
ANNUAL REPORT 2024-2025

1. FOREWORD

I am pleased to be able to commend to you this annual report, which has been prepared for the attention of the Board and reviews the work of the Committee for the financial year 2024-2025. As a result of the review undertaken into the effective management of Board Business, the name of this Committee changed in January 2025 from the Quality & Safety Committee to the Quality, Safety & Experience Committee.

During the year, I have been supported by Kath Palmer, Vice Chair (and Vice Chair of the Committee), Dilys Jouvenat, Nicola Milligan, Patsy Roseblade, Helen Lentle and Hayley Proctor who have contributed their considerable knowledge and wide-ranging experience to the Committee.

I would like to express my sincere thanks to all the officers of the Committee for their commitment in supporting the Committee in discharging its responsibilities through robust reporting. I would particularly like to extend my thanks to colleagues within the Corporate Governance Team for the support they provided me throughout the year. I also wish to record my appreciation for the support and contribution given by the Internal Audit team at the NHS Wales Shared Services Partnership (NWSSP), by Audit Wales, Llais Cymru and Healthcare Inspectorate Wales colleagues.

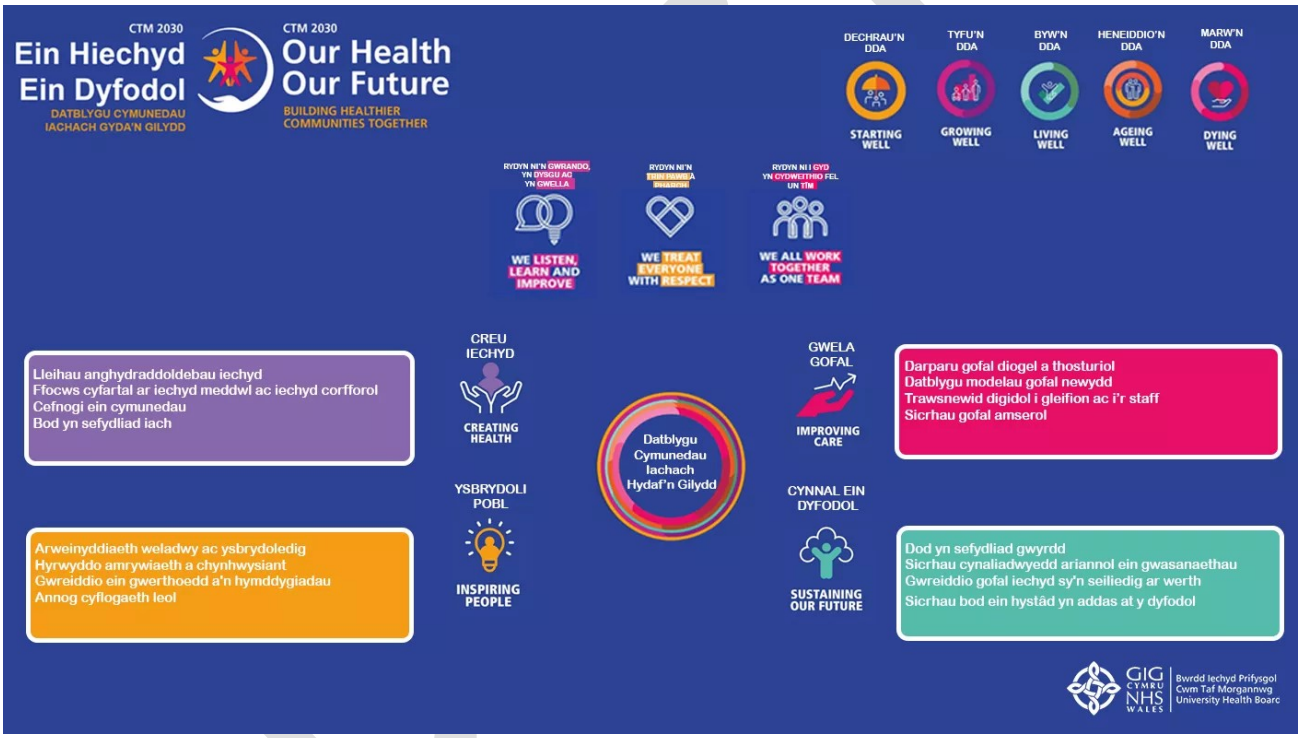
Going forward the Committee will continue to pursue a full programme of work covering quality and safety of care for our population together with matters affecting the health and safety of our workplaces with the aims of promoting learning and further strengthening the governance and assurance arrangements of the Health Board.

Carolyn Donoghue
Chair of the Quality, Safety & Experience Committee
Cwm Taf Morgannwg University Health Board (CTMUHB)

2. INTRODUCTION

The purpose of the Quality, Safety & Experience Committee "the Committee" is to provide assurance to the Board on the provision of safe and high quality care to the population we serve, including prevention through public health, primary and secondary care.

The Committee has embraced the Strategic Goals in how it manages its agenda to ensure that its activity supports the **'CTM2030: Our Health, Our Future'** Strategy and the **Values and Behaviours** of the Health Board.



The Committee meets every other month, with the key function to provide scrutiny on behalf of the Board on all matters relating to Quality, Safety and Experience.

3. ROLE, MEMBERSHIP, ATTENDEES AND COMMITTEE ATTENDANCES

3.1 ROLE

The role of the Committee is to advise and assure the Board on whether there are effective Quality & Safety arrangements in place – through the design and operation of the Health Board system of assurance – to support it in its decision taking and in discharging the accountabilities for securing the achievement of

the Health Board objectives in accordance with the standards of good governance determined for the NHS in Wales.

The Committee's Terms of Reference are reviewed annually and are available via the following link.

3.2 MEMBERSHIP

The membership of the Quality, Safety & Experience Committee comprises of six Independent members (this changed to four Independent Members in January 2025 as a result of the review undertaken into the effective management of Board Business), enabling the Committee to provide robust scrutiny and assurance to the Board independently of the management decision-making processes.

A summary of the Independent membership during 2024-2025 is outlined in table 1 below:

Table 1 – Composition & Membership of the Quality, Safety & Experience Committee Apr 2024-March 2025

Name	Period
Members	
Carolyn Donoghue (Committee Chair) Independent Member	April 2024 – March 2025
Kath Palmer (Committee Vice Chair) Vice Chair	April 2024 – March 2025
Nicola Milligan Independent Member	Apr 2024 – July 2025
Dilys Jouvenat Independent Member	April 2024 – December 2025
Patsy Roseblade Independent Member	April 2024 – March 2025
Helen Lentle Independent Member	April 2024 – March 2025
Hayley Proctor Independent Member	November 2024 – March 2025

3.3 ATTENDANCE AT QUALITY, SAFETY & EXPERIENCE COMMITTEE 2024 - 2025

During the year, the Committee met on six occasions in public. Five In Committee sessions were also held. All meetings were quorate and were well attended as shown in Table 2 below:

Table 2 - Meetings and Member Attendance 2023-2024

Public Meeting - In Attendance	16 May 2024	23 July 2024	18 Sept 2024	19 Nov 2024	21 Jan 2025	25 Mar 2025	Total
Independent Members							
Carolyn Donoghue - Independent Member (Chair of the Committee from July 2023)	✓	✓	✓	✓	✓	✓	**6/6**
Kath Palmer Vice Chair/Independent Member	✓	✓	✓	✓	✓	x	**5/6**
Dilys Jouvenat – Independent Member	✓	✓	X	x			**2/4**
Nicola Milligan – Independent Member (until July 2024)	✓	✓					**2/2**
Hayley Proctor – Independent Member (from November 2024)				✓	✓	✓	**3/3**
Patsy Roseblade Independent Member	✓	✓	✓	x	✓	✓	**5/6**
Helen Lentle – Independent Member (from January 2024)	✓	✓	✓	✓		✓	**5/5**

In Committee Meeting - In Attendance	16 May 2024	23 July 2024	18 Sept 2024	19 Nov 2024	21 Jan 2025	25 Mar 2025	Total
Independent Members							
Carolyn Donoghue - Independent Member (Chair of the Committee from July 2023)	✓		✓	✓	✓	✓	**5/5**
Kath Palmer Vice Chair/Independent Member	✓		✓	✓	✓	x	**4/5**
Dilys Jouvenat – Independent Member	✓		X	x			**1/3**
Nicola Milligan – Independent Member (until July 2024)	✓						**1/1**
Hayley Proctor – Independent Member (from November 2024)				✓	✓	✓	**3/3**
Patsy Roseblade Independent Member	✓		✓	x	✓	✓	**4/5**
Helen Lentle – Independent Member (from January 2024)	x		✓	✓		✓	**3/4**

3.4 ATTENDEES

The Committee's work is informed by reports provided by leads within CTMUHB, Llais Cymru (formerly Cwm Taf Community Health Council), Healthcare Inspectorate Wales, Audit Wales and Internal Audit. Although not members of the Committee, colleagues from these areas are invited to attend each meeting of the Quality, Safety & Experience Committee. Invitations to attend the Committee meeting are also extended, where appropriate and on an 'ad hoc' basis, to specific staff when reports which relate to their specific area of responsibility are being discussed.

4. QUALITY & SAFETY COMMITTEE BUSINESS

The Quality, Safety & Experience Committee provides an essential element of the Health Board's overall assurance framework. All meetings continued to be held virtually via Microsoft Teams during 2024/2025 with continued use of the Consent Agenda. Any items included on the consent agenda were considered by Members prior to each meeting, with Members provided with the opportunity to raise questions prior to the meetings regarding the reports. All reports included on the Main Agenda were discussed during each meeting. The Quality, Safety & Experience Committee agenda broadly follows a standard format, comprising of specific sections, and the activity of the Committee during 2024/2025 is outlined in Appendix 1 of this report.

Links with Other Committees/Boards

Key risk areas from the Quality, Safety & Experience Committee are highlighted at full Board by the Committee Chair via the Committee highlight report.

At each meeting, if any Committee referrals are identified, the Chair of the Committee or the Corporate Governance Lead will ensure that the following questions are captured to ensure a referral is managed effectively:

- What are you referring?
- Why are you referring?
- What is the outcome you are anticipating from this referral?

During the course of 2024-2025, there was one item referred to the Quality, Safety & Experience Committee from the Audit, Risk & Assurance Committee, the details of which are outlined below:

- A detailed discussion required on the reasons for the increases in medical negligence claims with the appropriate executives all being present to answer questions and provide assurance to the committee.

The item above has been scheduled for discussion at the Quality, Safety & Experience Committee taking place on 20 May 2025.

5. ACTION LOG

In order to monitor progress and any necessary follow up action, the Committee has developed an Action Log that captures all agreed actions. This has provided an essential element of assurance both to the Committee and from the Committee to the Board.

6. GOVERNANCE

The effectiveness of the Committee is monitored through the following key governance activity:

- Annual Review of the Terms of Reference & Operating Arrangements
- Committee Annual Report
- Highlight Reports from the Committee to the Health Board meetings

- Annual Committee Effectiveness Self-Assessment Survey
- Annual Cycle of Committee Business

The Corporate Governance Team maintain a "Committee Effectiveness Tracker" to ensure the above activity is undertaken at the appropriate times during the year.

Committee Annual Self-Assessment

The Committee is in the process of completing its Annual Self-Assessment for 2024-2025, any learning and themes identified following the assessment will be presented to the Committee for review and consideration.

7. ASSURANCE TO THE BOARD

The Quality, Safety & Experience Committee considers that on the basis of the work completed by the Committee during 2024 - 2025, there are effective measures in place that have delivered against its agreed Terms of Reference.

The forward work programme for 2025-2026 and beyond, ensures that the Committee retains scrutiny on key areas of activity, not exclusive to but including the following:

- Listening and Learning Stories (Patient and Staff)
- Learning lessons and sharing best practice
- Maternity & Neonate Services oversight and scrutiny (via the Childrens and Families Care Group Highlight Report)
- Dental Services
- Stroke Services
- Quality Governance arrangements
- Compliance with the Nurse Staffing Levels (Wales) Act
- Quality improvement initiatives
- Scrutiny of any Regulatory and Inspectorate Body reports
- Monitoring the activity considered by the Health, Safety & Fire Sub Committee established in August 2019

In addition the Committee Chair will meet with the lead officers and the Chair of the Board to discuss progress of the work of the Committee.

The Annual Cycle of Committee Business has continued to be presented to each meeting of the Committee during 2024/2025, alongside the Forward Work Programme. This supports and helps identify the key areas of focus for the Committee and is one of the key components in ensuring that the Committee is effectively carrying out its role. It also facilitates the management of agendas and Committee business.

8. LINKS WITH OTHER COMMITTEES

The Quality, Safety & Experience Committee will continue to have close links, and share risks with other Committees of the Board, particularly the Audit, Risk and Assurance Committee, Operational Delivery Committee and the Strategic Development Committee.

As a Sub Committee of the Quality, Safety & Experience Committee, regular highlight reports are received from the Health Safety & Fire Sub Committee. These reports are received via the main agenda when there are items contained within the alert/escalate section, and the consent agenda when there are no items requiring escalation to the Committee.

Through either specific meetings or the regular Independent Member meetings there is an opportunity for Committee Chairs to support the work of each of the Committees they Chair, share learning and avoid duplication. All Committee Chairs have access to Committee Highlight Reports to the Board.

APPENDIX 1

1. Main Agenda

During 2024 – 2025 the following items were received:

- Patient Experience/Listening & Learning Stories;
- Spotlight Presentations on:
    - Maternity/Neonates Metrics and Assurance Framework;
    - Mental Health & Learning Disabilities Quality Improvement Priorities;
    - Diagnostics, Therapies, Pharmacy & Specialties Care Group;
    - Sexual Safety & Safeguarding Briefing;
    - Welsh Ambulance Services NHS Trust (WAST) Joint Investigation Framework Thematic Review;
    - Stroke Unit Temporary Centralisation
- Report from the Clinical Executives;
- Organisational Risk Register – Committee Assigned Risks;
- Infection Prevention & Control End of Year Update;
- Infection, Prevention & Control Strategy;
- New NICE Guidance Process;
- Welsh Health Specialised Services Committee (WHSSC) Quality & Patient Safety Committee Chairs Report;
- NHS Wales Joint Commissioning Committee;
- Patient Safety, Quality & Experience Dashboard;
- Nursing & Midwifery Delivery Plan;
- Mental Health Adult Inpatient Improvement Programme;
- Stroke Services Progress Reports;
- Mortality Indicators and Mortality Reviews;
- Committee Annual Self Assessment;
- Body Store Recommendations from Welsh Government;
- Evaluation of the Success of the Falls and Pressure Damage Programme;
- Annual Report for Quality;
- CTMUHB Quality Strategy Work Plan Update;
- Health, Safety & Fire Sub Committee Highlight Reports;
- HMP Parc and Young Persons Unit – a Year on Report;
- Update on Dental Services;
- Human Tissue Authority Reportable Incident Reporting (verbal update also received via In Committee session);
- Impact and Governance around the Management of Medication Shortages;
- Ward Accreditation Progress Report;
- Coroners Cases/Inquests/Case Activity & Lessons Learned;
- Duty of Candour Annual Report;
- CTMUHB Welsh Risk Pool and Legal & Risk Services Annual Review 2023-2024 (an update was also received at an In Committee session on this matter);
- Covid 19 Inquiry Verbal Update;

- Safeguarding Strategy 2024-2027;
- Pressure Ulcer Prevalence Audit 2024;
- Safe Care Partnership 2 and Developing a Quality Management System.

Care Group Highlight Reports continued to be received from the following areas:

- Planned Care;
- Unscheduled Care;
- Children & Families;
- Diagnostics, Therapies, Pharmacy & Sciences;
- Primary Care and Community;
- Mental Health & Learning Disabilities.

The following reports were received at the In Committee Sessions:

- MBRRACE-UK Perinatal Mortality Report: 2022 Births;
- Bridgend Health Visiting Service Update;
- CCTV Cameras Prince Charles Hospital Mortuary Department;
- Listening & Learning Story – Experience of Care received from the CAMHS Services;
- Organisational Risk Register – Committee Assigned Closed Risks;
- Nationally Reportable Incident Cluster Deep Dive – Maternity & Neonatal Services, Princess of Wales Hospital

2. Consent Agenda

During 2024 – 2025 the following items were received on the Consent Agenda for Approval/Endorsement:

- Welsh Language Active Offer Policy;
- Committee Annual Report 2023-2024;
- Committee Terms of Reference;
- Putting Things Right Annual Report;
- Energy Policy;
- Management of High Voltage Electrical Systems Policy;
- CTM Learning Academy;
- Asbestos Management Plan Policy;
- Medical Gases Management Policy;
- Water Safety Plan.

During 2024 – 2025 the following items were received on the Consent Agenda for Noting/Information:

- Action Log;
- Committee Annual Cycle of Business;
- Committee Forward Work Programme;
- Clinical Policies Highlight Report;
- Controlled Drugs Local Intelligence Network Annual Report;
- Cancer Services Annual Report;
- CTMUHB Nosocomial Covid-19 Incident Management Programme Closure Report;
- Human Tissue Authority Act Progress Report;

- Healthcare Inspectorate Wales Action Plan Tracker (also periodically received via the main agenda);
- Recognition of Acute Deterioration and Resuscitation Committee Annual Report;
- Clinical Audit Quarterly Update Report and Clinical Audit Forward Plan for 2025/2026;
- Annual Unpaid Carers Report 2023/2024;
- Joint Commissioning Committee Quality & Patient Safety Committee Chairs Report;
- Infection, Prevention & Control Annual Report;
- Individual Patient Funding Request Annual Report;
- All Wales Learning from Events Framework;
- National Collaborative Commissioning Unit Quality Improvement and Assurance Service Annual Position Statement;
- Safeguarding & Public Protection Annual Report;
- Prescribing Annual Report;
- Clinical Education Annual Report;
- Antimicrobial Resistance Report;
- Organ Donation Committee Annual Report and Organ Donation Sub Committee Highlight Report;
- Access to Medicines Committee Annual Update;
- Report from the Medicines Safety Group;
- CTMUHB Infant Feeding Strategy 2025 - 2030

Family story	20th of May 2025		Gemma's Story

I would like to tell you my story

This is my second baby and I would like to tell you the story of both of my births, or what really sticks out for me during this time.

After giving birth to my baby vaginally on my first pregnancy, I was informed by the midwife that I had a tear that would need suturing, everything was set up and suturing seemed to take a while, after the midwife finished she asked the senior midwife to check my sutures, the senior midwife informed me that I had been sutured incorrectly and would need to be sutured again.

I didn’t mind this so much but this took a while and it was ages before I got to bond with my baby. Nobody asked me if I wanted to hold my baby, just presumed I wouldn’t as I was being sutured.

During my second pregnancy, I was booked for an induction of labour for my baby being large for dates, I read the leaflet and felt it was great, but the discussion around the induction process was very one sided and I would have really liked more of an informed discussion about my care.

On admission to the ward, I felt that no one really introduced themselves to me and I didn't have a clue where anything was on the ward.

I received a propess pessary as my bishop score was 3 and later on I become uncomfortable with tightening's. During the induction process, I felt one midwife gave me a fully informed choice regarding having a prostin and I wholeheartedly felt part of the decision making process.

When there was a change of shift, the next midwife pushed the induction agent onto me and I felt I had no other option but to have a prostin.

Not long after the prostin, my waters broke and I started to contract regularly.

The midwife asked to asses me on the ward but I was in so much pain, I just couldn’t tolerate an examination.

The ward staff transferred me to labour ward, where I was offered pain relief and I then consented to be examined.

I was told I was 2cms dilated and in the latent phase of labour.

I was offered and accepted pethidine at this point but within half an hour, I was pushing, I buzzed the buzzer for help and within 15 minutes my baby was born safely. My placenta took another 20 minutes to be delivered and I was then informed I had a third degree tear.

Due to the activity on labour ward there was a delay of a few hours before I was transferred to theatre, and when I did get there, I was taken back out for a little while due to another emergency before finally having my tear sutured.

I gave birth at 15:20 and was sutured at 20:05.

I didn’t mind the delays, as everyone kept me up to date and if there was an emergency, I would much rather they had the attention they need, just as I would expect for me, if I was in that situation.

This is the second time I have needed suturing and what makes me sad, is that on both occasions I felt I missed out on crucial bonding with my baby, I didn’t get the opportunity to dress my baby for the first time, or hold them or feed them.

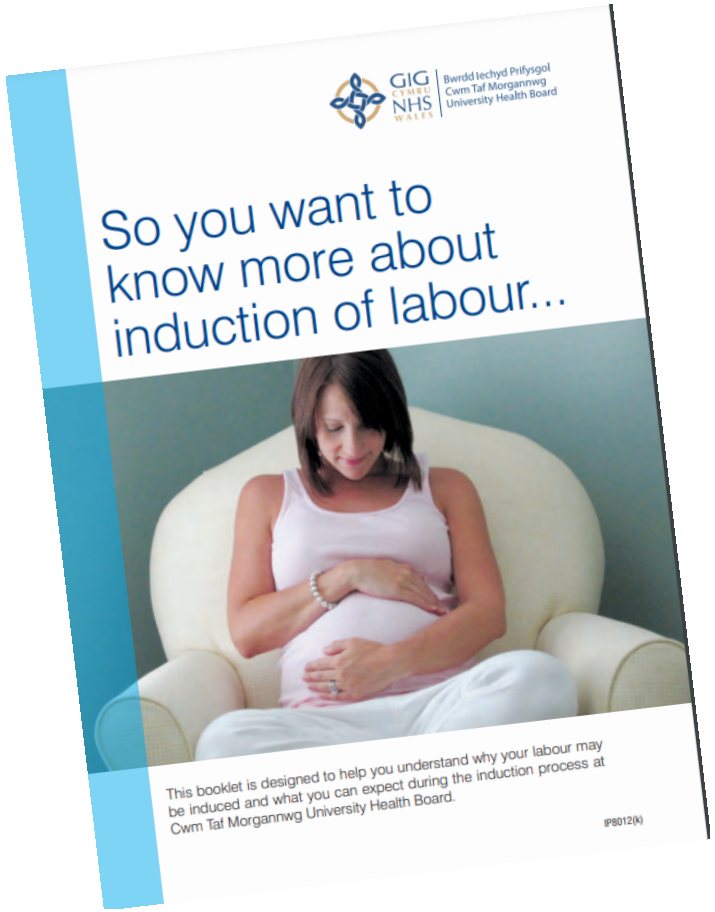
I suppose your wondering why I'm sharing my story?

I just want to remind staff to introduce themselves and not presume we know where everything is, including the bathroom!

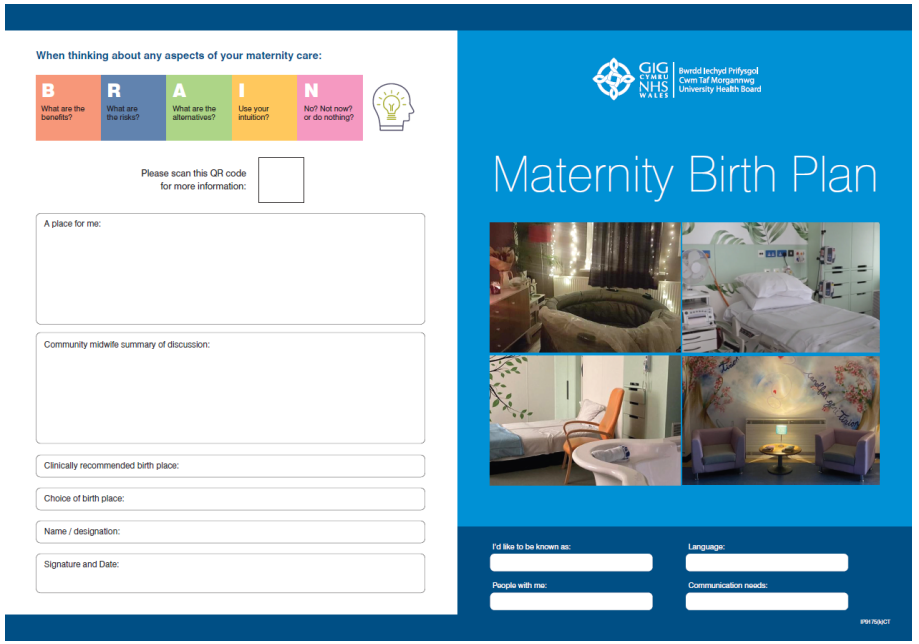
And when suturing women, don't presume they don't want to hold or feed their baby, give us options of when these things should be done.

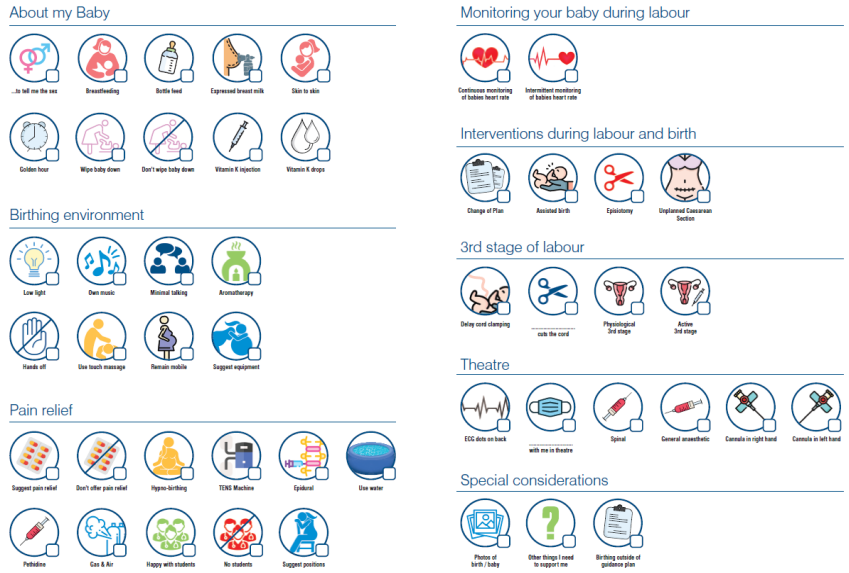
Thank you for listening to my story.

Recommendations for moving forward:	• Ensure updated versions of current IOL leaflet are in circulation and readily available in all clinical areas. • In the process of updating the IOL leaflet to include the BRAIN acronym which will encourage better conversation around the process. • In the process of creating an IOL workshops that are run by midwives discussing benefits / risks • Have open conversations around suturing and skin to skin / feeding / changing baby to ensure families have choices and feel part of decision making during birth plan appointment


GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board
So you want to know more about induction of labour...
This booklet is designed to help you understand why your labour may be induced and what you can expect during the induction process at Cwm Taf Morgannwg University Health Board.
IP8012(K)


What are my rights during my maternity care?
When thinking about any aspect of your maternity care
(any test, screening test, intervention, procedure or examination)
THINK...?
B What are the Benefits?
R What are the Risks?
A What are the Alternatives?
I What does your intuition (gut) say about what's right for you?
N What would happen if you said No, or Not now, or did Nothing? (and took some time to think)


When thinking about any aspects of your maternity care:
B What are the benefits?
R What are the risks?
A What are the alternatives?
I Use your intuition?
N No? Not now? or do nothing?
Please scan this QR code for more information:
A place for me:
Community midwife summary of discussion:
Clinically recommended birth place:
Choice of birth place:
Name / designation:
Signature and Date:
Maternity Birth Plan
I'd like to be known as:
Language:
People with me:
Communication needs:


About my Baby
Birthing environment
Pain relief
Monitoring your baby during labour
Interventions during labour and birth
3rd stage of labour
Theatre
Special considerations

Agenda Item
4.2

Quality, Safety & Experience Committee

Executive and Independent Member Walkaround Framework Cover Paper

Dyddiad y Cyfarfod / Date of Meeting	20/05/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	Ana Llewellyn, Nurse Director
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	Ana Llewellyn, Nurse Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Approval

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group /Forum Individuals	**Date**	**Outcome**
Board Development Session	12/12/2024	Endorsed

Acronyms / Glossary of Terms	

1. Situation /Background

1.1 The Health Board has had a programme of Executive and Independent Member Walkaround for some time.

1.2 In December 2024 a review of the evidence base underpinning Walkarounds was presented to a Board Development Session (appendix 1)

1.3 Recommendations for review of the existing framework were also proposed.

1.4 The revised Executive and Independent Member Walkaround Framework is attached for approval by Committee (appendix 2).

2. Specific Matters for Consideration

2.1 Executive and Independent Member Walkarounds are an opportunity to have exposure to practice, to seek to understand and to convey that safety is a priority focus for the Board.

2.2 The evidence base for Walkarounds centres on their impact on patient safety culture and staff experience, rather than having a focus on assurance and inspection-like activities. Informality, curiosity and a focus on amplifying good practice are associated with more favourable outcomes on safety culture.

2.3 Notably, exposure to as many staff as possible was also associated with better outcomes so ensuring good communication across the organisation will be key in ensuring a positive Walkaround programme.

3. Key Risks / Matters for Escalation

3.1 The key risk in embedding an evidence based Walkaround Framework is that there may be a default to surveillance orientated walkarounds, particularly when practice issues are observed, and this is associated in the literature with poorer outcomes on culture. Executives and Independent Members will need to ensure that any practice issues are communicated to senior leaders, with an emphasis on appreciative feedback to wider colleagues.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Inspiring People
	If more than one applies please list below: Improving Care
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable
	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))*	Culture and Valuing People
	If more than one applies please list below: Data to Knowledge; Leadership; Learning, Improvement and Research; Whole-systems Perspective
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Person Centred
	If more than one applies please list below: Safe, Effective, Equitable, Efficient, Timely
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	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: No changes to service provision proposed
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: No changes to service provision proposed
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.

5. Recommendation

5.1 The Committee is asked to **APPROVE** the revised Executive and Independent Member Walkaround Framework.

6. Next Steps

6.1 The Framework will become operational with immediate effect and will inform the approach taken by Board members when undertaking visits to Health Board teams and services.

CTM 2030
Ein Hiechyd
Ein Dyfodol
DATBLYGU CYMUNEDAU
IACHACH GYDA'N GILYDD

CTM 2030
Our Health
Our Future
BUILDING HEALTHIER
COMMUNITIES TOGETHER

Executive / IM Walkarounds

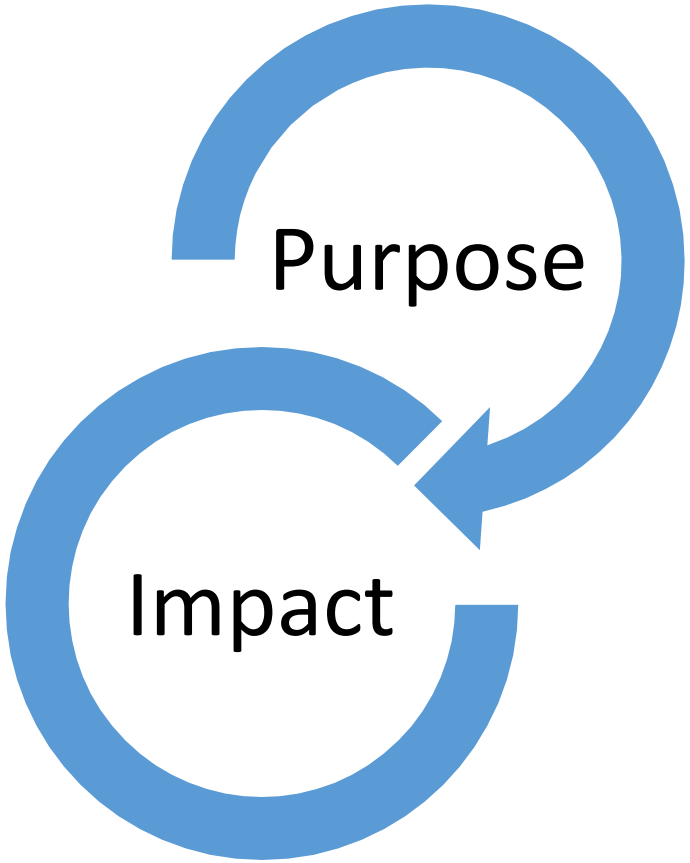
Board Development 12th December 2024

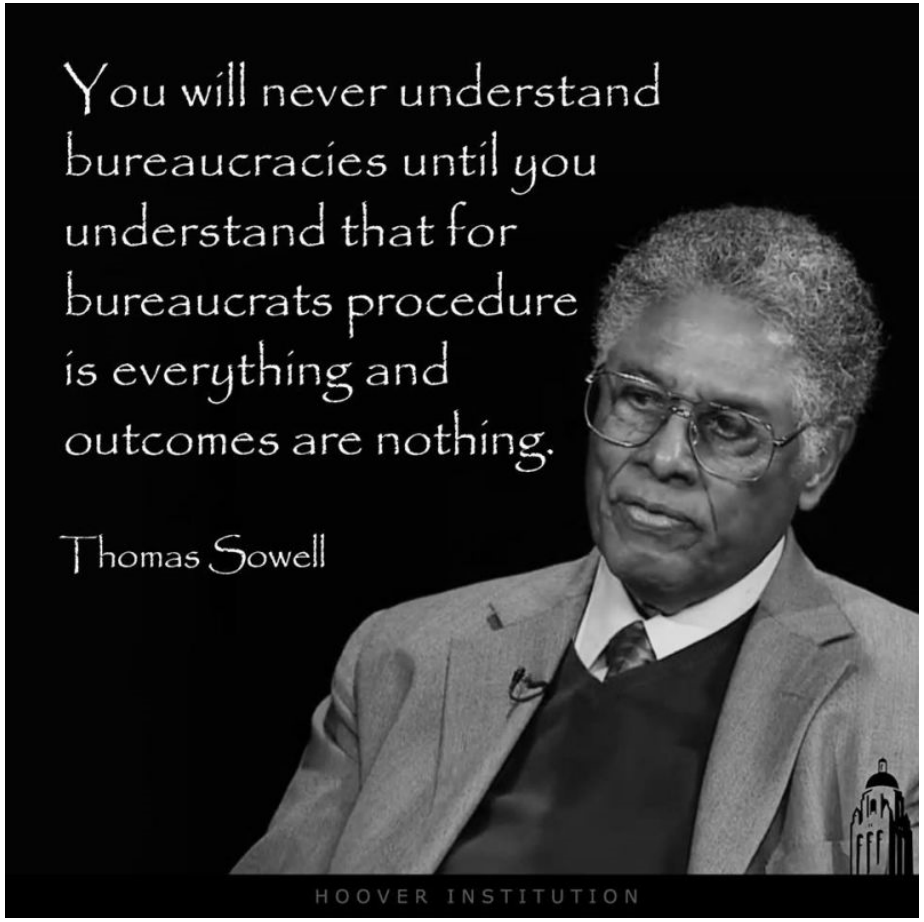
Ana Llewellyn

The Board Dilemma

- Planned versus Unplanned
- Structured versus Unstructured
- Walkaround Methodology
- The So What? - Governance and oversight of actions
- Who should be included in the walkaround?

Approach


Purpose
Impact


You will never understand bureaucracies until you understand that for bureaucrats procedure is everything and outcomes are nothing.
Thomas Sowell
HOOVER INSTITUTION

Purpose

So…what's the point of walkarounds?

What's your why?

The Role of the Board

"NHS boards are unitary boards made up of executive and independent members. Acting as stewards of the organisation's resources and responsible for overall governance, the board should act as the controlling mind of the organisation. The board should agree a vision, develop and set strategies, exert leadership, ensure accountability and transparency and ensure that the executive of the organisation is held to account."

Welsh NHS Confederation

Purpose: Quality Framework

People:

- Staff Experience
- Patient Experience
- SAFETY CULTURE

Best Practice Guidance: IHI

Patient Safety Leadership WalkRounds™ 2000

- Commit to weekly walkrounds to demonstrate commitment to building a culture of safety
- Informal method to show support for staff-related errors
- Leaders who focus solely on safety culture have greater impact than those who include patient satisfaction, budgets etc

Best Practice Guidance: IHI

Toolkit / Prompt Questions:

- "Can you think of any events in the past day or few days that have resulted in prolonged hospitalization for a patient?"
- "Have there been any near misses that almost caused patient harm but didn't?"
- "Have there been any incidents lately that you can think of where a patient was harmed?"
- "What aspects of the environment are likely to lead to the next patient harm?"
- "Is there anything we could do to prevent the next adverse event?"
- "Can you think of a way in which the system or your environment fails you on a consistent basis?"
- "What specific intervention from leadership would make the work you do safer for patients?"
- "What would make the WalkRounds™ more effective?"
- "How are we actively promoting a blame-free culture and working on the development of a blame-free reporting policy?"

Best Practice Guidance: IHI

Success Measures:

- Response to cultural survey of front-line workers and managers (process measure)
- Number of errors reported per month from voluntary reporting systems (outcome measure)
- Number of safety-based changes made by managers per year
- Percent of changes in overall surveillance data (for example, infection rates)

The Evidence Base on Impact

Kaiser Permanente 2005 Evaluation

Staff: Tangible improvements in safety climate questionnaires; increased reporting errors / near misses; improved understanding of patient safety

Managers: implementation of new patient safety measures; self-reported changes to approach to errors

Executives: self-reported improved understanding; opportunities for 'just culture' discussions; action taken

Graham S, Brookey J, Steadman C. Patient Safety Executive Walkarounds. In: Henriksen K, Battles JB, Marks ES, Lewin DI, editors. Advances in Patient Safety: From Research to Implementation (Volume 4: Programs, Tools, and Products). Rockville (MD): Agency for Healthcare Research and Quality (US); 2005 Feb. PMID: 21250012.

The Evidence Base on Impact

2021 American Study: Safety Culture and Workforce Well-Being Associations with Positive Leadership WalkRounds

- Slight departure from IHI approach in that it took broader focus on burnout, staff experience, culture in broadest sense – Postive Leadership WalkRounds
- Prompt questions focussed on culture /success
- Again, focus on informal executive enquiry seeking to understand but also amplify success / what's working well
- **Outcomes:** Improved safety climate, lower levels of burnout, leaders self-reported increases in positivity / energy, association between exposure and outcome

Safety Culture and Workforce Well-Being Associations with Positive Leadership WalkRounds - ScienceDirect

Evidence Base on Impact

Qualitative study 2014:WalkRounds in Practice. Corrupting or Enhancing?

- 82 semi-structured interviews English NHS
- Divergence in how walkrounds are put into practice
- Mixed benefit linked to difference in espoused model versus focus on surveillance orientated walkrounds
- May encourage staff to be on best behaviour; can be disruptive 'seagull management'; perceived as PR exercises; reinforce power differentials
- Those walkrounds that focused on transparency, building trust and informal conversations perceived more positively

Walkrounds in Practice: Corrupting or Enhancing a Quality Improvement Intervention? A Qualitative Study - ScienceDirect

Evidence Base on Impact

BMJ 2023: Impact of leadership walkarounds on operational, cultural and clinical outcomes: a systematic review

- Overall, evidence exists to suggest a positive association of LWs on operational and cultural outcomes.
- Longer exposure with feedback mechanisms increases impact – those most engaged directly in walkround regarded them more favourably
- LWs promote trust and shared accountability
- Some suggestion that LWs might be more effective in areas with lower baseline safety culture climates

https://www.researchgate.net/publication/374691342_Impact_of_leadership_walkarounds_on_operational_cultural_and_clinical_outcomes_a_systematic_review/fulltext/652941f11a05311a23fbd175/Impact-of-leadership-walkarounds-on-operational-cultural-and-clinical-outcomes-a-systematic-review.pdf?origin=publication_detail&_tp=eyJjb250ZXh0Ijp7ImZpcnN0UGFnZSI6InB1YmxpY2F0aW9uIiwicGFnZSI6InB1YmxpY2F0aW9uRG93bmxvYWQiLCJwcmV2aW91c1BhZ2UiOiJwdWJsaWNhdGlvbiJ9fQ

Existing Approaches in CTM

Approach	Risks	Benefits
Existing Executive / IM Walkaround	Experienced by colleagues as 'assurance' visits / not informal enough Limited focus on safety culture Risk of bureaucracy	Great opportunity for colleagues to meet Board
Purposeful Visits	Experienced by colleagues as 'assurance' visits. Risk of bureaucracy	Has its origins in IHI methodology
15 Steps	If delivered by exec / IM could be perceived as assurance visit Focus on 'place'	Great methodology – best delivered by patients, public, peers
Shadowing / Back to the Floor	Ability to scale and touch whole organisation	Listening – focus on culture Increases exec / IM understanding

Recommendations

Option 1: Walkaround based on IHI Methodology

- **Planned / Unplanned:** definitely planned
- **Structure:** Informal, conversational, showing interest in service experiences
- **Team:** with a service leader to pick up actions and to speak to as many people as possible
- **The So What:** Board evaluation of impact should focus on staff experience of walkaround / impact on safety culture / amplification of what works well (Safety11)
- **Who Should be Included:** staff, managers, exec/IM – actions owned by service
- **To Do It Well:**
  - Must be prioritised
  - Needs great comms so that impact extends across organisation
  - Thanks and feedback to teams
  - More listening and understanding than bringing board assurance role
  - Whole organisation not just DGHs

Recommendations

Option 2: Day in the Life Of…

- Shadowing / emersion in a team
- Perhaps focus on a theme?
- Opportunity to focus on culture / demonstrate Board interest
- Opportunity to triangulate, touch and feel
- Focus on whole organisation and all services
- Needs great comms and IM/Exec reflections focussing on IM/Exec learning
- **Caution:** limited evidence base; need to guard against bureaucracy / assurance seeking behaviours; sustainability

Executive Director & Independent Member Quality & Patient Safety Walkarounds Framework-revised April 2025

1.0 Aim

Executive Director and Independent Member Patient Safety Walkarounds are embedded into Cwm Taf Morgannwg University Health Board (CTMUHB) and provide an opportunity to promote a culture of patient safety and commitment to ensure the quality of care being delivered to our patients is of a high standard and that in all we do the Values and Behaviours of CTM UHB are adhered to.

The Health Board has multiple means of internal assurance, including audit, peer review and accreditation and Walkarounds are not intended to provide additional surveillance. Walkarounds will allow for Board Members to gain first-hand awareness, knowledge and understanding of the experience and outcomes for people receiving care and is a fundamental cornerstone of the Health Boards Quality, and Safety Framework.

CTM UHB aims to ensure that quality and patient safety is firmly at the heart of everything it does, with a culture that enables the active involvement of the people who receive care along with those who provide it, in every part of the organisation, with a focus on learning and improvement.

2.0 Purpose

Executive Director and Independent Member Quality & Patient Safety Walkarounds will provide an opportunity to enhance the patient safety culture by connecting senior leaders, clinical staff, support staff patients and carers. It will facilitate an opportunity to come together typically in a patient care setting to openly discuss patient safety, best practice, concerns and issues and staff experience.

The objective will be to increase visibility of the senior Executive team and Independent members across the whole of CTM UHB, to provide an opportunity to celebrate success stories and to convey to colleagues that patient safety is the key priority for the Board.

3.0 The Evidence Base

Executive Walkarounds were first described in the literature in 2000 by the Institute for Health Improvement and since then they become commonplace in health services but have often deviated from the original intent of focussing on patient safety.

The review of the literature in 2024 provides some indicators of positive impact and are helpful considerations for Executive and Independent Members when undertaking Walkarounds:

- Walkarounds are an opportunity to demonstrate to colleagues that the Board has a commitment to building a culture of safety

- A focus on safety culture during visits is associated with positive impact on safety metrics

- Informality, curiosity and a non-expert stance is the preferred mode of engaging with colleagues. Executive and Independent Members should seek to understand.

- Assurance seeking, surveillance and inspection-like behaviours are associated with poorer safety culture outcomes

- Appreciative enquiry, focussing on success and what's working well is a helpful approach

- Walkarounds that are focused on transparency, building trust, shared accountability and informal conversations are perceived more positively

- Overall, evidence exists to suggest a positive association of Walkarounds on operational and cultural outcomes.

- Longer exposure with robust feedback mechanisms increases impact – those most engaged directly in Walkaround regarded them more favourably

- There is a caution in the literature that Walkarounds can be disruptive, perceived as PR exercises and / or reinforce power differentials so it is important to interact

4.0 Process

- A 'Buddy Team' will consist of an Executive Director & Independent Member (detailed in Appendix A)

- The Walkarounds will take place across all Care Groups/sites/areas/wards/departments within CTM UHB including Primary Care and Community settings

- Walkarounds will comply with Health Board hospital visiting guidance

- Walkarounds should not be undertaken in an area of the Health Board which has been declared as an infection outbreak situation

- Walkarounds should not detract from the safe and effective provision of services

- Walkarounds will be pre-arranged and for the purpose of these Walkarounds, there will be NO Unannounced Walkarounds

- Natural, informal conversations demonstrating curiosity are encouraged and the sample questions in Appendix C are offered as potential conversation starters with a focus on patient safety culture.

- At the natural end of the Walkaround, immediate findings will be verbally fed back to the clinical lead/manager who supported the Walkaround and followed up with an email of thanks in the following 3 working days.

- Although the focus is on amplifying good practice it is possible that urgent patient safety matters will have been noted during a Walkaround. In the event of such matters being observed, these will be communicated to the clinical lead / manager and escalated to the Care Group triumvirate as a matter of priority.

- Wider organisational communication is important in amplifying impact of Walkarounds and Executive Directors and Independent Members are encouraged to either be supported by Communications colleagues or to

take photographs during visits, adhering to confidentiality and consent principles.

- To support organisational communication the Executive Director & Independent Member may complete and return the feedback summary template to the generic Walkaround email address, within 10 working days of the Walkaround CTM.PatientSafetyWalkarounds@wales.nhs.uk

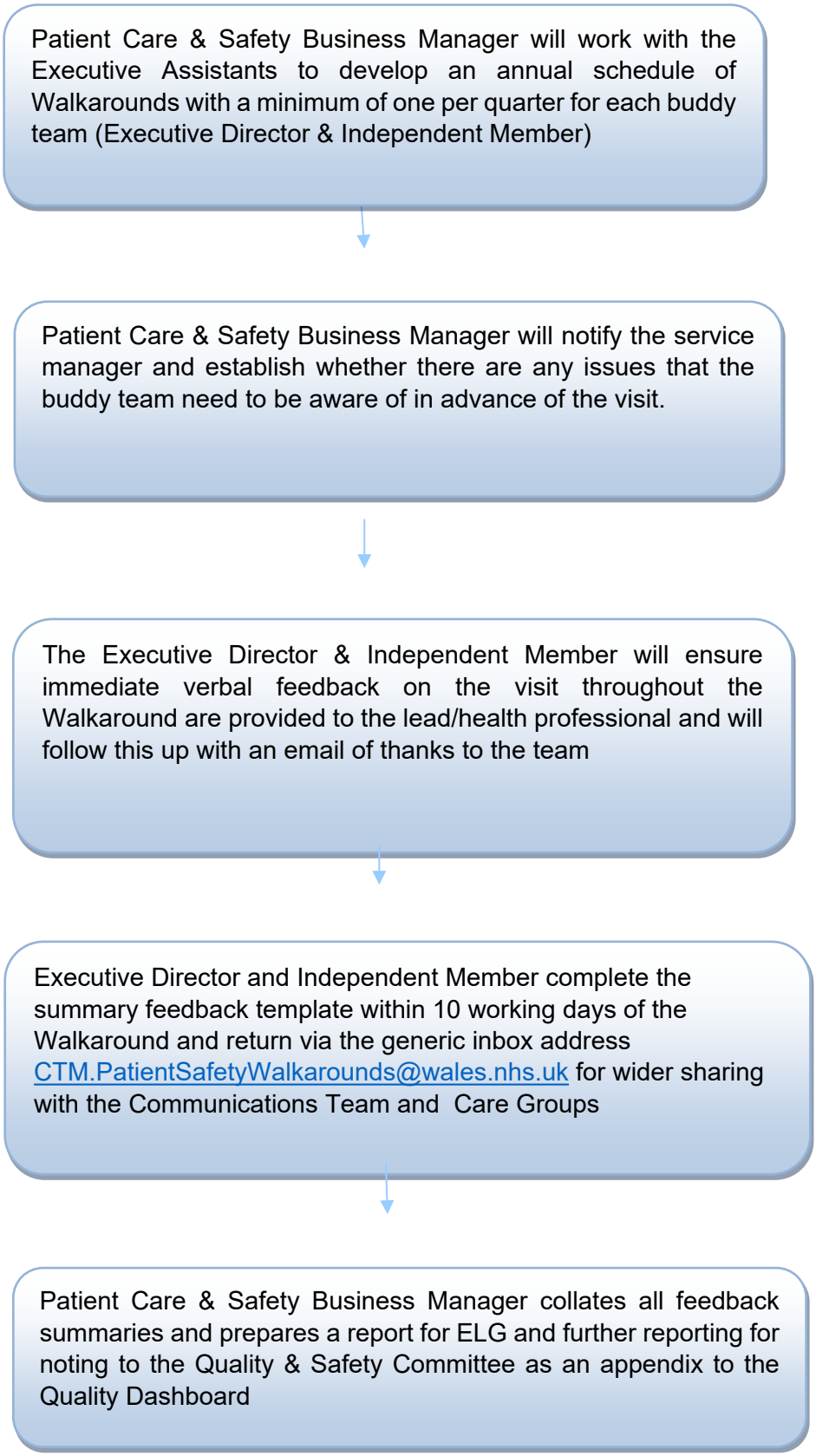
- The Patient Care and Safety Business Manager will share the completed feedback summary with the Communications team and will collate the feedback for annual evaluation.
- The anticipated duration for a Walkaround is not prescriptive and is determined on the discussion and engagement at the time however, it is envisaged that the Walkaround process will take no more than 1.5 hours from start to immediate verbal feedback and end.

3.1 Role and responsibilities:

- The Walkaround Buddy Team will be required to **arrive bare below the elbow** for the Walkaround, when taking place in any of the ward based clinical areas.

- The Executive Director & Independent Member will ensure immediate feedback is provided to the lead/health professional for the site/area/ward and then reported on the feedback summary template in Appendix B and submitted via the generic email inbox CTM.PatientSafetyWalkarounds@wales.nhs.uk

3.2 Process Flow chart for Walkarounds:



Supporting documents for the Executive Director & Independent Member Walkarounds:

Appendix A - Walkaround Buddy Team (Executive Director and Independent Member)

Appendix B - Feedback Summary Proforma 'buddy' partners to record findings and report findings via CTM.PatientSafetyWalkarounds@wales.nhs.uk

Appendix C – Suggested prompts and/or questions for engaging in conversation during the Walkaround process

Appendix A

Executive Director & Independent Member Walkaround

'Buddy Teams'

	Executive Director	Independent Member
1.	Executive Medical Director Dom Hurford	Dilys Jouvenat
2.	Executive Director Therapies & Health Sciences Lauren Edwards	To be confirmed
3.	Chief Operating Officer Gethin Hughes	Hayley Proctor
5.	Executive Nurse Director and Deputy Chief Executive Greg Padmore-Dix	Patsy Roseblade
6.	Executive Director for People Hywel Daniel	Carolyn Donoghue
7.	Executive Director of Public Health Philip Daniels	Neil Mesher
8.	Executive Director of Strategy & Transformation Claire Thompson	Helen Lentle
9.	Chief Executive Paul Mears	To be confirmed
10.	Executive Director of Finance Sally May	Rachel Rowlands
11.	Director of Digital Stuart Morris	Kath Palmer
12.	Health Board Chair Jonathan Morgan	Geraint Hopkins

Appendix B

Executive Director & Independent Member Walkaround

Feedback/Summary Report

Date of Walkaround	
Visited Ward/Area/Site	
Executive Director	
Independent Member	
Area Key Contact	
Additional comments/information	

Areas of Good Practice/ Achievements to Celebrate / Key Issues
What you learnt / What insight did you gain / How will visit influence your work
Any material to support comms team e.g. photographs etc
Any Other Matters

*Once complete please forward to the generic inbox via email to CTM.PatientSafetyWalkarounds@wales.nhs.uk within 10 working days of the Walkaround.

Appendix C

Prompts or suggested questions for consideration during the Walkaround are listed below. Your curiosity and engagement is more important that following a question script – the teams will appreciate your informality and showing a genuine interest in their work.

Questions/prompts to consider as an Executive Director or Independent Member

- Can you think of any events in the past day or two days that have resulted in prolonged hospitalisation or prolonged care for a patient?
- Have there been any near misses that almost caused patient harm and /or harm to yourself or colleagues but didn't?
- Have there been any incidents lately that you can think of where a patient, yourself or colleagues were harmed?
- What aspects of the environment are likely to lead to the next patient or staff harm?
- Is there anything we could do to prevent the next adverse event?
- Can you think of a way in which the system or your environment fails you on a consistent basis?
- What specific intervention from senior colleagues would make the work you do safer for patients and / or for you and your colleagues?
- What would make Executive and Independent Member visits more effective?
- How are we actively promoting a blame-free culture and working on the development of blame-free reporting?
- What works well in your department?
- What would you like to do more of to promote patient safety / staff safety?
- What could others learn from your service?
- What would you like to do to improve patient experience, your experience and that of your teams at work?
- What are you most proud of?

Agenda Item
5.1

Quality, Safety & Experience Committee

Spotlight Report
Update on cluster of incidents within maternity services at the Princess of Wales Hospital (March – May 2025)

Dyddiad y Cyfarfod / Date of Meeting	20/05/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	Director of Midwifery & Nursing, Children & Families Care Group Head of Midwifery & Neonates, Children & Families Care Group (Bridgend) Medical Director, Children & Families Care Group
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	Head of Midwifery & Neonates, Children & Families Care Group (Merthyr & Cynon)
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group /Forum Individuals	**Date**	**Outcome**
Maternity and Neonatal Safety Board	20/03/2025	Approved
Quality, Safety & Experience Committee	25/03/2025	Approved
Children & Families Care Group Maternity & Neonatal	24/04/2025	Approved

Programme Board (Monitoring & Oversight)		

Acronyms / Glossary of Terms	
BR+	Birthrate Plus (workforce acuity / staffing tool)
CTMUHB	Cwm Taf Morgannwg University Health Board
EWN	Early Warning Notification
MEWS	Maternity Early Warning Score
MNPB	Maternity & Neonatal Programme Board
MNSB	Maternity & Neonatal Safety Board
NRI	Nationally Reportable Incident
NEWTT 2	Newborn Early Warning Track & Trigger
PACE	Playfulness, Acceptance, Curiosity & Empathy (A trauma informed care approach)
PALS	Patient Advisory Liaison Service
PROMPT	Practical Obstetric Multi-Professional Training
QSE	Quality, Safety & Experience

1. Situation /Background

1.1 Three maternity nationally reportable incidents at the Princess of Wales Hospital Cwm Taf Morgannwg University Health Board (CTMUHB) occurred between 8th March and 13th March 2025.

1.2 A further nationally reportable incident occurred on 10th May 2025.

1.3 All incidents have occurred since the re-opening of the maternity unit on 17th February 2025.

1.4 All four cases are Nationally Reportable Incidents (NRI) and Early Warning Notifications (EWN) were submitted to Welsh Government on 14th March 2025, the fourth case was reported on 13th May 2025.

2. Specific Matters for Consideration

2.1 Staff de-brief and support for well-being in place.

2.2 Investigating Officers and Family Liaison Officers appointed.

2.3 Of the March incidents, two incidents are being investigated internally (multi-professional approach, external support requested to investigate one incident). The incident from 13th May will be externally reviewed.

2.4 A review of clinical outcomes across both obstetric units has been completed. The review found that outcomes across both units were broadly the same with the exception of major obstetric haemorrhage and increase in 3rd/4th degree tear in vaginal births – no themes identified within the review of cases.

2.5 Incidents and clinical outcome review presented at Maternity and Neonatal Safety Board on 20th March 2025; Quality, Safety and Experience Committee on 25th March 2025; Maternity and Neonatal Programme Board (oversight and assurance) on 24th April 2025.

2.6 A RAPID Multi professional review for incident number 4 took place on 12th May 2025.

2.7 Discussion with Care Group and Executive team held on 13th May to agree further action.

3. Key Risks / Matters for Escalation

3.1 Immediate make safes for all incidents have been completed.

3.2 Introduction of dedicated recovery area completed, standardising provision of care across both obstetric units.

3.3 Monitoring and compliance audits for fluid balance and MEWS (Maternity Early Warning Score) completed.

3.4 Hysterectomy equipment available in obstetric theatre environment during the temporary closure of the theatres at Princess of Wales Hospital.

3.5 Additional support and actions include:

3.5.1 Well-being service undertaking PACE review to support teams returning to PoW.

3.5.2 Handover times reviewed to align with Prince Charles Hospital.

3.5.3 '15 steps challenge' with service users undertaken in April, Patient Advisory Liaison Service (PALS) team undertaking unannounced visits.

3.5.4 Fortnightly partnership meetings in place with trade union colleagues

3.5.5 Midwifery workforce review commenced April 2025 across all sites to ensure Birthrate + safe staffing compliance.

3.5.6 Increased training and support for teams in line with the All Wales Incident Management Framework.

3.5.7 Launch of national MEWS and NEWTT 2 on 6th May 2025, working with critical care and resuscitation service colleagues.

3.5.8 Additional learning opportunities including emergency skills and drills underway. Multi-professional obstetric training (PROMPT) compliance at 82% in March 2025.

3.5.9 Multi-Disciplinary risk-assessed booking system introduced for elective caesarean sections and induction of labour.

3.5.10 Flow and acuity monitored via Birthrate Plus acuity tool, senior midwives attend wider site escalation meetings daily.

3.5.11 Team-building events planned for clinical leads and senior leaders within maternity and neonatal services in June 2025.

3.5.12 Support requested to ensure dedicated elective obstetric theatre cover (nursing, obstetric and anaesthetic) at Princess of Wales Hospital

3.5.13 Senior midwifery presence increased within maternity (intrapartum care).

3.5.14 Increased Clinical Director presence at Princess of Wales Hospital

3.5.15 External review of cases commenced.

3.5.16 Clinical Director and Head of Midwifery prospectively reviewing all elective activity to ensure safe, timely care is provided in the most appropriate setting.

3.5.17 Obstetric consultant attendance for all obstetric procedures (e.g. instrumental and caesarean section birth). To include a comprehensive review of the national trigger list and provide assurance around compliance.

3.6 Ongoing monitoring and review will be via the following activities:

3.6.1 Maternity and Neonatal Programme and Safety Boards continue to monitor performance and improvements.

3.6.2 Continue to work with national maternity and safety programme to ensure learning is adopted and embedded across all sites.

3.6.3 Continue to work with critical care / outreach teams to further enhance care of critically ill and deteriorating patients.

3.6.4 Ensure all investigations are progressed in accordance with the national incident management framework and learning is embedded across all service areas.

4. 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: • Creating Health • Inspiring our People
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Starting Well
	If more than one applies please list below: • Growing Well • Living Well
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))*	Whole-systems Perspective
	If more than one applies please list below: • Culture and Valuing People • Leadership • Learning, Improvement and Research • Data to knowledge
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Safe
	If more than one applies please list below: • Timely • Efficient • Equitable • Effective • Person Centred
	No - Not Applicable

Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	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. (At the time of writing)	
Enw da / Reputational	Yes (Include further detail below)	
	Trust and confidence could be impacted which may impact the reputation of the health board.	
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.	

5. Recommendation

5.1 The Committee is asked to **NOTE** the improvements made and actions taken to date.

6. Next Steps

6.1 Ongoing monitoring and review will continue as outlined in section 3.6 of this report.

Agenda Item
5.2

Quality, Safety & Experience Committee

Clinical Executive Directors Update Report

Dyddiad y Cyfarfod / Date of Meeting	20/05/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	1. Richard Hughes-Deputy Executive Director for Nursing and Midwifery 2. Dom Hurford-Executive Medical Director 3. Lauren Edwards-Executive Director for Therapies and Health Sciences, 4. Philip Daniels-Executive Director Public Gethin Hughes-Chief Operating Officer Health
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	1. Greg Padmore-Dix-Executive Director for Nursing and Midwifery 2. Dom Hurford-Executive Medical Director 3. Lauren Edwards-Executive Director for Therapies and Health Sciences, 4. Philip Daniels-Executive Director Public Health
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	1. Greg Padmore-Dix-Executive Director for Nursing and Midwifery 2. Dom Hurford-Executive Medical Director 3. Lauren Edwards-Executive Director for Therapies and Health Sciences, 4. Philip Daniels-Executive Director Public Health

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group /Forum	**Date**	**Outcome**

Acronyms / Glossary of Terms	
CEO	Chief Executive Officer
AHPs	Allied Health Professionals

1. Situation /Background

1.1 This paper aims to provide assurance to members of the Quality, Safety & Experience Committee in respect of the successes and challenges faced and highlighted by each of the four Clinical Executive Directors.

- Greg Padmore-Dix Executive Director Nursing, Midwifery & Patient Care/Deputy CEO
- Dom Hurford-Executive Medical Director
- Lauren Edwards-Executive Director of AHPs and Health Science
- Philip Daniels-Executive Director of Public Health

1.2 Additional information and assurance against the Quality metrics, together with Patient Experience activity, continues to be reported to each of the Quality, Safety & Experience Committee meetings through the Quality, Safety & Patient Experience Dashboard.

2. Specific Matters for Consideration

Section 2.1 Clinical Executive Director updates: Nursing & Midwifery

Specific Matters for Consideration:

2.1.1 Digital Exclusion in Maternity Care

The initiative, led by the Senior Midwife for Clinical Informatics at Cwm Taf Morgannwg University Health Board, addresses the significant issue of digital exclusion among maternity service users. This initiative was recognised with the Chief Nursing Officer (CNO) for Wales and the Royal College of Midwives Wales (RCM) Quality Improvement award for 2025. The project integrates the Good Things Foundation's national data bank into maternity services to provide essential connectivity through SIM cards and data packages to pregnant women experiencing data poverty.

An 8-week pilot project revealed that 7.8% of women were identified as digitally excluded, with 33.8% of the sample identifying themselves as excluded despite not meeting the data bank criteria. The initiative has positively impacted service users, improving access to care, support groups, and translated materials, benefiting families and children's learning. However, challenges remain, such as eligibility restrictions and gaps in device access, highlighting the need for a device bank to ensure comprehensive digital inclusion. The project aligns with the Welsh Government's 'A Healthier Wales' scheme, advocating for seamless, integrated health and social care tailored to individual needs while reducing inequalities.

2.1.2 Substantial Assurance in Service Users Experience

The internal audit review of the service user/patient experience audit concluded with substantial assurance, highlighting the effectiveness and positive impact of the current processes. The audit praised the use of the CIVICA system, which allows service users to provide feedback through various channels, generating valuable reports. Additionally, the implementation of the new Patient Reported Outcome Measures (PROMs) system, 'Promptly', is underway, integrating service user data from PREMs and 'Have Your Say' surveys. These initiatives demonstrate the Health Board's commitment to enhancing patient experience and ensuring respectful and professional care.

While the audit presented several positive findings, it also highlighted valuable opportunities for development, particularly in addressing the under-representation of certain patient groups in the feedback processes and the need for a robust patient experience strategy. The management team has embraced these insights and is proactively working to implement the recommended improvements. The recent release of the Welsh Government's service user experience framework will serve as a valuable resource in shaping the Health Board's strategy.

2.1.3 Present Challenges

Unscheduled Care Nurse Director Vacancy

The vacancy for the Care Group Nurse Director in Unscheduled Care presents challenges in maintaining the established oversight of clinical quality and governance. During this transition period, the Care Group collaborates with the Executive Director of Nursing, Deputy Executive Nurse Director, Deputy Medical Director, and Planned Care Nurse Director to implement an interim plan. This plan oversees clinical quality, governance, and professional issues. To address potential gaps in leadership, an interim Head of Quality is being recruited to manage the Unscheduled Care quality portfolio. This role is essential to ensure that quality standards are upheld, and any issues are promptly addressed while the search for a new Nurse Director is underway.

Effective coordination and communication among the various directors involved in the interim plan are also crucial. The Deputy Executive Nurse Director, Deputy Medical Director, and Planned Care Nurse Director work closely to ensure a unified approach to managing clinical quality and governance. The recruitment process for the new Nurse Director itself is also a challenge, as finding a suitable candidate with the necessary qualifications and experience in Unscheduled Care can be time-consuming. During this period, the interim Head of Quality and supporting Directors provide additional support to ensure the Care Group continues to function effectively and patient care is not compromised.

2.1.4 Patient Care and Safety Directorate Recovery Plan

The Deputy Executive Director of Nursing has initiated a recovery plan for the Patient Care and Safety Directorate. This plan involves the temporary redeployment of key personnel to provide essential support. The focus areas include addressing legal functions and concerns and Learning from Events Reports (LFERS).

Developed in collaboration with vital stakeholders, such as the Welsh Risk Pool and the Legal and Risk teams, this recovery plan has facilitated the review and standardisation of processes within the directorate. The ongoing Organisational Change Process (OCP) for the service is anticipated to conclude within the next week.

The measures implemented under this recovery plan aim to enhance patient care and safety. By closely collaborating with stakeholders and utilising the expertise of redeployed members, the directorate is committed to achieving its objectives and improving patient outcomes.

Section 3 Medical Directorate

This section of the paper provides an overarching update on the achievements and current challenges within the remit of the Medical Directorate.

This section covers the following achievements:

1. Revalidation and Appraisal 2024-25
2. Health Board Level Report for the 2024 Epilepsy12
3. Future Clinical Leaders Day

3.1 Achievements

Revalidation and Appraisal 2024-25

We are pleased to confirm we have achieved 95.95% engagement with annual appraisal for CTMUHB in its entirety (99.46% for Primary Care and 94.26% for Secondary care). This is an improvement of 1.45% to the overall figure from 2023-24, which is great to see.

This process assures us that our doctors are up to date and engaged with learning and developing – which is essential for our patient care and improvement.

Health Board Level Report for the 2024 Epilepsy12

As part of its annual reporting process the Epilepsy12 audit has conducted Trust/Health Board outlier analyses on two audit measures for clinical 'cohort 5' (2022/23) data. The purpose of the outlier process is to identify and highlight variation, enable local review of the causes of that variation and stimulate quality improvement.

We are pleased to confirm that the recent report from the National Paediatric Epilepsy Audit has confirmed CTMUHB as a positive outlier (excellent) in regard to the epilepsy nurse speciality (ENS) input into patient care. This is credit to our ENS team.

Future Clinical Leaders Day

In March, we arranged a very successful introductory day for the future clinical leaders of the health board. Nominees from current medical leaders across all specialties attended the day in Keir Hardie Health Park where inspiring guest speakers and networking took place.

We will continue to support these future leaders to ensure there is planning and sustainability in place for the next generation of medical leaders in CTMUHB.

3.2 Areas of Focus

1. Job Planning
2. Current Coroner Cases
3. Medical Examiner Service

This section of the report covers the following areas of focus and how the Medical Directorate aim to address them:

Job Planning

The Medical Directorate is overseeing the delivery of consultant job planning by the care groups. This is a resource intensive, challenging piece of work that is essential to understanding our medical capacity. Historically, CTM's compliance with job planning has been low. There has been some progress in improving this position with some Care Groups achieving in excess of 70% compliance, however, the overall Health Board position of 36% is behind where we'd wish to be. We continue to scrutinise and drive this improvement through the Medical Workforce Productivity Programme.

Current Coroner Cases

There are approximately 350 Coronial inquests open at present, with a significant increase in the number of inquests being opened over the last 12 months. There is a drive by the Coroner to address a backlog of cases which are causing an increase in inquiries from normal volume. As such, we are getting what seems like a high number of actions to manage. Action plans for these are being prioritised.

We currently have one active open Regulation 28 in respect of a patient whom was discharged and should have been referred for surgical review. Work is ongoing and this is due for submission by 31st July 2025.

Medical Examiner Service (MES)

There continues to be delays in the length of time for scrutiny of deaths by the Medical Examiner Service. Death certification are currently not being completed in a timely manner and consequently increasing the length of stay of the deceased.

In order to improve the timeliness of death certification CTM has introduced some measures including QR codes and videos from MES which together will provide more accurate information to the MES. We are working hard to improve on communication with families around delays and estimated timescales.

Section 4 ALLIED HEALTH PROFESSIONS (AHPs)

Successes

AHA Awards

The CTM AHP Community Rapid Access and Admission Prevention Service Model has been shortlisted for the National Advancing Health Care Awards 2025.

The Advancing Healthcare Awards recognise and celebrate the work of allied health professionals, healthcare scientists and those who work alongside them in support roles, leading innovative healthcare practice across the UK.

The multi-professional AHP model provides rapid access, maximises independence, prevents deterioration and avoids hospital admissions. There are several elements:

- Occupational Therapists support GPs and Paramedics by completing joint home with the aim of standing down ambulance services and providing the intervention needed so that the individual can remain at home safely.
- The Falls Prevention Service 'Don't Fall for It' was developed in collaboration with public community groups. Offering evidence community-based individual and group falls prevention and exercise programmes, the service also utilises the 'Falls Bus' to access more remote communities. In addition, they have delivered falls prevention training to all care homes across the Cynon Valley and are introducing the training across the CTM region.
- The community-based Speech and Language Therapy, Dietetic and Podiatry 'Hot Clinics' provide rapid access to diagnostics, treatment and signposting to appropriate services. Additionally, they ensure a rapid response to deterioration and reduce hospital admissions. Education and training to the wider multi-professional team and signposting to other services are also a key element.

The winner will be announced on 23 May 2025 at the celebration event in London.

AHP Advancement

- **Innovative Care Home Training Solution**

Virtual reality (VR) training programme, developed by Goggleminds, has been rolled out for social care staff in Bridgend, to enhance management of high-risk swallowing incidents. This immersive training equips staff with skills and confidence to handle dysphagia-related emergencies, improving patient safety and care.

- AHPs continue to celebrate the quality of care they provide with a selection of posters and abstracts being selected for a range of conferences such as the Macmillan Clinical psychologist leading a session at National Macmillan Conference, on 'How to manage the complexities of endings in cancer care work'.
- AHPs continue to build their research profile with a grant award for "WeightyGenes", a feasibility study looking at the prevalence of fat mass and obesity-associated genes in people with severe obesity. In addition, the physiotherapy team have been accepted on the "Initiate Trial". This trial evaluates if more in-patient rehabilitation after surgery for fractured Neck of Femur allows people to recover quicker and stay living in their own home longer.

HEALTH SCIENCE

Successes

Paediatric Audiology Quality Standards

The first pan-CTM external audit for paediatric audiology quality standards resulted in an overall compliance score for 2025 of **96.74%** against the nine

standards, which demonstrates the commitment of staff for continuous quality improvement in this service.

The following were reported as areas of exceptional quality, highlighting good practice that could be shared with other children's audiology services:

- The service is able to offer appointments in a wide range of clinic locations.
- Replacement ear mould appointments are offered same day at multiple sites.
- Repairs of children's hearing aids are provided same day at multiple sites.

Nomination for Institute of Biomedical Science Sustainability Award

The CTM Clinical Biochemistry Team have been nominated for a 2025 IBMS Sustainability Award. Being nominated for this award demonstrates Clinical Biochemistry Staff's commitment to sustainability, aligned to CTM 2030- Our Health, Our Future – Sustaining Our Future. Winners to be revealed at the 2025 IBMS Award Ceremony in July.

For Awareness

Joint EDAHPHS and DACDAHPHS Celebratory Event

On the 11th of April 2025 the Executive Directors of Allied Health Professions and Health Sciences (EDAHPHS) peer group held a joint event with their deputies' peer group (DACDAHPHS) in which they celebrated successes of 2024/25 and identified deliverables against their key priorities for 2025/26 through a series of workshops.

The celebration event was a great success, highlighting the diverse work of the groups and the associated impacts. The EDAHPHS group is chaired by CTM's Executive Director of AHPs and HS, and the DACDAHPHS Group is chaired by CTM's Deputy Director of AHPs and HS.

Four workshops were held to identify deliverables for the identified priorities of:

- Professional
- Digital and Computational
- Clinical
- Research and Innovation

The EDAHPHS peer group will now prioritise the deliverables to enable progress through the Deputies peer group, for local implementation.

Deaf Awareness Week is 5 – 9 May, with the theme of 'Beyond Silence'.

Deafness can take many forms and is often invisible. Appropriate communication is vital in all aspects of life but especially in a healthcare setting; shared decision making, informed choice and consent can only happen when a person has access to information.

For Deaf Awareness Week CTM Audiology Patient Reference Group (service-users and staff members), with input from Welsh Council for Deaf People (WCDP) produced a summary of tips and advice with the following shared across CTM:

1. Ask people what they need for good communication.
2. Use the person's preferred terminology, avoiding negative terms such as loss, disability, impairment.
3. Agree Reasonable Adjustments and stick to them.
4. Lead by example in all workplace and social situations.
5. Realise that hearing aids do not always help and may not be wanted or needed by some people.
6. Hearing aids do not mean perfect hearing. Hearing aids have limitations and do not give people perfect hearing when they wear them. Additional communication aides are often still needed, such as lip reading and extra equipment.
7. When in a healthcare setting it is important to let patients know if they can keep their aids on during a procedure (example of MRI scan); the communication barrier will be greater if they cannot.
8. If they can't keep their aids on during a procedure, make sure they have all the information beforehand and prepare them for whatever they may need to do without their hearing aids.
9. Take it in turns to speak in a group setting. People interrupting each other during meetings at work can be very difficult for those with hearing loss. It can also be a difficult environment to speak up in and let others know they are struggling, meaning things are easily missed.

Section 5 Public Health Update

Substance Use Services in CTM. Recommission for 26/27 and integration with Criminal Justice.

Background

Alcohol and drug use contribute significantly to morbidity and mortality in CTM.

In 2023/24 there were 6399 hospital admissions attributable to alcohol in CTMUHB and 51 registered drug misuse deaths (CTM having the highest rate in Wales).

Substance use services in CTM are commissioned through the Area Planning Board.

Tier 1 and 2 services (non-clinical) are provided by Barod, while Tier 3 services (clinical) are provided by CTMUHB. A parallel children and young people's service operates along the same lines.

Services for people in the criminal justice system are commissioned on a South Wales footprint, jointly by the Police and Crime Commissioner (PCC) and HMPPS. The current provider is Dyfodol, a collaboration between G4S, Kaleidoscope and Adferiad. Dyfodol provide clinical and non-clinical services.

The Alcohol Care Team provides support to inpatients with an alcohol use disorder, funded by Value Based Health Care.

Mainstream level 1-3 services have around 2500 to 3200 people in treatment at any one time (ranging from brief intervention to longer term structured psychological support and pharmacological therapy)

The Dyfodol service has around 300 people in treatment at any one time, split between psychosocial interventions and pharmacological therapy.

Recommissioning services for 2026/27

Tier 1 and 2 services are due to be recommissioned for 2026/27, as are criminal justice services. This presents an opportunity for joint commissioning and service integration, as the PCC/HMPPS look to split their service onto APB footprints.

Integrating the criminal justice service with mainstream services offers an opportunity to improve continuity of care, reduce stigma and provide a wider range of services to clients through increased scale.

Integration will require inclusion of the criminal justice components within the new service specification of the Tier 1 & 2 service, and assurances from the CTMUHB on meeting clinical service requirements within an adapted version of the current Tier 3 service.

Clinical service requirements will include assurances around waiting times for those receiving treatment orders, or released from custody, and capacity to continue prescription and support for those released from custody on Buvidal.

The recommission also presents an opportunity to strengthen integration between the non-clinical and clinical service and develop a clearer understanding of current APB investments in health board substance use services.

Progress updates will be reported to this meeting as the re-commission process progresses.

6. Key Risks / Matters for Escalation

All challenges identified for this reporting period have been highlighted under each section of the updates from each of the four Clinical Executive Directors.

7. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	Creating Health Inspiring People Sustaining Our Future
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Living Well
	Growing Well Ageing Well

	Dying Well
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))*	Whole-systems Perspective
	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))*	Effective
	Efficient Equitable Person Centred Timely Safe
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	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:	Quality of patient care is at the forefront of improvements and decisions made and individual quality impact assessments are completed at the right time by the right team. This paper is presented for information and noting purposes.
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):	Quality of patient care is at the forefront of improvements and decisions made and individual quality impact assessments are completed at the right time by the right team. This report is

	POSITIVE/NEUTRAL NEGATIVE	presented for information and noting purposes. If required, this paper can be made available in Welsh and other languages upon request
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	Yes (Include further detail below)	
	Providing high quality, safe care is vital to the reputation of the health board. This paper covers items as a broad update for assurance to the members of the Quality, Safety & Experience Committee however, under the directorship and leadership of the four Clinical Executive Directors who hold joint responsibility for this paper, there is a collective strive and dedicated commitment to protect the health board's reputation.	
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.	

8. Recommendation

8.1 Quality, Safety and Experience Committee members are asked to **NOTE** the contents of this paper with the updates provided for assurance by the four Clinical Executive Directors.

9. Next Steps

9.1 Members of the Quality, Safety & Experience Committee will continue to receive regular updates for assurance and for awareness of successes and challenges together with any identified risks.

Agenda Item
5.3.1

Quality, Safety & Experience Committee

Highlight Report from the Children & Families Care Group Quality, Safety and Experience Meeting held on 10th April 2025

Dyddiad y Cyfarfod / Date of Meeting	20/05/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	Suzanne Hardacre, Director of Midwifery & Nursing, Carl Verrecchia, Service Director Mohamed Elnasharty, Medical Director Angharad Oyler, Head of Midwifery Merthyr & Cynon
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	Angharad Oyler, Head of Midwifery, Merthyr & Cynon.
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
BR+	Birthrate + (workforce planning & acuity tool)
CNO	Chief Nursing Officer
CMO	Chief Midwifery Officer
CTM	Cwm Taf Morgannwg
HSJ	Health Service Journal
MBRRACE	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK
MEWS	Maternity Early Warning Score
NEWTT 2	Newborn Early Warning Track and Trigger
PACE	A trauma informed approach: **P**layfulness, **A**cceptance, **C**uriosity and **E**mpathy
PoW	Princess of Wales Hospital
QSE	Quality, Safety & Experience
RGH	Royal Glamorgan Hospital
SCPHN	Specialist Community Public Health Nursing
SEHS	School Entry Hearing Services
WG	Welsh Government

1. Introduction

1.1 This report has been prepared to provide the Committee with details of the key issues considered by the Children and Families Care Group at its meeting on 10th April 2025.

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

2. Purpose of this Meeting

2.1 The Children & Families Care Group Quality, Safety and Experience Meeting (QSE) will:

- Put the needs of patients, carers and the public at the centre of all its business.
- Provide evidence based and timely advice based on local need, to assist in discharging its functions and meeting its responsibilities.
- Provide assurance to the Children and Families Care Group in relation to the arrangements for safeguarding the public and continuously improving the quality and safety of the services we provide.
- Ensure that care is delivered in accordance with the Health & Care Standards for Health Services in Wales.
- Ensure that services are delivered in compliance with regulatory legislation and accreditation bodies.

3. Highlight Report

Alert / Escalate	• Special school nursing – workforce vacancies and long-term sickness absence resulting in increased pressures and gaps in provision, also impacting on community consultant caseloads. Paper submitted for investment in relation to core health provision (awaiting feedback). Senior nurse currently reviewing job plans with headteachers.
Advise	• Children's continuing care packages being recruited to substantively, some delays continue while new members of the team complete relevant training. Once trained and in post, a further risk assessment will be completed. • School Entry Hearing Service (SEHS) Cwm Taf Morgannwg (CTM) remain in breach of their responsibility to implement direction from Welsh Government (WG) to handover the governance arrangements of the programme to audiology services. A workforce review in both School nursing and Audiology has been completed. This was submitted as an investment priority for 2025 but has not been supported. Alternatives within the Care Group are now being explored. • UNITE industrial action ceased on 31st October 2024 following extensive collaborative working with staff and trade union colleagues to implement a recovery plan. Partnership working continues with Unite in relation to the Job Description appeal. • Business case to increase clinical rooms/capacity including air handling for hysteroscopy services at the Royal Glamorgan Hospital, unit has been approved. Awaiting timescales for commencement of works. • Review of midwifery workforce commenced April 2025, in accordance with Welsh Government requirements to maintain Birthrate + compliance. Report anticipated late Summer. • Business case for elective obstetric theatre list in accordance with MBRRACE recommendations being developed. • Residual issues with the loss of paediatric ward 18 at the Royal Glamorgan Hospital (RGH) to accommodate adult patients due to the roof repairs at Princess of Wales Hospital (PoW) continue. Mitigating actions being worked through with many already in place, some estates issues outstanding.

	Child protection medical assessment room requires capital input. • Service wide review of paediatric phlebotomy provision in progress (Acute and Community sites) due to increase in demand and waiting times. • Inaugural transition and handover meeting chaired by Executive Medical Director took place on 28th April. • A review of allergy services across the health board recently commenced due to increased referrals and inequity across sites. • Well-Being team supporting colleagues on return to Princess of Wales Hospital following the re-opening of the maternity and neonatal units (PACE programme). Regular trade union, workforce and care group partnership meetings in place.
Assure	• The Care Group attended Integrated Quality, Planning and Delivery Meeting in April to present key maternity and neonatal metrics. An update of progress against the Women's Health Plan was also provided. • Partnership working with corporate safeguarding team continues to monitor service improvement actions. • Increase in CIVICA patient feedback responses noted across Children & Young People services. • Leadership, culture and engagement framework developed for Specialist Community Public Health Nurses (SCPHN) circulated for comments. • Care Group are developing plans in response to the staff service results, to be shared at next Operational Management Board meeting in May. • Maternity and Neonatal Safety Support Programme – introduction of MEWS and NEWTT 2 progressing, Lead Perinatal Improvement Manager (8a) and Maternity / Neonatal Improvement Specialists (7) being advertised.

<table>
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Risk Register

There are currently two risks risk scoring 'high' with 15 or more.

Risk ID	Description	Score
5903	Unfunded Continuing Care Packages / unfilled packages	16
5753	Inadequate special school nurse provsion	16

</td></tr>
<tr><td>Inform</td><td>

- Care Group team building events for senior and clinical leaders planned with Ministry of Defence colleagues on June 5th & 16th.
- Digital Informatics Midwife shortlisted for two national Health Service Journal (HSJ) awards, presented at Florence Nightingale Foundation Annual Scholar Welcome Day on Thursday, 8th May, shortlisted in NHS Wales Sustainability Awards and CNO/CMO awards for their work with families experiencing digital exclusion / poverty.
- Temporary Consultant Midwife for Quality Improvement and Population Health appointed.
- Permanent recruitment of senior midwifery manager at Princess of Wales Hospital, postholder commences 8th June.
- Community of Practice for 'Play' introduced with support from Allied Health Professional colleagues to address recommendations from the Play Wales report.
- Paediatric teams actively promoting the use of Welsh language across services.
- Neonatal nursing team recognised for 'simply do' idea of the month
- International Day of the Midwife celebrated across CTM on 2nd May 2025, many nominations received from colleagues and public. International Day of the Nurse celebrated across the Care Group on 12th May.

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<tr><td>Appendices</td><td>None identified.</td></tr>
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4. 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: • Creating Health • Inspiring People • Sustaining our Future
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Starting Well If more than one applies please list below: • Growing Well • Living Well
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))*	Whole-systems Perspective If more than one applies please list below: • Culture and Valuing People • Leadership • Learning, Improving and Research
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Safe If more than one applies please list below: • Timely • Effective • Efficient • Equitable • Person Centred
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable If more than one applies please list below:

Impact Assessment		
Ansawdd	Yes: ☐	No: ☒

Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Outcome:	If no, please include rationale below: Not a policy or a guideline
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: Not a policy or a guideline
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.	

5. Recommendation

5.1 The Committee is asked to **NOTE** the highlights outlined in section 3 of this report.

Agenda Item
5.3.2

Quality, Safety & Experience Committee

Highlight Report from the Unscheduled Care Group Quality & Safety Committee

Dyddiad y Cyfarfod / Date of Meeting	20/05/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	Sarah Follows, Operational Director for Unscheduled Care. Owen Weeks, Unscheduled Care Medical Director & Robin Martin, Unscheduled care Deputy Medical Director & Victoria Healey, Head Of Quality & Patient Safety
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	Sarah Follows, Operational Director for Unscheduled Care
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

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	09/04/2025	

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
QIM	Quality Management System

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 9th April 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 (QSE) Committee on the provision of safe and high quality patient care and experience to the population we serve.

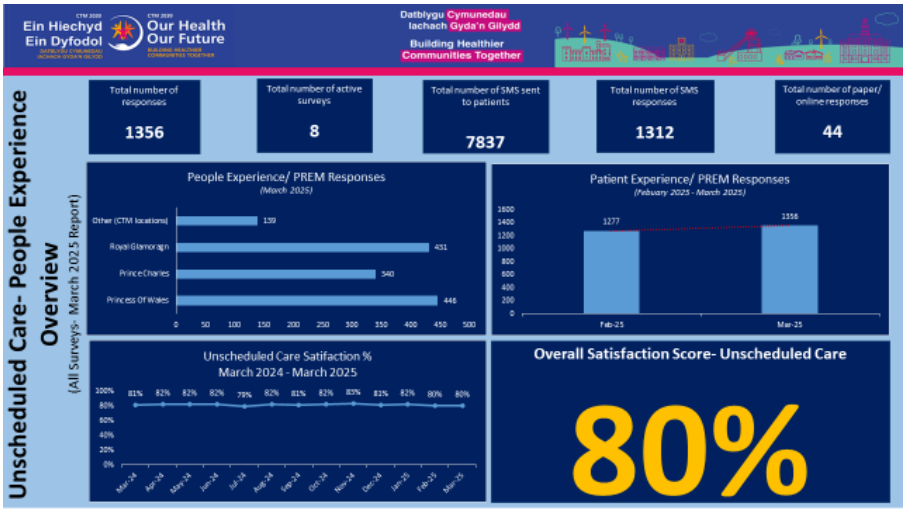
2.2 The Committee is requested to **NOTE** the report

3. Highlight Report

Alert / Escalate	An unannounced internal ward assurance visit was conducted on Ward 3 (27th March 2025) and ward 20 (20th March 2025) at the Royal Glamorgan Hospital (RGH) official feedback has now been provided within an assurance report. The review utilised the current ward accreditation domains, incorporating observation, documentation review, and staff/patient engagement. The Environmental and Infection and Control Annual Audit (via Audit Management and Tracking (AMaT) was also included. Each domain was assessed using the Red/Amber/Green (RAG) rating system and supported by qualitative findings. Ward 3 was provided a Red rating, primarily due to the results of the Environmental and Infection Control audit and immediate feedback obtained during the visit. Areas of good practice were observed, particularly regarding the pharmacy audit and teamwork within the multidisciplinary team. However, several critical areas require urgent improvement, notably infection control and audit compliance. Ward 20 was also provided a red rating, primarily due to the results of the Environmental and Infection Control audit and immediate feedback obtained during the visit. Areas of good practice were observed, particularly regarding the pharmacy audit and teamwork within the multidisciplinary team. However, several critical areas require urgent improvement, notably infection control and audit compliance. A robust improvement plan has been implemented across the 2 wards to address the issues identified and immediate infection control measures have been completed in order to improve the cleanliness of the ward.

Advise	Complaints have been transferred to a central quality governance team within the organisation since February 2023. This has ensured that we maintain equity, consistency and strengthen resilience. USC compliance with the 30-day target has increased in March 2025 to 91%. Currently, there are 16 open complaints and 2 are over the 30-day compliance. This is a decrease from 21 to 16 open complaints since the last report. The USC leadership team have provided a commitment to support, improve trajectories and have developed a mechanism to escalate when clinicians and nurses are unable to achieve 30-day compliance. This has been closely monitored by the USC Senior Leadership Team. During April's QSRE meeting analysis of concerns and incidents are being triangulated. Ensuring that there is targeted intervention when any themes or trends have been identified. AMaT actions for USC as reviewed weekly by the USC Nurse Director (ND). There are no outstanding AMaT actions for the PCH Acute Site as of the 9th April 2025 - there is a rigorous approach to daily assurance checks by either the Head of Nursing (HoN) or Lead Nurse. For RGH and POWH 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.
Assure	We are pleased to report that PCH currently, has no Registered Nurse vacancies in the Emergency Department. This is a significant achievement, as filling these positions has been challenging for several years and a testament of how the department has developed. In our previous report, we highlighted that the Dare to Dream Welsh Charity initiated weekly music sessions starting in March 2024 for patients in the Care of the Elderly (COTE) wards at the Princess of Wales Hospital (POW). These sessions feature two musicians who perform and foster interaction among patients and their relatives. The Members of the Senedd (MS) for Bridgend and Porthcawl have provided positive feedback, stating that "Daring to Dream has brought together such important, joyous, regular musical afternoons for patients, their visitors, and staff. The pleasure they bring to the elderly, who often spend many weeks in hospital, is incredible and wonderful to see and appreciate."

Inform



The Emergency Department (ED) national Patient Reported Experience Measures (PREM) survey continues to have excellent service user engagement, with the patient experience team providing a monthly report via CIVICA.

This patient feedback is reviewed by the department leads and actions are undertaken accordingly with positive and constructive feedback shared. We continue to have the best engagement with this survey pan Wales which allows us to develop themes and key work streams and to share 'you said, we did' feedback with service users.

Through Value-Based Health Care, funding has been allocated for three Health Independent Domestic Violence Advisors (IDVAs). This initiative aims to ensure equity for patients and staff of CTMUHB in accessing support related to domestic abuse. Currently, there are low numbers of domestic violence risk assessments and referrals to Multi-Agency Risk Assessment Conferences (MARAC) from Acute services. The pilot program for Health IDVA was initially based at the Royal Glamorgan Hospital (RGH) Emergency Department (ED). In collaboration with the ED and safeguarding teams, there is a proposal to extend this pilot across three sites.

Additionally, the Samaritans have expressed interest in collaborating with the RGH ED and mental health colleagues to provide enhanced support to patients. This collaboration aims to assist patients in managing longer wait times, direct them to appropriate support services, and offer emotional support to parents and carers. A terms of reference document is currently being drafted in collaboration with ED and mental health services.

Stroke

As part of the service review of the temporary service change centralising stroke services at RGH a quality dashboard has been developed by the central patient safety team to allow for detailed analysis of pre and post move allowing for the comparison of incidents, patient experience metrics, mortality and safeguarding. This allows for thematic analysis and for a detailed service review to be performed to evaluate the impact of the change. This is also explored in more detail in the spotlight report.

Recent SSNP changes have impacted on performance reporting. However, this has been escalated and outstanding SSNAP data has been submitted.

The temporary move of Stroke Services from POW/PCH to RGH continues with consultation in progress for services to remain for up to a further 12 months.

Stroke Operational Group and Stroke Performance Group meetings are planned with refreshed agendas.

Service scoping workshop arranged for 30/04/25 which will inform further pathway and workforce workstreams task and finish groups with key stakeholders to support service redesign

There continues to remain an element of risk associated to Stroke Services which includes:

- Sickness/upcoming vacancies – particularly within the nursing workforce.
- Unable to move POW Stroke clinics to RGH until May due to different ICT systems and limited capacity in Outpatients Department (OPD).
- RGH demand – increased diagnostic demand for doppler, echo and MRI
- Increased pressure on Welsh Ambulance Services NHS Trust (WAST) due to having to transfer self-presenters

Progress so far:

- Nursing teams working together to review rosters across both wards to support safe staffing across the Acute Stroke Unit
- Nursing workforce from YGT has moved to Ward 19 to support vacancies and lateral moves

	• One junior medical roster has now been designed to ensure all the team have exposure to acute and rehab parts of the Stroke pathway for learning purposes • Stroke Consultant interviews planned for June 2025. • Dedicated therapy bay for Stroke patients (monitoring usage within this area) • Monitoring and Evaluation plan being pulled together to enable data to be produced on a monthly basis (will support shaping longer-term Stroke Service plans) • Referral to Treatment (RTT) targets achieved for year end with no patients waiting over 104 weeks. • Multidisciplinary ward huddles ongoing identifying 'wins, concerns of the day and rapid problem solving' • PCH TIA clinics have now moved onto RGH site • Central Monitoring has now been installed on the Stroke Unit
Appendices	None identified.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Creating Health
	If more than one applies please list below: Inspiring People Improving Care
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Living Well
	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: Safe Timely
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 Outcome for Welsh Language (delete as appropriate): POSITIVE	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	

5. Recommendation

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

Agenda Item
5.3.3

Quality, Safety & Experience Committee

Highlight Report from the Planned Care Quality, Safety, Risk & Experience (QSR&E) Committee meeting

Dyddiad y Cyfarfod / Date of Meeting	20/05/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Sharon O'Brien, Nurse Director, Planned Care
Cyflwynydd yr Adroddiad / Report Presenter	Sharon O'Brien, Nurse Director, Planned Care
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
ED	Emergency Department

1. Introduction

1.1 This report had been prepared to provide the Quality, Safety & Experience Committee with details of the key issues considered by the Planned Care Group, Quality, Safety, Risk & Experience meeting on 28th April 2024.

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

2.1 Purpose of this Meeting

The purpose of the Planned Care/Surgery Quality, Safety, Risk & Experience Group (QSRE) is to provide assurance to the Care Group and the Health Board's Quality Safety & Experience (QSE) Committee on the provision of safe and high quality patient care and experience to the population we serve.

2.2 The Planned Care/Surgery QSRE Group will:

- Put the needs of patients, carers and the public at the centre of all its business.
- Provide evidence based and timely advice to the Planned Care Group, based on local need, to assist in discharging its functions and meeting its responsibilities.
- Provide assurance to the Planned Care Group in relation to the arrangements for safeguarding the public and continuously improving the quality and safety of the services we provide.
- Ensure that care is delivered in accordance with the Health & Care Standards for Health Services in Wales.
- Ensure that services are delivered in compliance with regulatory legislation and accreditation bodies.

3.0 Highlight Report

Alert / Escalate	**Critical Care capacity** • Critical care demand remains high across all 3 acute sites PCH continues to be the surge ITU for CTM increasing to 10 beds from funded 8 frequently throughout April. **Staff training** • Lack of provision of Manual Handling and Violence & Aggression - staff are working for long periods of time out of compliance. **Trauma demand in RGH** • Increased consistent high volume of trauma patients in RGH. • Aim to create new trauma clinical model for a single trauma unit • Opened a new Trauma Assessment Unit (TAU) end of April to support rapid assessment and treatment and help alleviate the pressures in the ED.

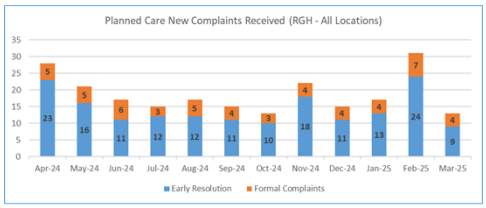
Advise

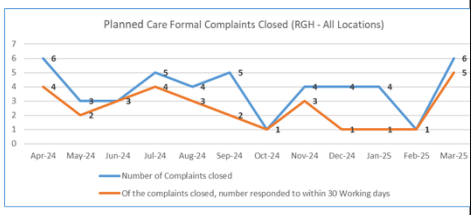
Concerns & Incidents

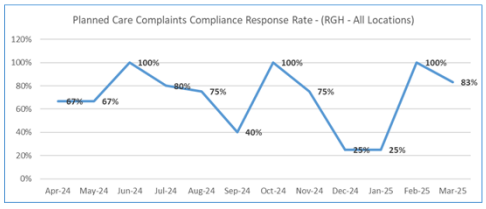
Concerns Trends/themes

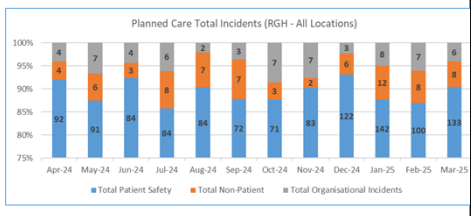
- Communication with MDT - Most common theme
- Clinical issues
- No early resolutions at time of report
- Pain Assessments
- NEWS Scoring and Escalation of Care
- Missed Fractures

RGH

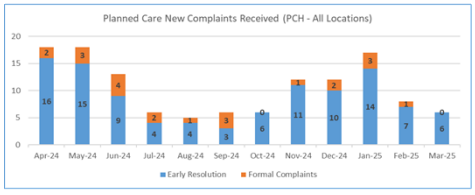


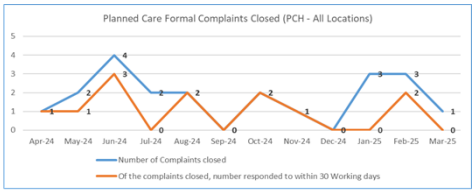


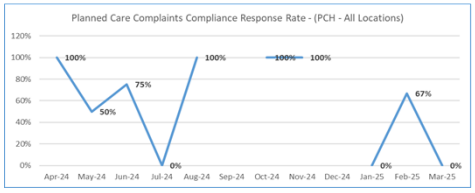


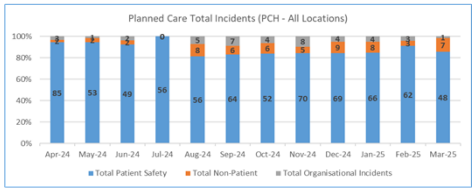


PCH

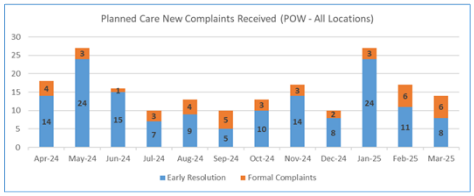


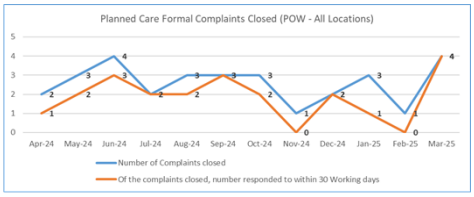


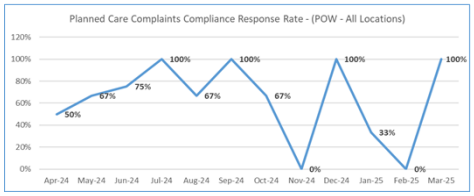


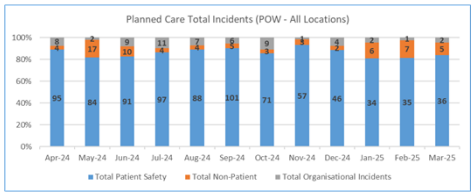


POW









Incidents by Site (March 2025)

Incidents	PCH Mar-25	POW Mar-25	RGH Mar-25
Total Number of Incidents Reported	56	43	147
Total Patient Safety	48	36	133
Total Non-Patient	5	5	8
Total Organisational Incidents	3	2	6
Total Number of Incidents Closed this month	52	70	145
Total Number of Open Incidents on Datix Cymru	63	323	353
New Incident	19	181	209
Management review/Make it safe plus	21	85	32
Under Investigation	15	26	64
Awaiting Closure	8	31	48
Number of Nationally Reportable Incidents	0	1	0
Number of Never Events reported	0	0	0
Number of Open Nationally Reportable Incidents	7	0	0

Assure	**Vanguard Theatres** • Endoscopy Vanguard opened 04/04/25, Surgical Vanguard theatres opened 10/04/25 • Dedicated Day surgery unit with 4 theatres and 14 trolleys. Theatre, Recovery and ward staff, all from PoW • RGH and PoW Anaesthetists and Surgeons.   Patient Feedback *"All the staff were lovely"* *"Everyone made me feel at ease"* *"Nothing was too much trouble"* *"I experienced 5 star treatment"* **Elective Orthopaedic Surgery** The Vanguard Unit move has led to the Elective Orthopaedic Unit to return to a ward in RGH with 16 beds from its current location with only 8 beds. This has enabled an increase in Athroplasty surgery.
Inform	• Bespoke QR code for critical care and surgical wards being created by senior nurses in Planned Care to obtain patient and staff feedback being expanded from PCH to PoW ward 21 and Bridgend Clinic. Plan to roll out into RGH. • Senior Nurse ED and Ward Manager Ward 6 in PCH presented their patient story at CTM Board Committee, which was successful and they were able to showcase the positive impact SSDEC has on their patients.
Appendices	None identified.

2. 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	Not Applicable 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))*	Whole-systems Perspective 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))*	Safe If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable 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*	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:

Impact Assessment Screening?		
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)*	Yes (Include further detail below)	

3. Recommendation

3.1 The Committee is asked to **NOTE** the highlights outlined in section 3 of this report.

5.3Agenda Item
5.3.4

Quality, Safety & Experience Committee

Highlight Report from the Mental Health and Learning Disabilities Care Group

Dyddiad y Cyfarfod / Date of Meeting	20/05/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	Lloyd Griffiths, Head of Nursing
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	Ana Llewellyn, Nurse Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group /Forum Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
AMAT	Audit Management and Tracking system
CMHT	Community Mental Health Team
CTM	Cwm Taf Morgannwg University Health Board
HEIW	Health Education and Improvement Wales
HIW	Health Inspectorate Wales
iCTM	Improvement Cwm Taf Morgannwg
IPC	Infection Prevention and Control
MHA	Mental Health Act
MH	Mental Health
MHLD	Mental Health and Learning Disability
MOJ	Ministry of Justice
NRI	Nationally Reportable Incident
OPMHS	Older Peoples Mental Health Services
QSE	Quality Safety and Experience Meeting
RAG	Red, Amber, Green
RC	Responsible Clinician
RCRP	Right Care Right Person
SWP	South Wales Police
WTE	Whole Time Equivalent

1. Situation /Background

1.1 This report had been prepared to provide the Committee with details of the key issues considered by the MHLD Care Group at its QSE meeting on 09/04/2025.

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

2. Specific Matters for Consideration

2.1 The purpose of the Care Group is to provide assurance to the Board on the provision of workplace health & safety and safe and high-quality care to the population we serve, including prevention through public health, primary and secondary care.

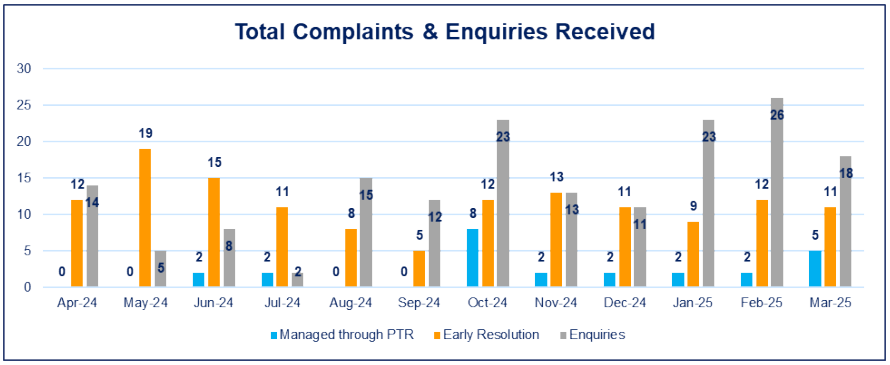
2.2 The MHLD Care Group QSE Board will:

- Put the needs of patients, carers and the public at the centre of all its business.
- Provide evidence based and timely advice to the MHLD Care Group, based on local need, to assist in discharging its functions and meeting its responsibilities.
- Provide assurance to the MHLD Care Group in relation to the arrangements for safeguarding the public and continuously improving the quality and safety of the services we provide.
- Ensure that care is delivered in accordance with the Health & Care Standards for Health Services in Wales.
- Ensure that services are delivered in compliance with regulatory legislation and accreditation bodies.

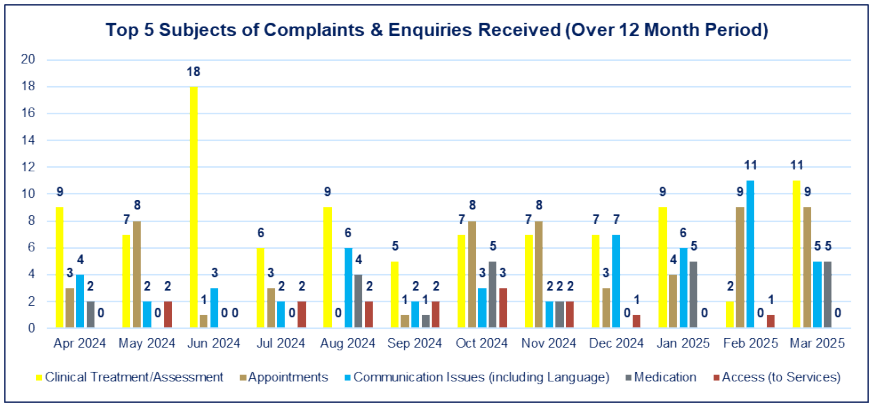
3. Key Risks / Matters for Escalation

Alert / Escalate	• The number of Psychology vacancies in the Adult Directorate is having a direct impact on timely care. The vacancy rate is around 28% (21WTE) which is affecting the Care Group's ability to offer supervision to a range of staff and to contribute to risk formulation and management plans. The vacancies are across both Adult Inpatients and Adult community services. Psychological therapies have been made a priority of the Adult Directorate IMTP and a waiting list work stream is underway. The Waiting Well initiative provides support and guidance for those waiting for psychological therapy. Any unmet needs are highlighted to the Directorate Lead Consultant Psychologists and are reported and monitored through the Care Group's QSE meeting.

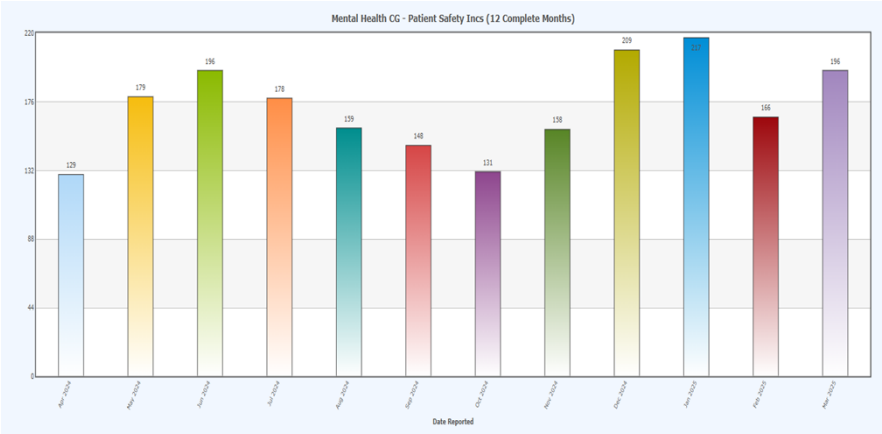
	• Medical staffing remains fragile across the whole of Adult MH services and this has been added to the organisational risk register with a score of 16. There are significant pressures across inpatient services at Consultant level and particularly in relation to availability of Approved Clinicians. The Care Group continues to manage medical staffing with daily scrutiny to identify and communicate pressures, prioritise work and release Consultant time. The clinical teams are working with patients, families and advocates to minimise the impact on patients.
Advise	• The implementation of Phases 3 + 4 of RCRP, which relate to the transportation of patients and patients who are detained under S136 of the MHA, commenced on the 10th March 2025. At present there is no agreed alternative approach to the transportation of patients who currently require police support, leaving individually commissioned, private transport as the only available alternative. SWP are continuing to transport patients in the absence of a viable alternative. No issues regarding the implementation of Phases 3+4 have been escalated. The Care Group continues to engage with SWP stakeholder events and is working with neighbouring Health Boards to develop a regional response. The request for a jointly developed S135/6 policy between SWP and all stakeholders has been accepted and preliminary discussions are taking place. • The All-Wales strategic action plan for Learning Disabilities prioritises reducing the dependency on specialists learning disability inpatient care in favour of strengthening community provision. Since April 2020 all Health Boards in Wales are required to complete and return a census to the NHS Executive on the numbers of people with a learning disability requiring care and treatment in specialist MHLD inpatient facilities. For CTMUHB there has been a steady reduction in inpatients during this time, from 26 at its highest in 2020, to its lowest, 20 reported in 2025. The nature of the inpatient services falls into 3 categories; Assessment and Treatment Units (AATU's), Continuing Care Units (CCU's) and Secure inpatient services. Whilst CTM is reporting lower than the national average number of patients in AATU's, we are reporting above the national average for the number patients in CCU's. In addition to the quarterly

	inpatient census the NHS Executive are undertaking more focussed reviews of the nature of inpatient services, starting with AATU's and more recently CCU's. The review of the units observed a dedicated staff team; however, the functions and the environments of care require review. The Care Group continues to monitor this provision and the patients receiving care and treatment in these facilities through its established Performance and Commissioning Governance structures with SBUHB who provide specialist LD services to the population of CTM. Patients who are assessed as ready for discharge as supported by the MHLD Commissioning Team to secure appropriate levels of ongoing care and support in a range of community facilities in conjunction with the region's local authorities.
Assure	• Through the support of the Business Intelligence Manager in Patient Care and Safety the Care Group now has a fully functional Quality Dashboard which allows themes and trends to be more easily identified. The next steps are to operationalise the dashboard for individual teams and services and then to implement Power-Bi. • The number of complaints received by the Care Group during this reporting period was lower than the mean (18 per month over the last 2 years). The number of formal complaints received in February and March was 7 which is within the monthly mean.  Complaint closure compliance in the Care Group was 33% in February and 50% in March, however, the low volume of formal complaints can artificially skew the reporting and contributes to a perception of variation in closure compliance performance in the Care Group.

At the end of March there were 3 open formal complaints (the 2-year mean is 7).
The new quality dashboard now enables the Care Group to thematically analyse the themes from complaints which will be one of the 2025/26 priorities.



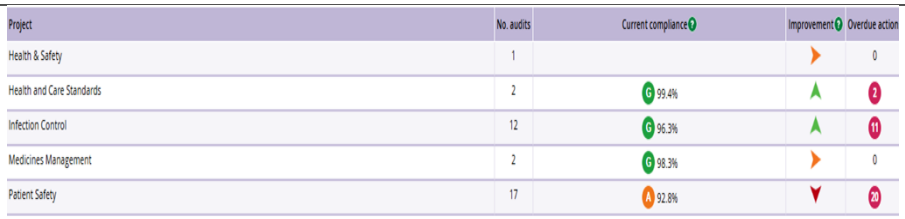
- The Datix incidents reported this period, 166 in February and 196 in March are consistent with the 2-year mean of 198, and lower than the last reporting period despite the continued high acuity in Ty Llidiard.



- There are 5 open NRIs which is consistent with the 2-year mean.

  There was 1 new NRI reported during this period.

- All the MHLD wards are now using AMAT. Compliance with ward audits as of the end of March is shown below.

	 There has been a slight decrease in IPC compliance to 96.3%, the overdue actions relate to estates issues and the need for replacement furniture which is on order. Patient safety compliance has improved to 92.8% from 88%. There are now 20 overdue actions in the Patient Safety category, down from 25 in the last reporting period. Of these 20, 12 are RAG rated green with 8 RAG rated as amber, these relate to IPC and estates issues. No actions are rated as red. Performance against these audits is monitored in the individual directorate's QSE meetings.
Inform	• The Falls Collaborative work by the OPMHS inpatient team and iCTM have had an article published in the British Medical Journal entitled "Using a collaborative approach to reduce falls in older people's adult mental health wards in a local health board in Wales" • As part of the National Patient Safety Programme, HEIW have facilitated Collective Leadership and Safety Cultures (Co-Lead) workshops on the Adult Admissions Ward at RGH. Co-Lead helps to create psychologically safe working environments by encouraging team members to share learning and improve the quality of their work. CTMUHB is the first MH service in Wales to take part in the initiative. • Ward 14 POW, is one of five wards across Wales selected to participate in the Safe Wards pilot program as part of the National Inpatient Improvement Programme Relational Safety work stream. An initial meeting will be held in April, followed by a two-day training course for key staff in May 2025. • The OP Directorate will be trialling the Guardian Watch as part of a Bevan Exemplar Research Project. The Guardian Watch is a mobile phone watch featuring a personal alarm that contacts friends, family and loved ones who can view the location and well-being of the wearer remotely. The service is currently deciding on their outcome measures for the project, which feeds into the national Bevan Exemplar Scheme for 2025
Appendices	None

4. 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	Ageing Well If more than one applies please list below: Growing Well Living Well Dying Well
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))*	Learning, Improvement & Research If more than one applies please list below: Culture and valuing people Learning, improvement and Research Leadership
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Effective If more than one applies please list below: Efficient Person centred Equitable Timely Safe
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	Choose an item. 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**	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate):	If no, please include rationale below:

Have you undertaken an Equality and Welsh Language Impact Assessment Screening?	POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	
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.	

5. Recommendation

5.1 The Committee is asked to **NOTE** the highlights outlined in section 3 of this report.

Agenda Item
5.3.5

Quality, Safety & Experience Committee

Highlight Report from the DTPS QSRE

Dyddiad y Cyfarfod / Date of Meeting	20 May 2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	DTPS Team
Cyflwynydd yr Adroddiad / Report Presenter	Hannah Wilton, Director of Pharmacy and Medicines Management
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Lauren Edwards, Executive Director of AHPs and Health Science

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
N/A		

Acronyms / Glossary of Terms	
AHP	Allied Health Professionals
CDs	Controlled Drugs
CT	Computed Tomography
DHCW	Digital Health and Care Wales
DI	Designated Individual
DTPS	Diagnostics, Therapies, Pharmacy & Sciences
FUNB	Follow Up Not Booked
HTA	Human Tissue Authority
ISO	International Organisation for Standardisation
LIMS	Laboratory Information Management System
NOUS	Non-Obstetric Ultrasound Scan
MRI	Magnetic Resonance Imaging

MH&LD	Mental Health & Learning Disabilities
OOH	Out Of Hours
PCH	Prince Charles Hospital
POW	Princess of Wales Hospital
QSRE	Quality, Safety, Risk & Experience
RGH	Royal Glamorgan Hospital
SDEC	Same Day Emergency Care
SLT	Speech and Language Therapist
SLA	Service Level Agreement
UKAS	United Kingdom Accreditation Service
USC	Urgent Suspected Cancer
HO	Home Office

1. Introduction

1.1 This report has been prepared to provide the Committee with details of the key issues considered by the Diagnostics, Therapies, Pharmacy & Sciences (DTPS) Quality, Safety, Risk and Experience (QSRE) Group at its meeting on 28th April 2025.

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

2. Purpose of this Meeting

2.1 The purpose of the Care Group QSRE meeting is to ensure delivery of workplace health and safety standards and safe, high-quality care to the population we serve, including prevention through public health, primary and secondary care. The purpose of this report is to provide assurance regarding these matters to the Quality, Safety & Experience Committee.

2.2 The Diagnostics, Therapies, Pharmacy and Sciences Care Group Quality, Safety, Risk and Experience meeting (QSRE) will:

- Put the needs of patients, carers, colleagues and the public at the centre of all its business.
- Provide evidence based and timely advice to the Care Group based on local need, to assist in discharging its functions and meeting its responsibilities.
- Provide assurance to the Diagnostics, Therapies, Pharmacy and Sciences Care Group in relation to the arrangements for safeguarding patients, colleagues and the public and continuously improving the quality and safety of the services we provide.
- Ensure that care is delivered in accordance with the Health and Care Standards for Health Services in Wales.
- Ensure that services are delivered in compliance with regulatory legislation and accreditation bodies.

1. **Highlight Report**

Alert / Escalate	**<u>Pathology</u>** • **LIMS 2.0:** The overarching risk in relation to meeting the project timelines has already been escalated to the organisational risk register and has been discussed through Operational Management board with a further update due on 14th May. The project timeframe is tight and there are significant concerns regarding the resource required to deliver this project safely within expected timeframes. The current UAT (User Acceptance Testing) Mitigation Plan, agreed on the 3rd March, for completion of UAT by end April 2025, has not been realised. At the LIMS Programme Board 8th April 2025, the LIMS2.0 Project was upgraded to RED RAG status. DHCW met with all Health Board CEOs to update them on the current LIMS status. The CEO requirement was to achieve LIMS deployment within 2025. The Programme Board also agreed the decision to decouple the Transfusion Medicine discipline on to a separate timeline for 2025. The task set of the Programme Board was to urgently conduct Discipline specific Deep Dive sessions and gather all information to present a workable Mitigation Plan, at the next Programme Board on 13th May. Discipline deep dive sessions were held during mid-April to extract the main blockers and work required to conclude UAT. Sessions included All Wales representation from Health Boards, Disciplines and Technical workstream Leads, together with Intersystems and DHCW Leads. A new deployment proposal was presented to the Health Board for discussion at the sessions, of a Discipline Go Live and as well as the Health Board Go Live approach. We await the next Programme Board meeting on the 13th May, for an agreed, workable Mitigation Plan for 2025. • **Cellular Pathology Space:** The lack of space to adequately accommodate the Cellular Pathology service is a long-standing risk. This inhibits recruitment into both the consultant team and technical workforce as there is very little space to accommodate additional staff. The Lack of space also makes working in CTM a less attractive option compared with other Health Boards. The demand on Cellular Pathology services is ever increasing; to operate effectively there will be a requirement for additional equipment, improved workflows and adoption of Digital Pathology, which is impossible to achieve within the current space constraints. The resounding impact of this is the inability to repatriate work that is currently being outsourced or support future plans to repatriate Cell Path services from POW (currently delivered by Swansea Bay under SLA). There is also an impact on development of lean working, to make efficiencies

	to workflows that are required to improve Cellular Pathology result turnaround times (needed to meet current cancer targets). An options appraisal is due to be undertaken to review opportunities to address the issue of space within the Cellular Pathology service.
Advise	**AHPs** • Discussions between Local Medical Committee (LMC) and CTM (Primary care and Podiatry) around the reluctance from GPs to consider prescribing antibiotics on the request of the Podiatrist (community and hospital based). Patient Group Directions are being pursued to allow the prescriptions to be drafted by non-medical prescribers with pharmacy support, independent of District Nursing (DN) and Wound Service, which will help cover soft tissue infection. Associated risks with delayed care and unnecessary demands on Emergency Department (ED) have been escalated. Further discussions with Primary Care and LMC are required. **Radiology** IR(ME)R incidents remain the most common source of incidents from January to March (n=24). Thematic and RC analysis have been conducted and identified that 41% of incidents occurred due to incorrect detector selection in the General X-ray departments at PCH/RGH. The manufacturer's applications team have installed a digital reminder alert prior to radiation exposure and have provided additional refresher training on the equipment. We have demonstrated a reduction in these incidents in April following the intervention, but we are not an outlier in the frequency of incidents and do have a healthy culture of reporting. The most common cause of patient concerns was administrative delays, leading to increased wait times for responses to queries and difficulties in contacting the department. Radiology is concerned that the hold on administrative vacancies will result in these complaints continuing. The installation of the X-ray room in Maesteg has overrun by four weeks. We are currently addressing issues with ventilation and minor Infection, Prevention & Control (IPC) compliance. We have received reassurance from contractors and manufacturers that the room will be handed over to the health board during the week commencing May 5th. Capacity issues are still an issue out of hours (OOH) for CT/X-Ray. With the temporary move of services to RGH we have temporarily rostered additional staffing to mitigate the risks. Additional

funding is required for staffing resource to maintain a safe and resilient service OOHs and a paper has been submitted outlining the requirements. The out of hours model will be reviewed following approval of this paper.

Pathology

- **Impact of Medical Examiner Service (MES) Reform on Mortuary Services:**
- Winter pressures now appear to be subsiding and time to complete death certification is showing signs of improvement. However, a significant amount work is still required to improve the process further and CTM continues to engage with the MES to support this.

  We are looking at further internal improvements, including improvements to the forms required to the MES to notify of a death. A CTM specific QR code will be implemented to increase efficiency and awareness of the process of death notification to the MES. We will also be supporting the bereavement clinical lead to produce a strategic paper on Bereavement services and how they can more effectively support Mortuary flow by following best practice as demonstrated by the Swansea Bay UHB (SBUHB) model.

  Concerns are still being raised by bereaved families in relation to the length of time for death certification, although the number of concerns has declined significantly. The CTM Comms team has supported with an update on the bereavement support page of the CTM website, informing families of the potential delays in receiving a death certificate.

- **Clinical Haematology:** Two locum consultants commenced on the 10th of March, improving consultant capacity to review new patients and increase clinic capacity. However, there is still significant risk to the service as demand continues to outstrip capacity which the care group is working through solutions to address quickly.

- **Cellular Pathology – Transfer of reports from outsourcing**: currently all reports received from the outsourcing company are manually transferred from the results portal to the Pathology system. This has resulted in several incidents where reports have been incorrectly transcribed, and the risk has been increased to reflect this. Cellular Pathology is currently working with the outsourcing company to implement an automated solution which will enable results to be electronically transmitted directly to the pathology system. A statement of need has been submitted to progress this. In the

	meantime, enhanced quality checks are being implemented to mitigate the risk until an automated solution is implemented. **Clinical Engineering** Following the previous escalation of inadequate bed management workforce provision at POW, Clinical Engineering colleagues reviewed their vacant posts and are now able to provide more weekday cover at POW. Further options will be developed to demonstrate how equity of bed management service provision could be delivered across the HB. **Medicines Management** ▪ Incident reported from care home involving suspected diversion of controlled drugs (CD) (no further detail appropriate as under Police investigation). Review of controlled drugs management practices conducted by the medicine's management team, and all recommendations have been actioned by care home management. Visit to GP practice and community pharmacy also undertaken. Follow up visit to home undertaken April 2025 ▪ Initial scoping exercise around potential for cost savings in care homes being investigated ongoing; working with Primary Care to develop. ▪ Transcribing errors found using the 'Pharmacy Tracking System' (tracking system for prescriptions used in secondary care). Discussion with Medicine Management Digital lead around functionality and this has been fed back to the users ▪ A number of complaints received about provision of medication via homecare providers continue to be received. These have been escalated to homecare providers as complaints ▪ Formal complaint received from family member regarding medication treatment received since arriving at Parc Prison and there being an initial delay in treatment being prescribed. Formal response provided by pharmacy and GP team to family member (with consent). ▪ PCH site- Chemocare prescription not ready when needed. Pharmacy Team were not aware that prescription was urgent. Information cascaded to staff to ensure all prescriptions are processed before due date. Meeting to be arranged between pharmacy dispensary manager, dispensary co-ordinator and Principal Pharmacist in Haematology
Assure	**Radiology** All imaging modalities met the Welsh Government target of having no patients waiting over 8 weeks at the end of March 2025, with the exception of a single outlier in NOUS. **Medicines Management**

	CD audits: Target= 100% Current figures for completion of CD audits are: • **RGH**: 98% [Previous Quarter 41%] • **PCH**: 100% [Previous Quarter 100%] • **POW**: 92% [Previous Quarter 38%] • **YCR/YCC:** 100%[Previous Quarter 100%] • Considerable improvement from the previous quarter **Pathology** The Microbiology department has a longstanding risk on the risk register in relation to the provision of equipment, referring to aging equipment that is no longer adequate to efficiently support the service. This risk has recently been increased to high due to a complete analyser failure that has resulted in the Microbiology department having to culture all urine specimens. The impact is that some infections may not be detected by this method and could result in over prescribing of antibiotics. A replacement analyser is currently being verified and should be fully implemented by July.
Inform	**Radiology** The Healthcare Inspectorate Wales (HIW) IR(ME)R inspection self-assessment and supporting documentation were submitted on April 16, 2025. The onsite inspection is scheduled to take place on May 20-21, 2025. Feedback from the inspectors indicated that the self-assessment form was comprehensive. Pan-CTM Radiology Employer Procedures have been developed and implemented on April 28, 2025. These new EPs reflect the IR(ME)R 17 *Amendments 24* and ensure the service is compliant with current legislation. **Pathology** **Combined Major Haemorrhage Procedure Flow Chart** – changes are being implemented to standardise practice in CTM with the rest of Wales. A further driver to this is the merging of switchboards which could add complications if there was difference in practice at POW which is currently under the management of Swansea Bay. The changes have been approved by the Hospital Transfusion Committee (HTC), the MHP procedure will be updated once implementation date is planned, procedure will then be brought through DTPS QSRE and then on for Health Board approval. **Medicines Management** • CD incident with CDs (not subject to register or CD storage requirements) in Ysbyty Cwm Rhondda (YCR). Meeting with senior site nurse to discuss and plan. In the meantime, all non-

registered CDs have been moved to registers and in cupboard. Negative feedback from ward staff with regards to this, leading to longer medication round. However assertive message around CD governance

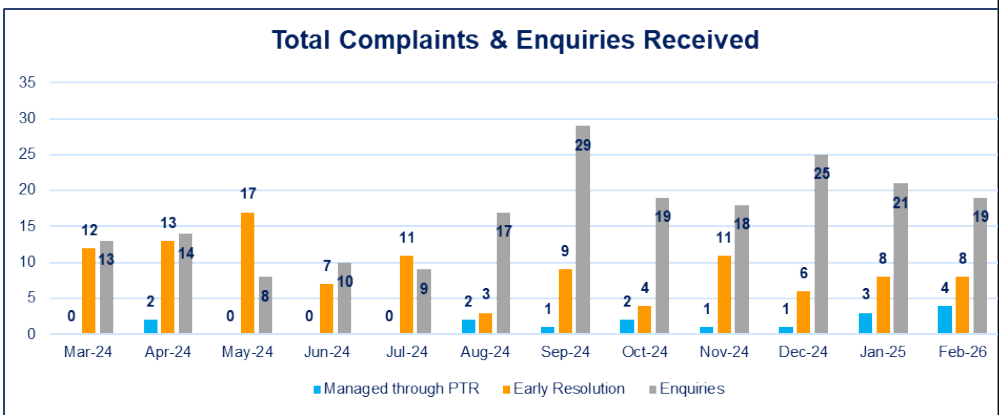
Respiratory Physiology

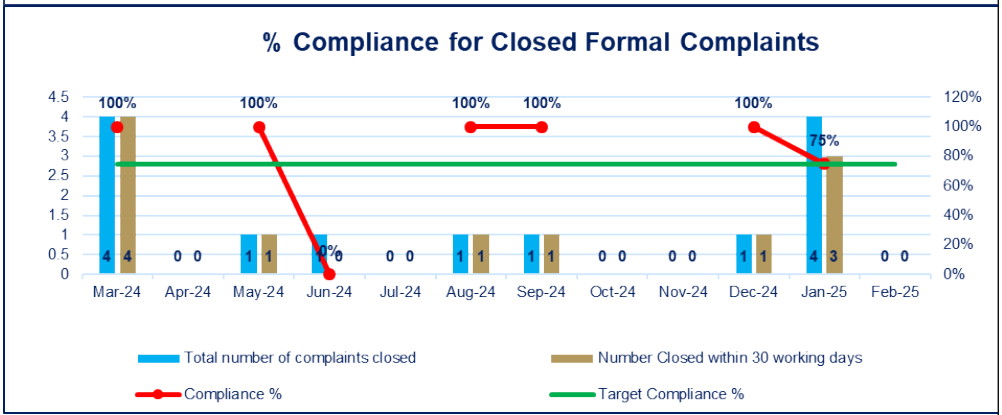
Colleagues are currently reviewing respiratory services and remodelling to incorporate use of healthcare science support staff following a Quality Improvement project. This review is mirroring a previously successful service review in cardiac physiology, with the expectation being that remodelling will improve timely access to diagnostics for patients, reducing waits and avoiding patient concerns.

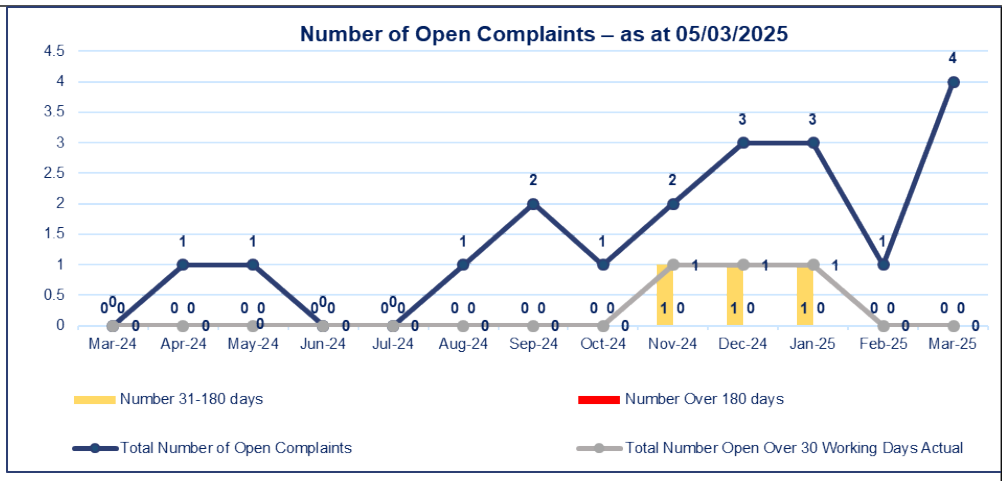
Clinical Engineering

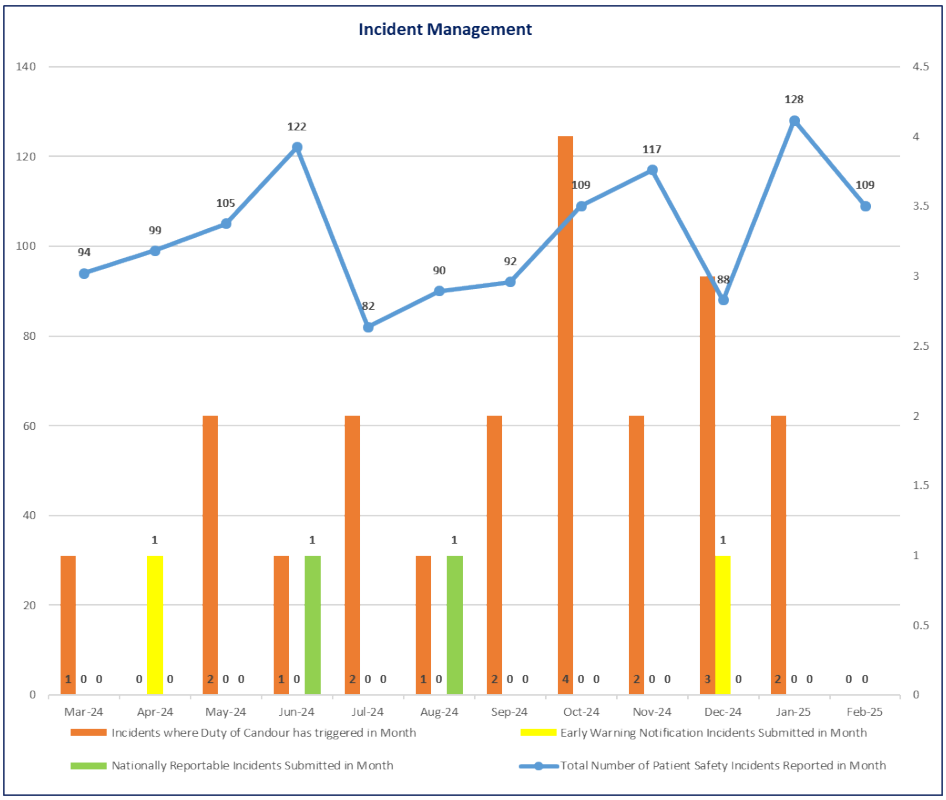
A Band 6 (Annex 21) Anaesthetics/Ventilation Technologist is now in post and training to re-establish this cover at RGH and PCH and remove requirement for expensive external service contracts. The establishment of this post is expected to improve on-site responses to any identified issues resulting in improved patient experience and safety.

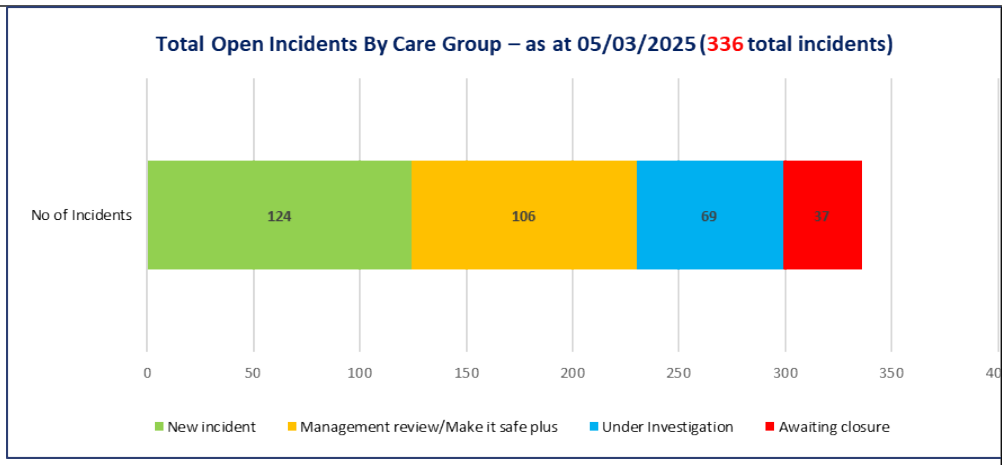
DTPS Complaints Received and Compliance






Number of Open Complaints – as at 05/03/2025
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Mar-25
Number 31-180 days
Number Over 180 days
Total Number of Open Complaints
Total Number Open Over 30 Working Days Actual


Incident Management
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Incidents where Duty of Candour has triggered in Month
Early Warning Notification Incidents Submitted in Month
Nationally Reportable Incidents Submitted in Month
Total Number of Patient Safety Incidents Reported in Month

	
Appendices	None identified.

3. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Living Well
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
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Data to Knowledge
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Effective
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not required at this point
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: NEUTRAL Outcome for Welsh Language: NEUTRAL/	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.	

4. Recommendation

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

Agenda Item
5.3.6

Quality, Safety & Experience Committee

Highlight Report from the Primary Care and Communities Care Group

Dyddiad y Cyfarfod / Date of Meeting	20/05/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	Nurse Director, Primary Care & Communities
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	Nurse Director, Primary Care & Communities
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
APP	Advanced Practice Paramedic
BBV	Blood Bourne Virus
CNH	Clinical Navigation Hub

COPD	Chronic obstructive pulmonary disease
CPR	Cardiopulmonary resuscitation
CTM	Cwm Taf Morgannwg
DBST	Dry Blood Spot Test
DN	District Nurses
DNA	Did not attend
ECC	Enhanced Community Care
ED	Emergency Department
GA	General Anaesthetic
GMS	General Medical Services
GP	General Practitioner
HIW	Health Inspectorate Wales
HMP	His Majesty Prison
PCH	Prince Charles Hospital
POW	Princess of Wales Hospital
PPO	Prison and Probation Ombudsman
RTE	Rhondda Taff Ely
SPOA	Single point of access
WAST	Welsh Ambulance Service Trust
WGOS	Welsh General ophthalmic services

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 Primary Care and Communities Care Group at its meeting on the 11th April 2025.

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

2. Purpose of this Meeting

2.1 The purpose of the Care Group is to provide assurance to the Board on the provision of workplace health & safety and safe and high-quality care to the population we serve, including prevention through public health, primary and secondary care.

2.2 The Primary Community Care Group QSRE Board will:

- Put the needs of patients, carers and the public at the centre of all its business. ese
- Provide evidence based and timely advice to the Primary Community Care Group, based on local need, to assist in discharging its functions and meeting its responsibilities.
- Provide assurance to the Primary Community Care Group in relation to the arrangements for safeguarding the public and continuously improving the quality and safety of the services we provide.

- Ensure that care is delivered in accordance with the Health & Care Standards for Health Services in Wales.
- Ensure that services are delivered in compliance with regulatory legislation and accreditation bodies.

Highlight Report

Alert / Escalate	**Salaried Dental Service:** This service remains on the risk register and an updated report is shared specifically on this service (Please see appendices).
Advise	**Lymphoedema Service** Current risk is due to change of non-recurrent funding for the service. Potential disruption to service delivery and urgent discussions are being held with the PCC care group senior management team. **GP practices** – the practices are now required to report to the Health Board and Welsh Government on the Diabetes 8-Care Processes. The All-Wales group reported Diabetes 8 Care Processes compliance data for CTM shows the total percentage of Type 2 patients who have had all 8 Care Processes recorded is 39.78% and target is 80% compliance for all 8 care processes. The team are working with the practices to ensure compliance is achieved. **District Nursing Services -** Community Nursing Specification. Weekend Capacity to be at 80% by end of March. The DN teams continue to work towards this target and CTM currently have the highest percentage of weekend capacity across All Wales. Currently locality data is Bridgend 63.52%, Rhondda Taf 65.24% and Merthyr/ Cynon 52.48% **Bridgend DN SPOA** – Consultation process has commenced along with staff engagement and support proposed changes from July 2025. This change would provide a single contact number for the DN services, in line with the community nursing specification. **Primary Care** - Primary Care – A risk has been identified in relation to failure to secure an alternative Clinical System for GP practices. This is a significant risk to the 29 GP Practices who remain using the system whilst awaiting transition to a new system. Heads of Primary Care seeking engagement from the National Emergency Planning Team in addition to HB Level and Practice Level Business Continuity Planning. **ECC** – the introduction of this team will allow for more patients to be cared for at home as opposed to in hospital. The ECC team

have reconfigured current services and will provide new services for patients. it is important to note this team have not changed or stopped any clinical provisions whilst increasing the offer of services available.

Navigation Hub there has been a change to the APP model currently provided. This change will be implemented during May 2025 and will allow for a new model to be introduced where the APP staff will be co-located in the CNH but directing the work of those WAST resources on the ground. They will be office based and will no longer be able to facilitate face to face home visits. The reduction in the amount of face-to-face work could result in a reduction in the number of avoided conveyances. This change will be monitored by the team and findings will be shared with WAST.

Optometry - WGOS 4 Monitoring Services-Implementation

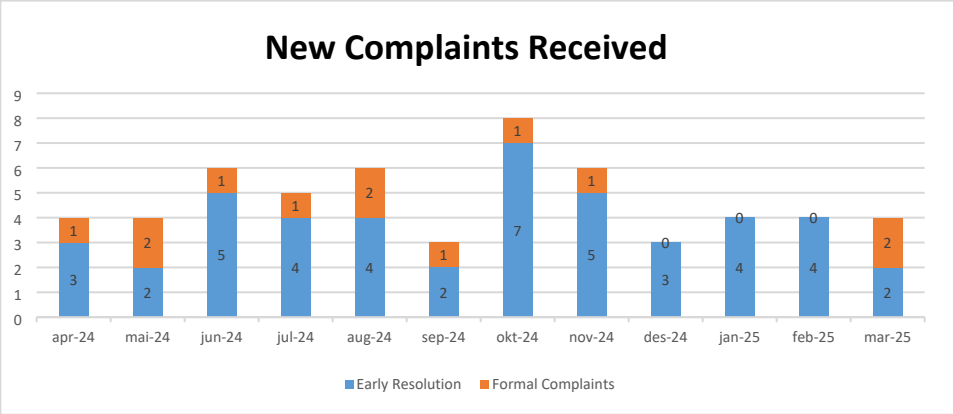
- The HB is responsible for implementing all WGOS 4 services under the new Optometry regulations that came into effect in Oct'23
- Primary Care have implemented the WGOS 4 filtering services for Glaucoma/Wet AMD/Diabetic Ret to reduce the number of referrals into hospital eye care services.
- However, WGOS 4 monitoring pathways still require development.

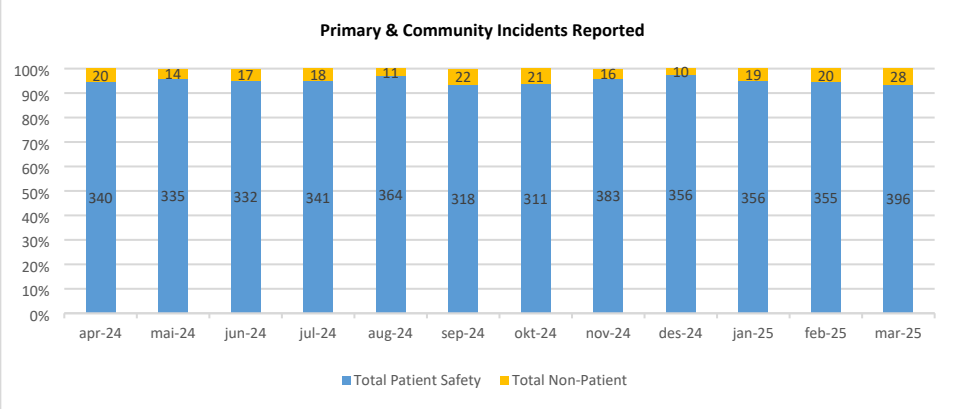
Regular meeting to discuss a HB implementation plan for WGOS 4 is required, with task and finish groups established to progress each pathway. A plan needs is now in place to progress this work, WG have requested sight of this plan.

Parc Prison Dental services there are currently 394 patients are on the waiting list, of which 392 are waiting for initial assessment. Utilisation for February was 61% with 102 missed appointments, which is the highest number for 2024/25, of the missed appointments, 52 were DNAs and 50 were missed. Actions are awaiting decision on approval of funding by HMPPS for weekend working to reduce backlog and improve access. Long term solution is a 2nd surgery which is on the re-design plan for healthcare wing.

HMP Parc Prison During March 2025, a team from the Royal College of Psychiatrist visit as part of the all-Wales review into mental health and substance misuse services. During the visit, the inspectors spoke to team members, partner organisations and patients to assess the services against Welsh Government standards for mental health and substance misuse in prison

	healthcare teams. The directorate have now received the report during April 2025 and are working through an action plan to address the findings.
Assure	**Concerns**





	Dental Access current waiting list numbers on Dental Access Portal is 8364 patients. This should reduce during 25/26 as patients are allocated to 17 practices awarded new funding since October 2024. Level of urgent access appointments in practices has been reduced due to the new 25/26 contract metrics, this could impact access to urgent care, this will be closely monitored over the next few months and practices asked to amend metrics to support provision of access which can be actioned under the contract variation notice if required and practices agree. BBV screening at **HMP Parc**, as part of WHO's elimination strategy for hepatitis, the local plan has a work stream to achieve elimination status within HMP Parc. During the last year, the team at HMP Parc have improved the position with the percentage of population offered DBST in the previous 12 months improving from 78% to 97%. Likewise, the percentage of those screened improving from 34% to 89% at the end of March 2025. **HMP Parc** following several instances where WAST colleagues have been delayed accessing the prison site and treating patients who require emergency treatment and possible conveyancing to the hospital, a working group between WAST, Prison Healthcare and G4S has been established. Following the completion of the group, a protocol has been drafted and is being shared with all stakeholders prior to approval. **HMP Parc** the PPO aims to make a significant contribution to safer, fairer custody and community supervision by carrying out independent investigations into deaths, due to any cause of prisoners. In Wales, the HIW are commissioned by the PPO to undertake the clinical review of the care the prisoner had at the prison.
Inform	**Professional Nurse advocacy and Practice Development** Launch of the new Nurse Advocacy and Practice Development Service planned for May 12th, 2025. The team have currently undertaken a significant amount of improvement work: • Developed and implemented best practice guidance (using SBAR format) regarding the completion and submission of a pressure ulcer incident report (QI initiative). • Developed and implemented a training programme for Registered Nursing staff including Interview techniques, CPR, Manual Handling, Venepuncture, TRAC. • Facilitated training events for Level 4 Assistant Practitioners in relation to the core skills training framework. • Developed and implemented a Band 7/6 development programme.

- Developed a "Summary of Annual Review" guidance document for the Assistant Practitioner role based on the national governance framework awaiting ratification.
- Developed a Student Nurse induction pack for District Nursing awaiting ratification.
- Developed a patient information leaflet for District Nursing which includes a QR code for patients/families to provide feedback regarding their experience awaiting ratification.
- Developed a staff information leaflet for the Professional Nurse Advocacy & Practice Development service awaiting ratification.
- Developed a staff information leaflet for Restorative Clinical Supervision awaiting ratification.
- Developed an evaluation form for Restorative Clinical Supervision awaiting ratification.

International Nurses Day planning with Senior Nurses and clinical teams are productive and events planned to celebrate Nurses Day on May 12th

Ysbyty Cwm Cynon Music therapy introduced and was very well received by patients on the wards. Patient feedback has been very positive and lovely to hear.

Ysbyty Cwm Cynon the site has a hairdresser attending the ward and support the patients. This has been really well welcomed by patients and relatives.

Urgent Treatment Centre at PCH this service is now being incorporated into part of the ED department and will now be managed by the Senior team in PCH.

Respiratory Virtual Ward now has 20 patients across RTE and Merthyr. Bridgend COPD team to begin to refer in patients in May.

District Nursing – bespoke safeguarding training sessions in place across the service the support the teams.

GP Practices – the GMS team are working alongside the safeguarding team to provide a robust training programme for GP and wider colleagues across the practices.

GP practices GMS Unified Contract Assurance Framework Visits (UCAF) have commenced and four practices will receive an in-depth whole day visit undertaken by a multi-disciplinary team to including a Clinical Director (GP) and Medicines Management covering all 12 Quality Standards.

Appendices	Paediatric Dental GA Services Update

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	Living Well 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: Ageing well Dying Well Growing Well
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Learning, Improvement & Research If more than one applies please list below: Culture and valuing people Leadership
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Effective If more than one applies please list below: Efficient, Person centred, Equitable, Timely, Safe
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable 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**	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please include rationale below:

Have you undertaken an Equality and Welsh Language Impact Assessment Screening?	Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	
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.	

4. Recommendation

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

Agenda Item
5.36b

Quality Safety and Experience Committee

Community Dental Service: Paediatric Dental General Anaesthesia

Dyddiad y Cyfarfod / Date of Meeting	20/05/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Directorate Manager for Dental Services
Cyflwynydd yr Adroddiad / Report Presenter	Nurse Director, Primary Care and Communities Care Group
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Primary Care Performance Board	09/04/2025	This is a standard agenda item for updated position/ escalation
Primary Care, QRSE	11/04/25	This is a standard agenda item for updated position/ escalation

Acronyms / Glossary of Terms	
CDS	Community Dental Service
CTMUHB	Cwm Taf Morgannwg University Health Board
GA	General Anaesthesia
GAA	General Anaesthesia Assessment
PCH	Prince Charles Hospital
POW	Princess of Wales Hospital
RGH	Royal Glamorgan Hospital
RTA	Referral to assess
RTT	Referral to treatment

1. Situation/Background

The purpose of this report is to provide an update on the paediatric dental GA service across CTM UHB.

1.1 The Community Dental Service (CDS) receives both internal and external referrals for children who require dental treatment under general anaesthetic (GA). Following the triage of referrals, patients are placed on a waiting list for a general anaesthetic assessment (GAA), undertaken by CDS Dentists and Paediatric Specialists.

1.2 As previously reported, the paediatric service has a significant backlog of children waiting for GAA. As of April 2025, there is approximately 721 children in the awaiting for an assessment, once assessed, 541 children will require GA for dental treatment. This figure does not include 244 children that are on an alternative assessment list that has been put in place since the backlog, to ascertain if alternative treatment options can be considered. Unfortunately, despite considering alternative treatment methods such as sedation and local anaesthesia, a significant number of children still require GA for treatment.

1.3 Historically, the service had access to two GA theatre lists per week in RGH. These lists were cancelled due to the POW estates issues and no replacement lists were able to be provided. Due to the cancellation of the lists during COVID and the POW estate issue, this has resulted in a significant backlog within the service.

1.4 Since the cancellation of the regular GA lists, the service has been securing provision with ad hoc lists, although allocation of a theatre list through this process is not always guaranteed. A temporary urgent list per month was also offered to the service via the maxillofacial team in PCH, where 5 patients were able to be seen. Whilst this enabled a small number of patients to receive treatment per month, the backlog has continued to increase due to the level of demand. The urgent list is no longer available due to the maxillofacial team requiring the list for their own patients.

1.6 Due to the length of time children are waiting for assessment, dental issues faced by this cohort of patients are exacerbated, therefore the conversion rate to GA has risen from 50% [pre-covid] to 75%. If the backlog could be reduced, the conversion rate to GA would reduce, which would mean less theatre lists would be required for the service.

2. Plans for the service

2.1 An opportunity has arisen to reinstate 1 x regular list per week in PCH as part of the new theatres opening in May 2025. This will allow on average up to 6 patients per week to be seen [approx. 24 per month]. Whilst this is a significant improvement since the cancellation of the 2 x GA lists in RGH, in order to reduce the backlog and manage the ongoing demand, additional

theatre lists are essential in order to have any significant impact on the problem.

2.2 The use of the Vanguard theatres currently operating from the RGH site are being considered. Should this list go ahead, over 6-month period an estimated 240 patients could be seen. However due to staffing costs, the willingness and availability of staff to work every Saturday, particularly over holidays periods, will mean the numbers treated will be far less.

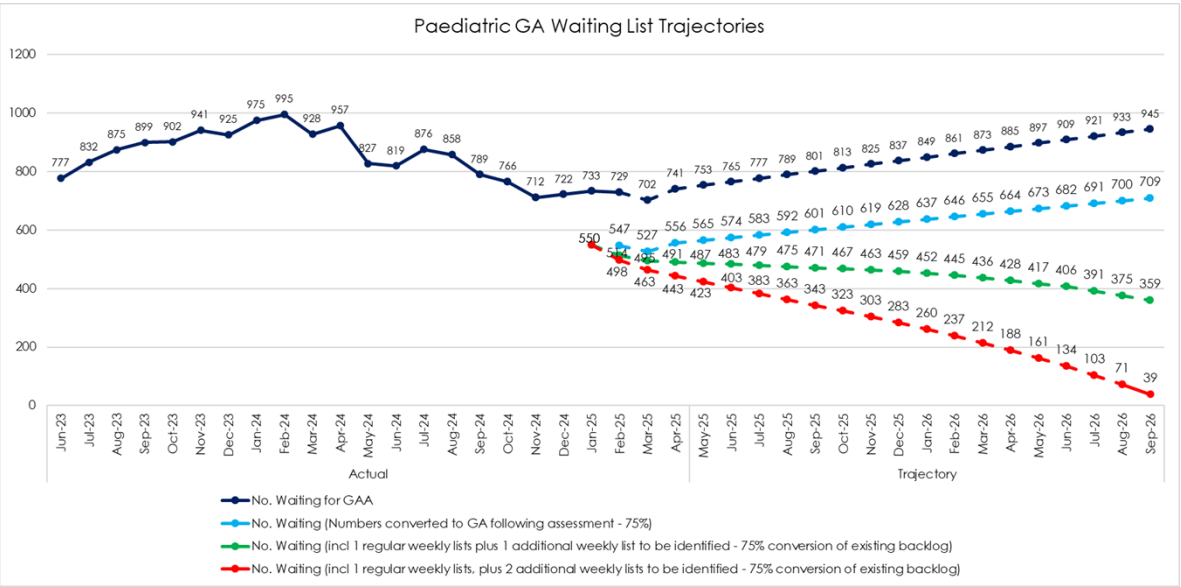
2.3 Discussions are ongoing as to whether the RGH lists are able to be reinstated in addition to the PCH weekly list. If progress can be made on reducing the backlog and children seen in a timelier way, the needs of the service will change, with only 2 lists per week being required.

3. Key Risks

3.1 The service is listed on the risk register [score of 20].

3.2 The main risk within the service is patient harm [children]. With the growing waiting list for GAA and the limited access to regular GA lists for children to receive treatment, children's oral health is deteriorating resulting in more children needing to receive a GA and more complex cases being seen. Without access to more regular lists, the service is not able to effectively reduce the backlog with the current numbers of theatre lists allocated.

3.3 The graph below shows the projected number of children waiting to be treated under GA and how the backlog could be reduced if additional access to theatre lists was available:



3.4 The blue lines are the projected number of children waiting within the service if the status quo is maintained. The green line indicates the impact if one additional weekly theatre list was available and the red line shows the impact if there were two additional weekly theatre lists available. The red line clearly demonstrates how effective 2 additional routine lists would be in reducing the backlog, enabling the service to revert back to the 2 original lists.

4. Recommendation

4.1 The Committee is asked to:

- Recognise the urgency for additional regular GA lists to run in conjunction with the weekly PCH list, to improve reduction of the backlog/waiting times for children.
- Acknowledge that if additional lists are provided and the backlog is significantly reduced, the service will require less theatre lists once the backlog is removed, releasing theatre lists for other service use.
- Understand that if timely care under GA is made available to children, it will:
  a) reduce the current level of demand for multiple tooth extractions
  b) reduce the number of children converting to GA and allow for alternative treatments to be considered
  c) Prevent children from being absent from school due to tooth pain/swelling, having multiple courses of antibiotics for urgent care whilst waiting for treatment.

5. Next Steps

5.1 Ongoing discussions between primary and secondary care regarding the reinstatement of GA lists in RGH.

5.2 Discussion required on where the ownership of the GA lists for Community Dental should sit within the Care Groups. GA provision is not a primary care function. This is being raised nationally by Dental Directors to ascertain if RTA and RTT targets need to be applied to this service area.

Agenda Item
6.1

Quality, Safety & Experience Committee

Patient Safety, Quality & Experience Dashboard

Dyddiad y Cyfarfod / Date of Meeting	20/05/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Head of Concerns & Business Intelligence
Cyflwynydd yr Adroddiad / Report Presenter	Head of Concerns & Business Intelligence
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Review

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group /Forum Individuals	**Date**	**Outcome**
Discussions with key individuals in corporate services and within Care Groups	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf Morgannwg University Health Board
PTR	Putting Things Right
PSOW	Public Service Ombudsman for Wales
PALS	Patient Advisory Liaison Service

1. Situation /Background

This presentation of the Patient Safety & Quality Dashboard to Committee provides data from 01.03.25 and 30.04.25 taken from systems on 02.05.25, unless otherwise specified.

Key areas to note in this reporting period are:

- Decrease in the number of new complaints and enquiries received
- Improved compliance to above National Target of 75% for responding to complaints within 30 working days
- Decrease in number of open Public Service Ombudsman of Wales Information
- Increase in number of National Reportable Incidents submitted to NHS Wales Executive
- Overview of Inquest activity
- Summary of Clinical Negligence Activity
- Decrease in medication incidents reported
- Increase in patient fall incidents reported
- Decrease in restrictive incidents reported

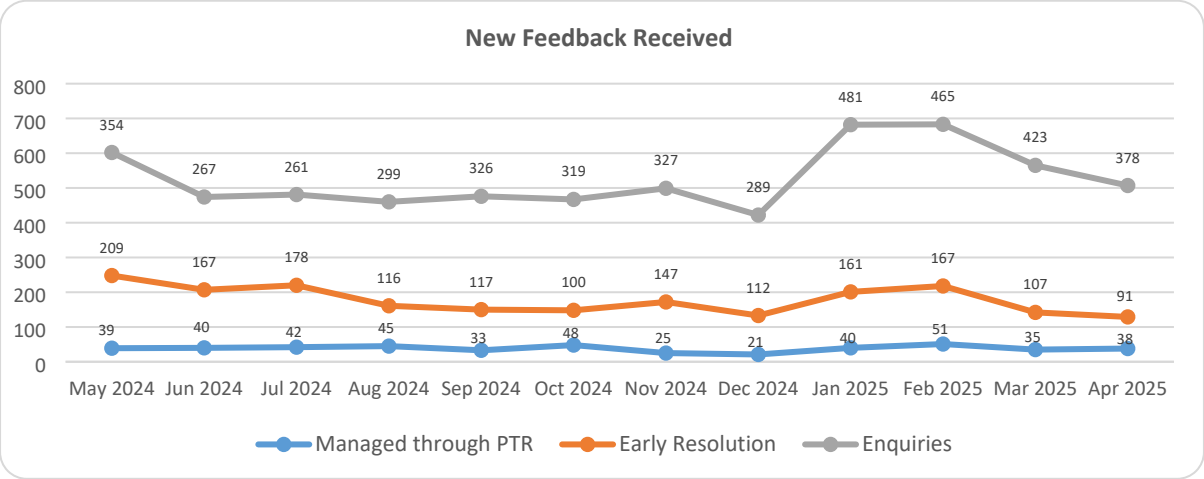
2. Specific Matters for Consideration

2.1 Patient / Service User Feedback

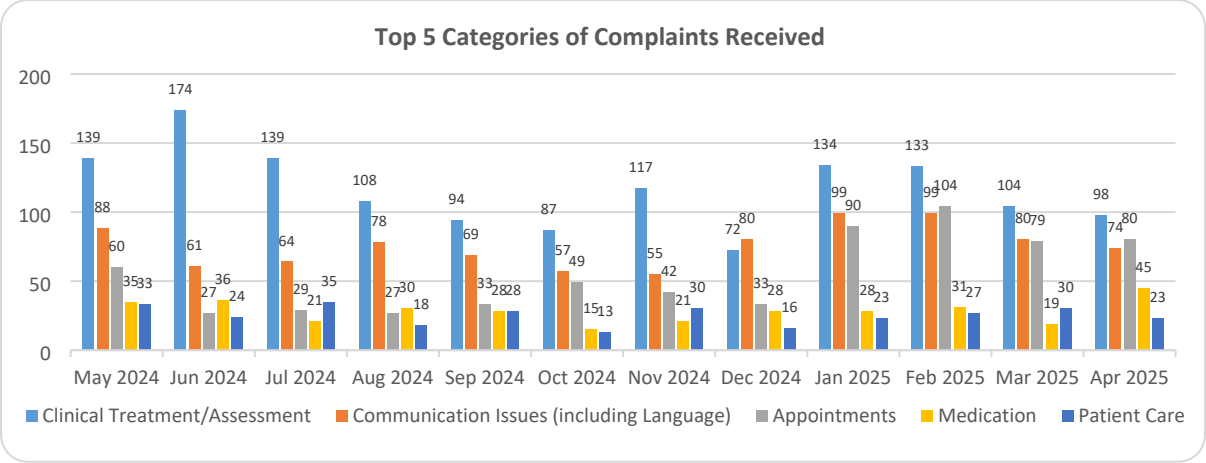
Complaints & Enquiries

New Complaints Received

Between the 01.03.25 and 30.04.25 the Health Board received a total of 268 complaints and 801 enquiries. Of 268 complaints received, 73 were categorised as formal and managed under the Putting Things Right Regulations (PTR). Following a significant increase during the previous two month period, the number of complaints and enquiries received has decreased.

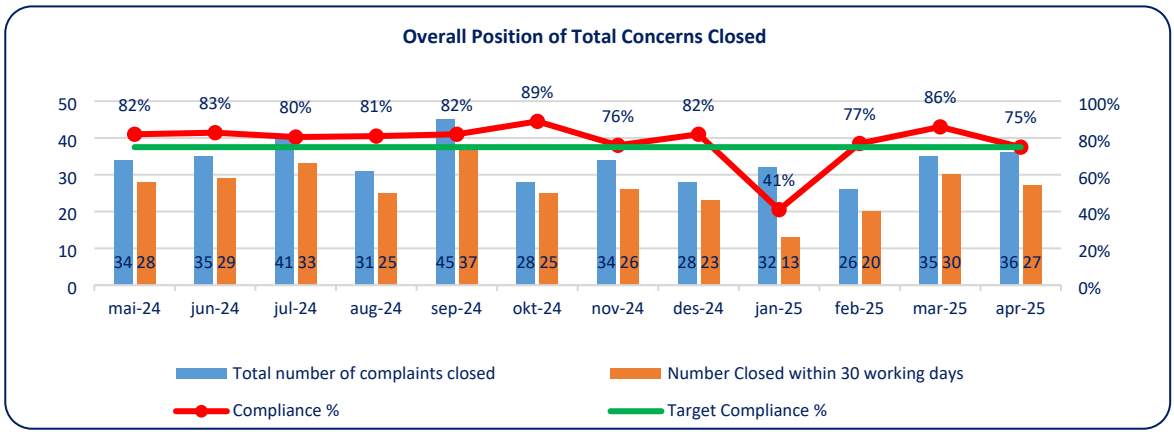


For <u>all feedback (Complaints and Enquiries)</u> received in March and April 2025, accounting for 51% of the feedback received, the top 3 types remain consistent with previous months. These relate to Clinical Treatment / Assessment (202), Appointments (159) and Communication Issues (154).



Closed Complaints

Within the period of 01.03.25 to 30.04.25, the Health Board closed a total of 62 formal complaints (managed through PTR). During the 2 month period, the national target of 75% compliance for responding to complaints within 30 working days was achieved. As at 02.05.25, the Health Board had 64 open formal complaints. Of these, 21 complaints were open over 30 working days. A review of all complaints procedures is currently being undertaken to identify opportunities to improve efficiency in processes, along with embedding the importance of timely escalation.



Public Services Ombudsman for Wales

Open cases

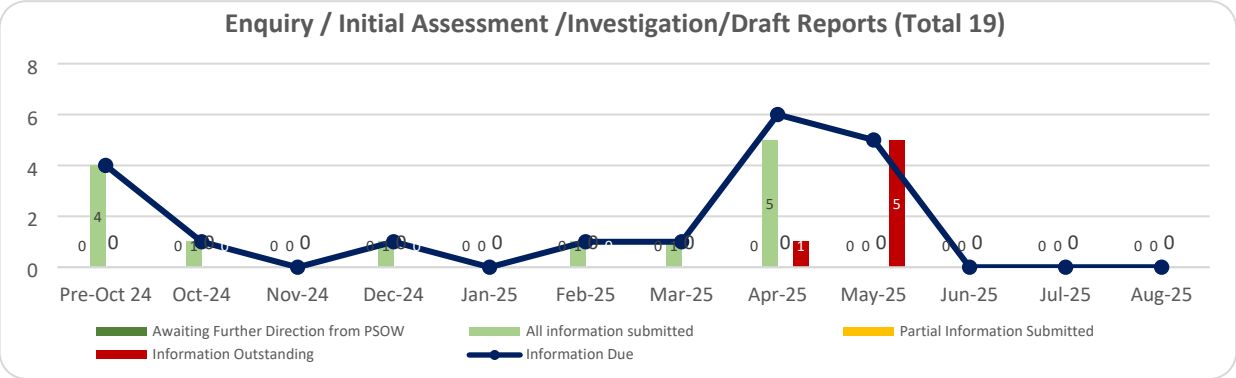
As at the 02.05.25 the Health Board has 27 open Public Services Ombudsman for Wales (PSOW) Cases. This is a significant decrease from the 72 open at the end of February, as a result of a consolidation exercise undertaken with the PSOW. Of these, 17 are awaiting a response from the PSOW.

Current Status	Enquiry / Initial Assessment/ Investigation	Early Settlement	Draft Report Comments	Final Report Compliance	Information Only	Total
All evidence submitted and awaiting closure by PSOW	0	0	0	0	0	0
Awaiting further direction from PSOW	0	0	0	0	2	2
Information Received	0	0	0	0	0	0
Information Submitted	14	1	0	0	0	15
Information Outstanding	3	2	2	1	0	8
Information Partially Submitted	0	0	0	2	0	2
Total	**17**	**3**	**2**	**3**	**2**	**27**

New PSOW Cases Received

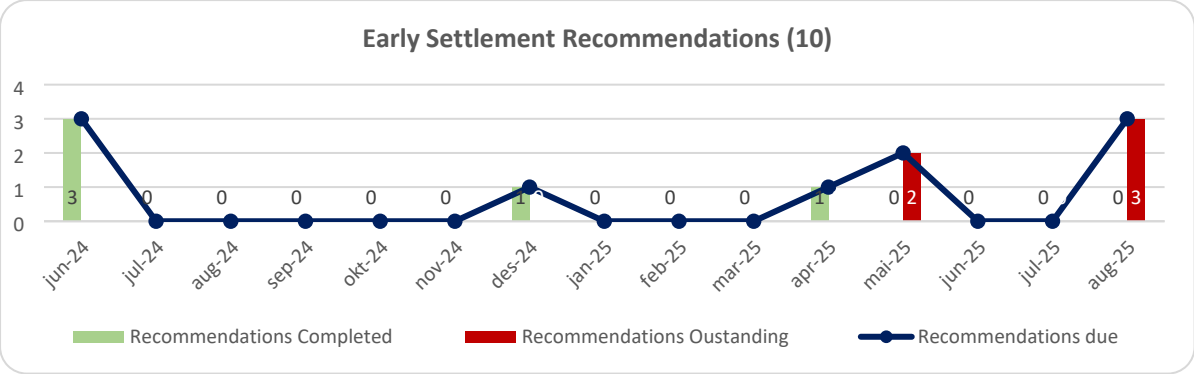
The Health Board received notification of 13 new referrals to the Public Services Ombudsman for Wales (PSOW) between the 01.03.25 and 30.04.25. Of the 13, 8 were received as enquiries, 2 as full investigation, 2 as decision not to investigate and 1 as an early settlement proposal.

Of the 19 cases, the Health Board currently has at 07.03.25 in the enquiry / initial assessment/investigation stage, 6 cases have outstanding actions. One action is currently overdue. This is reflected in the chart below:



Early Settlement Proposal

During the same period the Health Board agreed 2 early settlement proposals. It should be noted that more than one action can be attributed to a case. As at the 07.03.25, the Health Board has 3 open early settlement cases, with 10 associated case actions. Of the 10 actions, none are overdue the deadline agreed with the PSOW.

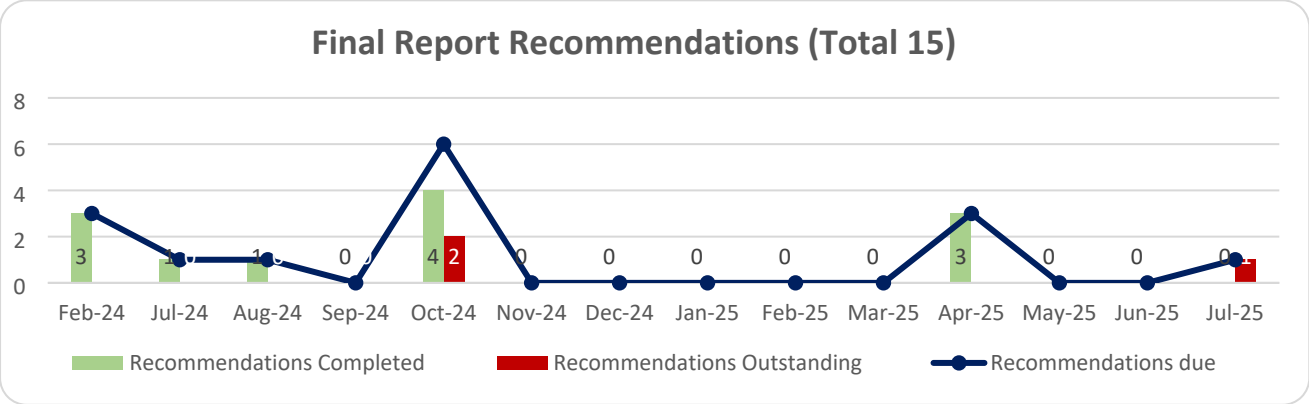


Final Reports

During March and April 2025, the PSOW issued 2 final reports to the Health Board. Of these, 1 was partially upheld and 1 was not upheld.

The PSOW issued a partially upheld case following its investigation as to whether the Health Board had appropriately managed a funding request for surgery in a second Health Board. The Ombudsman's investigation found that there was confusion within Cwm Taf Morgannwg University Health Board regarding the process for arranging funding between itself and the second Health Board. The report also determined that the Health Board had failed to communicate appropriately with the Complainant regarding the outcome of the funding application in respect of the patient's surgery. In recognition of the findings of the report, the PSOW recommended that the Health Board review and amend its communication process following the outcome of a prior approval funding application.

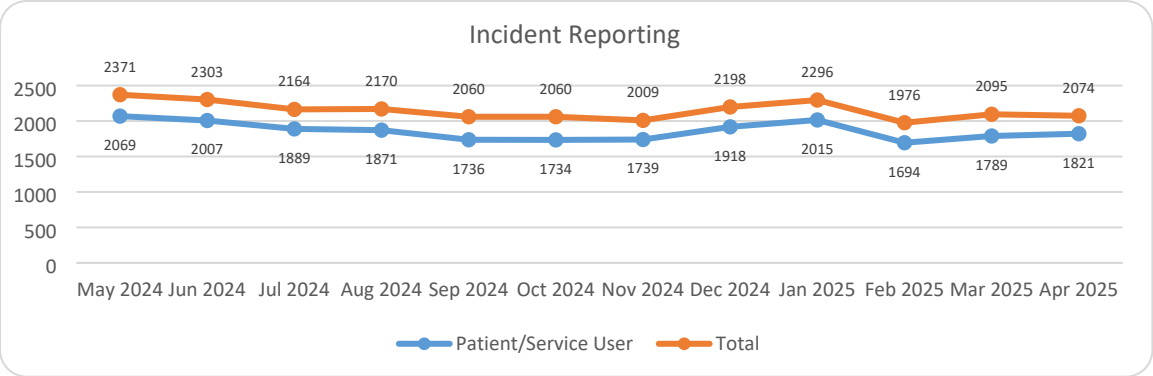
As at 02.05.25, the Health Board has 3 cases which are currently in the final report stage of the PSOW process. These cases have 15 associated recommendations. Of these recommendations, 3 are currently outstanding, with 2 currently overdue the timescale for completion.



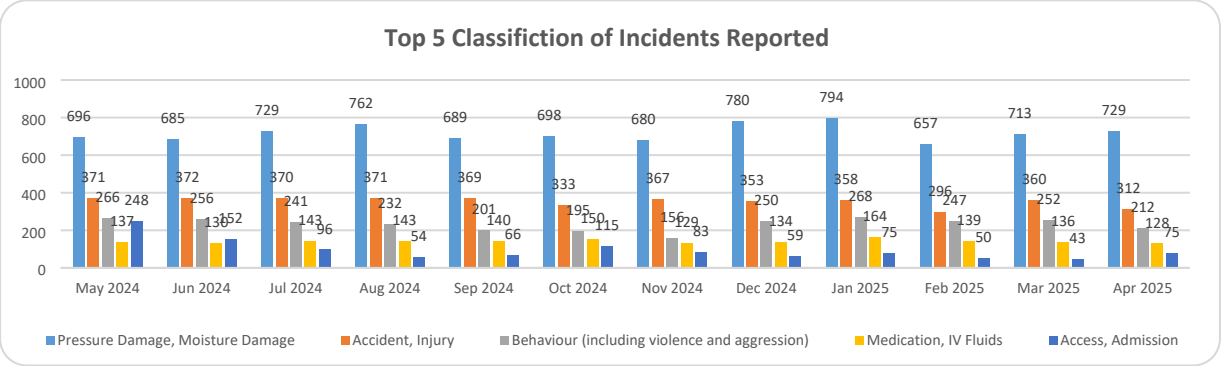
2.2 Patient Safety Incidents

Total Patient Safety Incidents

A total of 4,169 incidents were reported as occurring between 01.03.25 to 30.04.25, this represents a decrease of 103 when compared with the previous 2 months (4,272). The proportion of incidents reported where the patient is identified as the person affected has remained relatively consistent over the last 6 months period. Of the 4,169 incidents reported, 87% (3,610) were reported as the patient affected. The trend in incident reporting is reflected in the chart below.

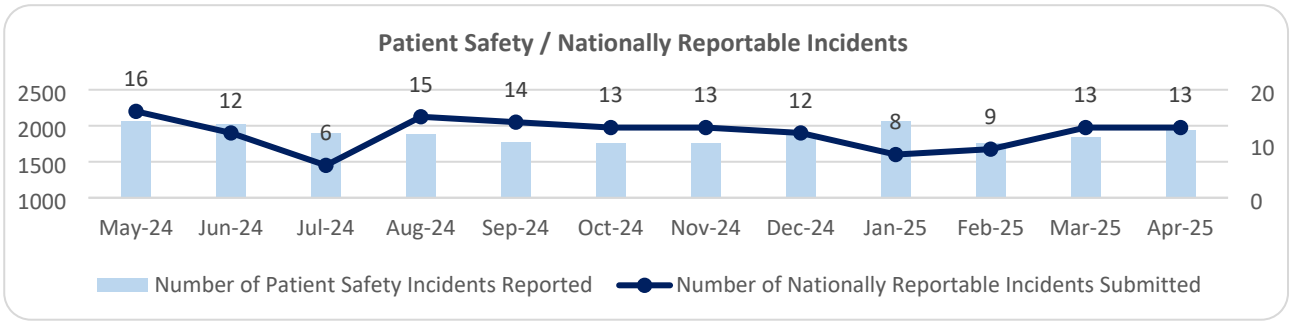


The top 5 classification of incidents reported as occurring in March and April 2025, linked to a patient affected incident are: Pressure Damage /Moisture Lesion (1,442), Accident, Injury (672) and Behaviour (including violence and aggression) (464), Medication, IV fluids (264) and Access, Admission (118). This is consistent with the previous two month period. The trend for the top 5 classification of incidents is highlighted in the chart below:



Nationally Reportable Incidents

Between 01.03.25 and 30.04.25, 26 Nationally Reportable Incidents were submitted to the NHS delivery unit. The ratio of Nationally Reportable Incidents to the overall number of patient safety incidents is demonstrated in the chart below.

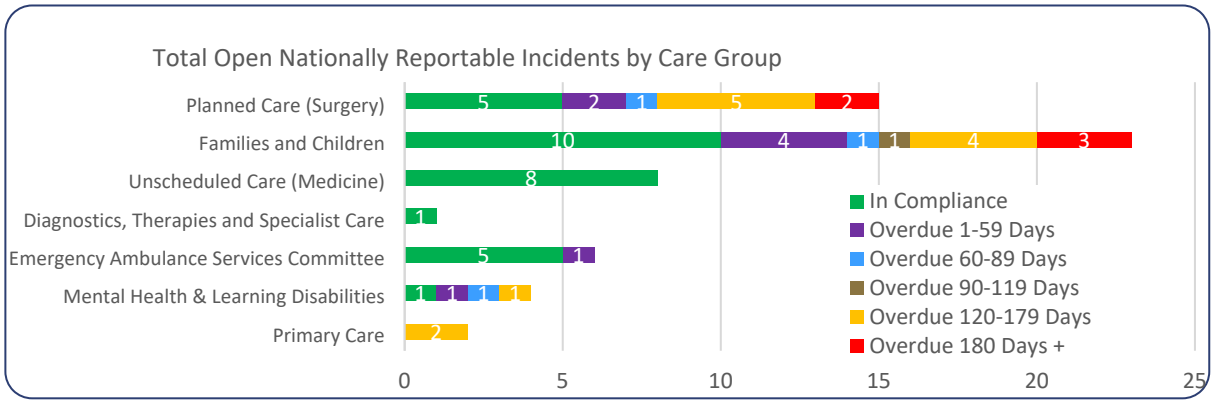


As highlighted in previous reports to Committee, it should be noted that Nationally Reportable Incident data is presented based on the date the notification was submitted to the NHS Executive. The significant decrease in the number of incidents reported during July 2024 can be linked to the transition to the NRI Reporting Portal which resulted in some delays in the submission process. These incidents were subsequently reported in August 2024. The trend for the classification of Nationally Reportable Incidents submitted is reflected in the table below:

	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	Total
Access, Admission	1	0	0	3	2	0	0	0	0	0	1	1	8
Accident, Injury	0	0	0	0	0	1	0	0	0	0	0	0	1
Assessment, Investigation, Diagnosis	1	2	0	2	2	1	0	0	0	0	1	0	9
Behaviour (including violence and aggression)	0	0	0	0	0	0	1	0	0	0	0	0	1
Equipment, Devices	0	0	0	0	0	0	0	0	0	0	0	1	1
Infection Prevention and Control	0	2	1	1	3	0	0	2	0	0	4	3	16
Maternity adverse occurrence	2	3	0	2	1	3	2	2	4	1	3	0	23
Medication, IV Fluids	0	0	0	1	0	0	0	0	0	0	0	0	1
Monitoring, Observations	0	0	0	1	1	0	0	0	0	0	0	0	2
Nutrition, Hydration	0	0	0	0	0	0	0	0	0	1	0	0	1

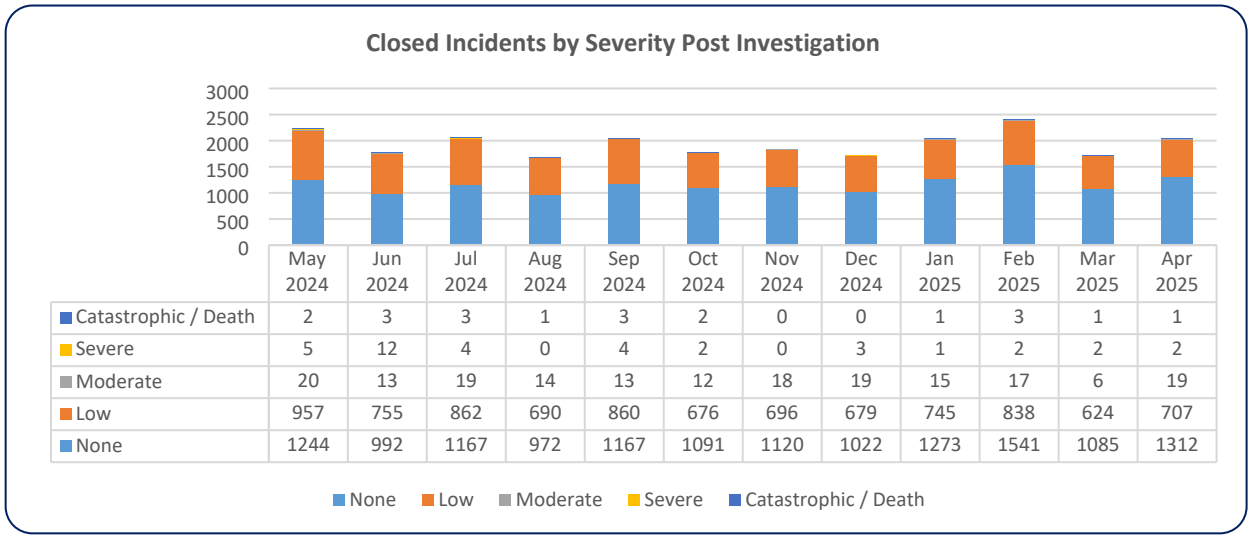
Patient/service user death	1	2	1	0	0	0	2	0	1	1	0	1	9
Pressure Damage, Moisture Damage	3	3	4	3	3	8	6	7	2	4	4	3	50
Transfer, Discharge	1	0	0	0	1	0	0	0	1	1	0	4	8
Treatment, Procedure	7	0	0	2	1	0	2	1	0	1	0	0	14
Total	16	12	6	15	14	13	13	12	8	9	13	13	144

As at the 02.05.25, the Health Board currently has 59 open Nationally Reportable Incidents, of which 29 are overdue the timescale for completion. Focused work continues to be undertaken to ensure investigations are concluded and ensure a timely outcome is provided to patients and their families. An overview of the open Nationally Reportable Incidents by Care Group is provided in the chart below:



Closed Patient Safety Incidents

Between the 01.03.25 and 30.04.25 a total of 3,759 patient safety incidents were closed. The 12 month trend is reflected in the table below.

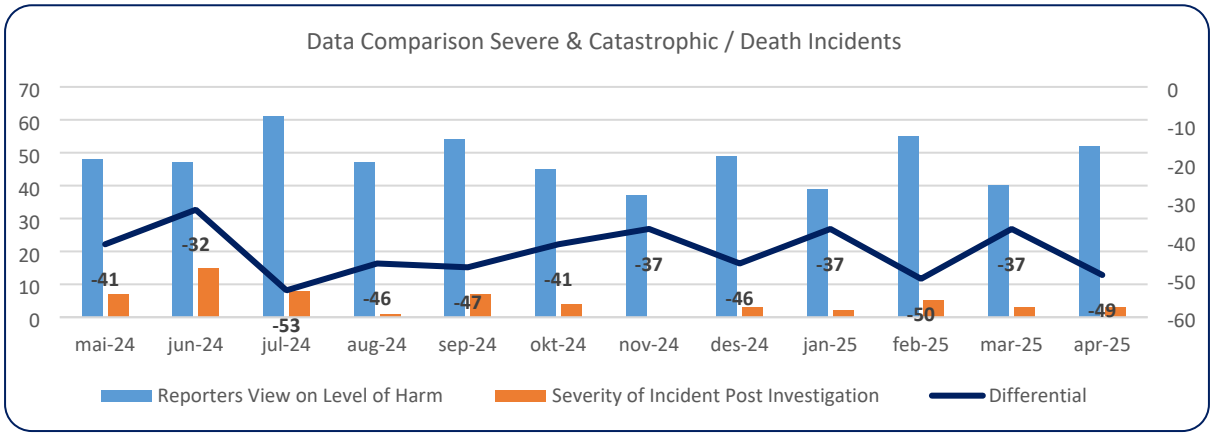


	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025
Catastrophic / Death	2	3	3	1	3	2	0	0	1	3	1	1
Severe	5	12	4	0	4	2	0	3	1	2	2	2
Moderate	20	13	19	14	13	12	18	19	15	17	6	19
Low	957	755	862	690	860	676	696	679	745	838	624	707
None	1244	992	1167	972	1167	1091	1120	1022	1273	1541	1085	1312

Of the 3,759 patient safety incidents closed, 6 were closed with severity post investigation of severe harm (2) or catastrophic/ death (2). A breakdown of incidents is provided in the table below:

	Mental Health	Diagnostics, Therapies and Specialist Care	Unscheduled Care (Medicine)	Planned Care (Surgery)	Total
Assessment, Investigation, Diagnosis	0	1	1	1	3
Infection Prevention & Control	0	0	1	0	1
Patient/service user death	1	0	0	1	2
Total	1	1	2	2	6

Work continues to be undertaken to ensure that a severity of moderate, severe or catastrophic / death recorded on conclusion of an investigation accurately reflects where it can be determined that an incident has been directly caused or attributable to an intervention (action/inaction) by the Health Board. In addition, mechanisms to support a comparison of reporter's view of level of harm and the severity recorded post investigation have been established. The level of harm attributed to an incident is reviewed and recorded at 3 stages within the incident management process, reporter view on Level of harm, level of harm following management review and severity determined post investigation. Trend information providing a comparison between the reporters view on level of harm and severity of incident post investigation is provided below:



Duty of Candour

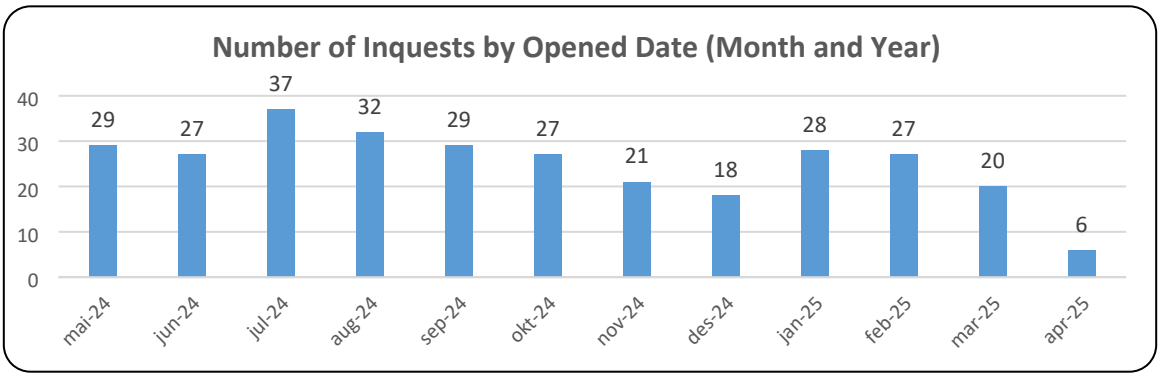
The Duty of Candour regulations were implemented from the 01.04.23. To enable monitoring of requirements, a number of metrics have been devised, which are summarised in the table below. To support the implementation of the Duty of Candour processes, dashboards have developed to provide 'live' data at a glance along with the introduction of weekly data validation audits.

Number of Incidents	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025
Where Duty of Candour Triggered	17	9	11	11	13	7	15	11	9	5	13	15
Where In-person notification completed	13	8	8	8	12	4	14	8	8	4	12	13
Where letter of notification sent	6	4	6	6	12	4	14	8	7	4	11	11

2.3 Inquests Case Activity

New Inquests Received

In the time period 01.03.25 to 30.04.25, the Health Board received notification of 26 inquests. This is a significant decrease when compared with the previous 2 month period. A trend graph of the inquests opened during period is provided below.

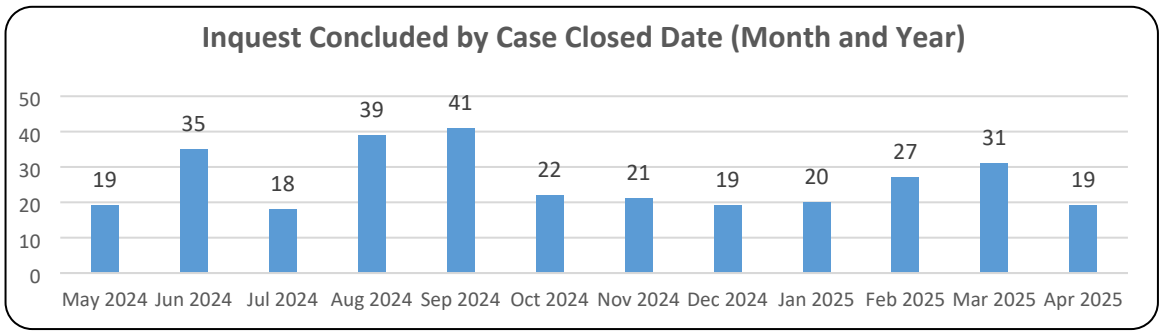


Of the 26, the highest number of inquests were received for the Unscheduled Care Group. A breakdown of inquests received by Care Group is provided below.

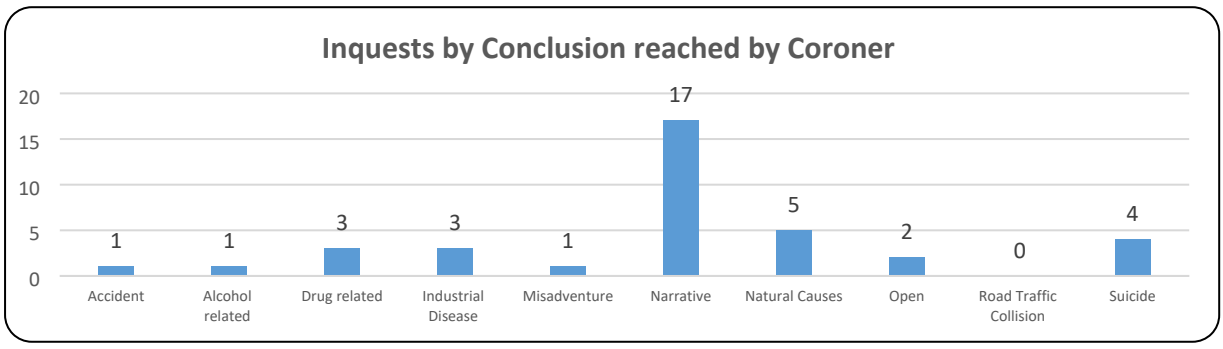
Care Group	Number Received
Community	0
Diagnostics, Therapies & Specialist Care	1
Families & Children	3
Mental Health	7
Planned Care (Surgery)	4
Primary Care	1
Unscheduled Care (Medicine)	10
Total	94

Inquests Concluded

During the same 2 month period, 50 inquest cases were closed on the Health Board's Datix system. A trend graph of inquests concluded during the period is provided below. It should be noted that inquests will not always be opened and closed in the same period.



Of the 50 inquests cases closed on Datix, 13 were discontinued by the Coroner prior to hearing. Of the remaining cases, 59% were concluded with a narrative conclusion (17) or with an outcome of natural causes (5). A further breakdown of the outcome of inquests closed between the 01.03.25 and 30.04.25 is provided in the chart below.



Regulation 28 Reports / HMC Letter Received

On conclusion of an Inquest, under the Coroners Regulations 2013, the Coroner has the power to make a report to prevent future deaths, referred to as Regulation 28 reports. Between the 01.03.25 and 30.04.25 the Coroner issued 1 regulation 28 reports to the Health Board relating to Hospital Death (Clinical Procedures and Medical Management) related deaths.

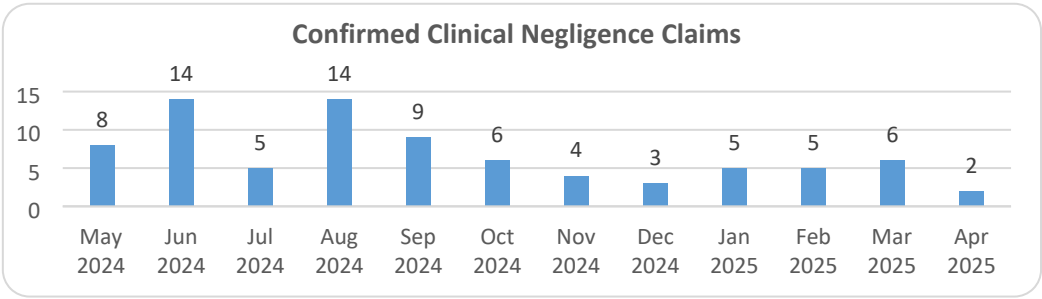
The Regulation 28 Report outlined that the patient should have been referred for surgical review rather being discharged. It was further highlighted that work on a "Failed Discharge" Policy has been ongoing for some time, with progress being difficult and no definitive timescale for implementation. When the policy is implemented patients re-attending Emergency Departments in similar circumstances would be automatically and swiftly filtered to the appropriate specialist team, which would reduce the risks for those individual patients and reduce pressures and the consequent risk of errors within Emergency Departments.

On a further case whilst the Coroner did not issue a regulation 28 report, a letter identifying opportunity for improvement in relation to training and approach to medical note taking was issued to the Health Board during the same time period.

2.4 Clinical Negligence Claims

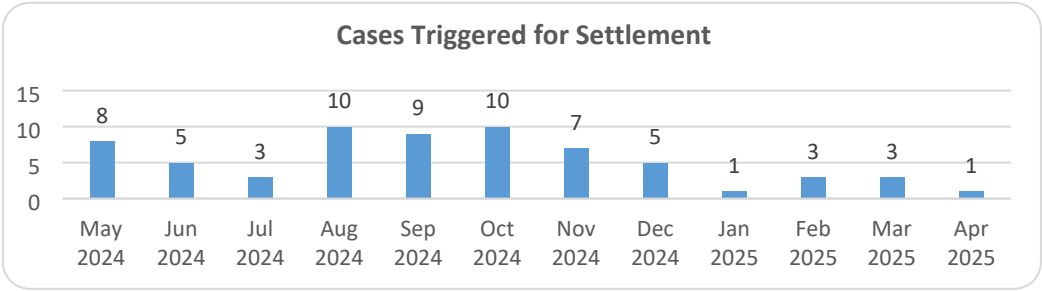
New Confirmed Clinical Negligence Claims

Between the 01.03.25 and 30.04.25 the Health Board received confirmation of a total of 8 Clinical Negligence Claims. The trend in new confirmed clinical negligence claims in the last 12 months is highlighted in the chart below:



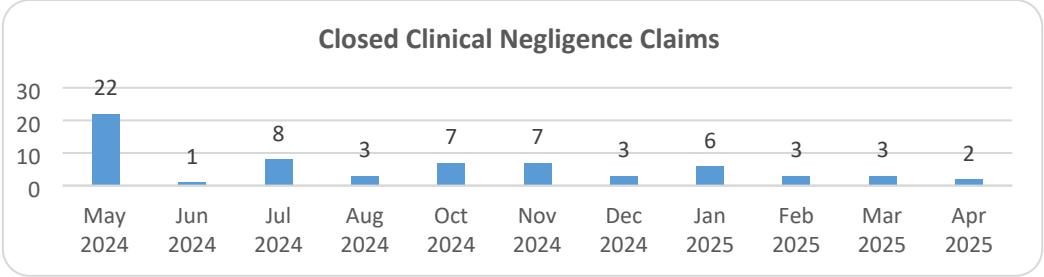
Clinical Negligence Claims triggered for settlement

Between the 01.03.25 and 30.04.25 the Health Board, 4 Clinical Negligence Claims for trigger for settlement. The trend for clinical negligence claims settled in the last 12 months is highlighted in the chart below:



Closed Clinical Negligence Claims

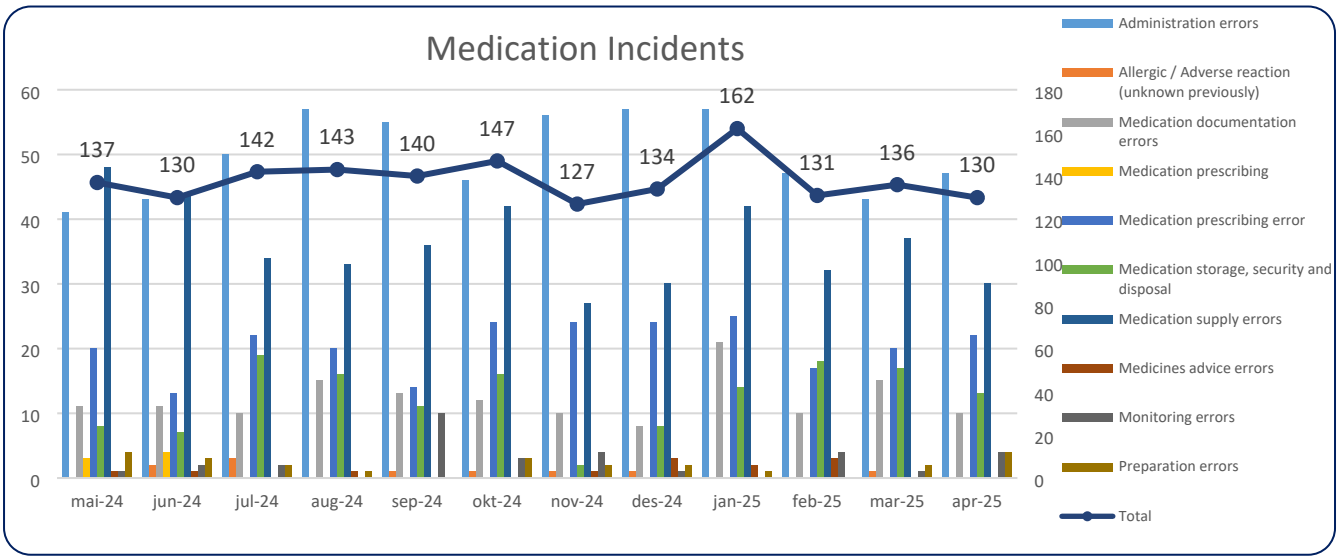
Between the 01.03.25 and 30.04.25 the Health Board, 4 Clinical Negligence Claims for trigger for settlement. The trend for clinical negligence claims settled in the last 12 months is highlighted in the chart below:



2.5 Specific Quality & Safety Metrics

2.5.1 Medication Safety

A total of 266 medication incidents were reported as occurring between 01.03.25 and 30.04.25. This is a decrease of 27 when compared with the previous 2 month period. Of the total number of medication incidents reported, the top 3 types of medication incidents relate to administration errors (90), supply errors (67), and medication prescribing errors (42).

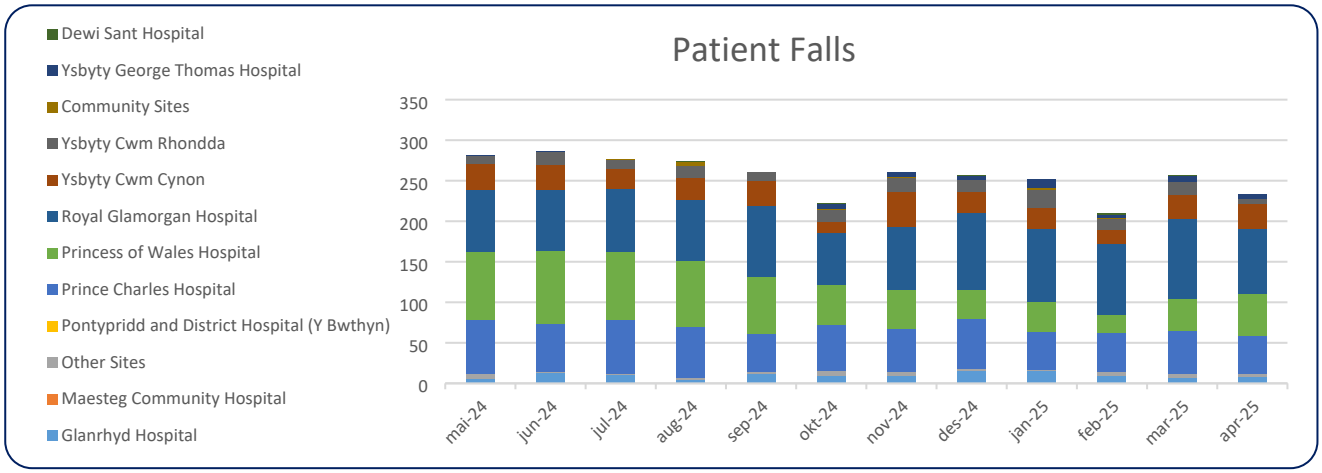


87% of the medication incidents were reported as resulting in no (130) or low (103) harm, with the remaining reported as resulting in moderate harm (28) and severe harm (5) harm. No incidents were reported as resulting in catastrophic harm / death. It should be noted that this is the reporter's view of the level of harm and is subject to change following investigation.

2.5.2 Patient Falls Incidents

A total number of 490 falls, where the person affected was a patient, were reported during March and April 2025. This represents an increase of 28 compared with the previous two months.

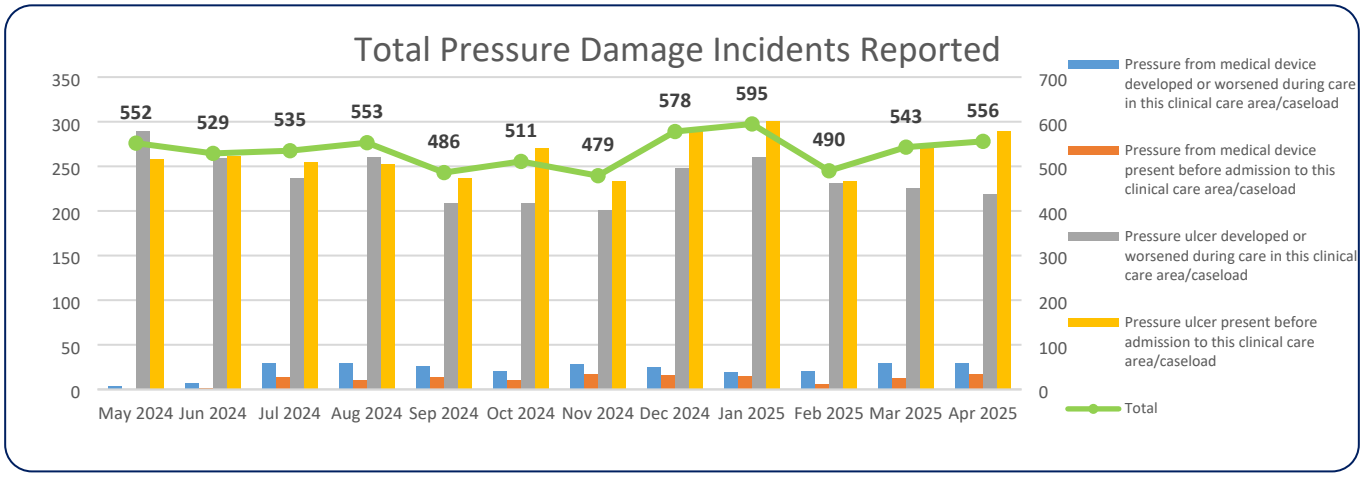
Of the falls incidents within the time period, 94% were reported as no (145) or low (317) harm. The remaining incidents were reported as resulting in moderate (27) and severe (1) harm. No incidents relating to patient falls were reported as resulting in severe harm or catastrophic harm / death. Once again, it should be noted that this is the reporter's view of the level of harm and is subject to change following investigation.



The falls improvement programme continues to implement agreed initiatives to reduce the number of patient falls.

2.5.3 Pressure Damage

Between the 01.03.25 and 30.04.25, a total of 1099 pressure damage incidents were reported, of which 505 were reported as developing or worsening during the current case load. The remaining pressure damage incidents (594) were reported as being present before admission to this clinical care area/caseload.



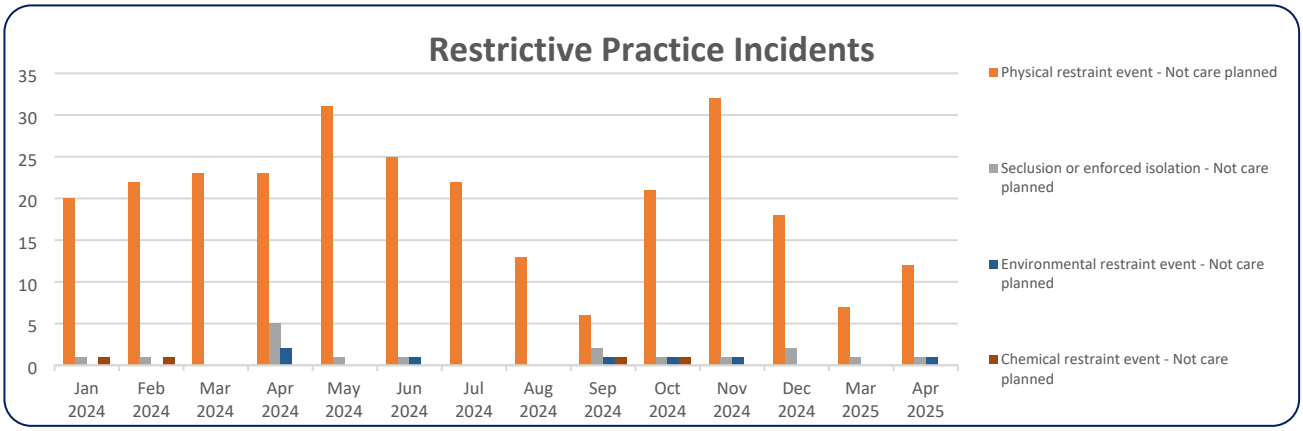
Of the 505, identified as developing or worsening during current caseload, 214 were identified as occurring within the community, which represents a decrease compared with the previous two month period.

The pressure Ulcer steering group has been established to gain strategic oversight to develop a robust prevention and monitoring program and ensure learning is shared and embedded where available pressure damage has occurred.

2.5.4 Mental Health Metrics

Restrictive Practices

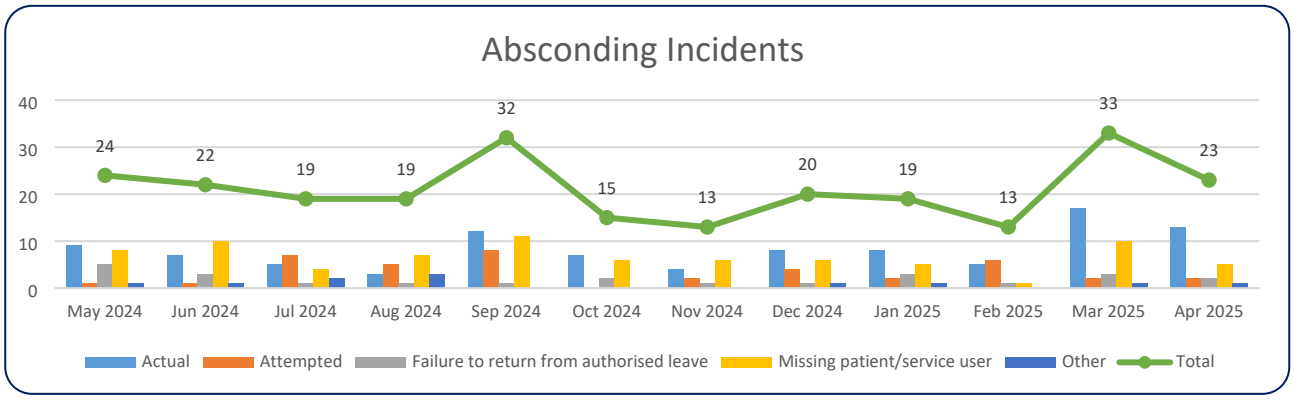
Between 01.03.25 and 30.04.25, a total of 137 incidents relating to using Restrictive Practices were reported within Mental Health. This is a decrease of 64 incidents when compared to the previous two months.



Of the 137 incidents, 22 were reported as not care planned (not included in the care and treatment plan for the patient) and 115 were reported as care planned (included in the care and treatment plan for the patient). The 3 highest number of incidents were reported as occurring on the Enfys Ward, Princess of Wales Hospital (90).

Absconding incidents

During March and April 2025, a total of 56 incidents were reported under the category of absconding, which represents an increase of 24 when compared with the previous two month period. 30 were recorded as actual absconding, with the remaining recorded as missing patient/service user (15), failure to return from authorised leave (5), attempted absconding (4), and other (2). The highest number of incidents were reported as occurring in the Emergency Care Centre at the Royal Glamorgan Hospital (12).



3. Key Risks / Matters for Escalation

The following issues/risks have been identified in relation to quality reporting within the Health Board.

- The transition to the new operating model poses a challenge in relation to the extraction and presentation of data. Work continues to align the Datix Cymru System to the Care Group Structure and ensure up-to-date information is accessible across the Health Board on a range of metrics.
- Maintaining compliance with the 30 working days' complaints response rate.
- Continuing the reduction of open Nationally Reportable Incidents
- Timely management of Public Services Ombudsman for Wales Cases
- Responding to Coroner's Inquest requests within timescales

4. 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	Not Applicable
	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))*	Learning, Improvement & Research
	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))*	Safe
	If more than one applies please list below: Timely Effective Person Centred
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	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: This report outlines key areas of quality across the Health Board.	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: This is an overarching position report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment.
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.	
	Activity where performance falls short of the Health Board's quality & safety performance measures may result in impact to the trust and confidence in the Health Boards processes.	
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.	

5. Recommendation

5.1 Members of the Quality, Safety and Experience Committee are asked to:

- **NOTE** the content of the report
- **DISCUSS** the content of the report and flag areas (if not already identified) where further assurance is required
  NOTE the risks identified

6. Next Steps

6.1 Improvement actions identified within the report to continue to be monitored via the Quality. Safety & Experience Committee and Weekly Quality & Safety Executive Meeting.

Agenda Item
7.1

Quality, Safety & Experience Committee

Organisational Risk Register

Dyddiad y Cyfarfod / Date of Meeting	20 May 2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Cally Hamblyn, Assistant Director of Governance & Risk
Cyflwynydd yr Adroddiad / Report Presenter	Cally Hamblyn, Assistant Director of Governance & Risk
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Approval

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Service, Function and Executive Formal Review	April / May 2025	RISKS REVIEWED
Operational Management Board	April / May 2025	ENDORSED RISKS WHERE APPLICABLE FOR ELG
Executive Leadership Group	Circulated via email 6-9 May 2025	MANAGEMENT SIGN OFF RECEIVED

Acronyms / Glossary of Terms	

1. Situation /Background

1.1 The purpose of this report is for the Committee to review and discuss the organisational risk register and consider whether the assigned risks have been appropriately assessed.

2. Specific Matters for Consideration

Risk Review

2.1 Care Groups and Central leads are continuing to review and update their assigned risks considering feedback received from Members in relation to scoring, actions with associated timeframes and ensuring timely reviews.

2.2 The Operational Management Board / Chief Operating Officer approves escalation of Care Group risks to the Organisational Risk Register.

2.3 The Executive Lead approves escalation of central/core function risks to the Organisational Risk Register.

2.4 Risks on the organisational risk register have been updated as indicated in red in Appendix 1.

2.5 Please note that the risk updates are captured at the time the Organisational Risk Register being finalised for submission, which on this occasion was the 2 May 2025.

Training

2.6 Risk training, although not a core training requirement under the statutory and mandatory framework, has been added to the Electronic Staff Record (ESR) to support staff in registering for training and to support ease of reporting. This is managed by the Quality Assurance and Compliance Team. Interest in the course continues with positive uptake.

2.7 The sessions are run by the Assistant Director of Governance & Risk and Heads of Quality and Safety. The session is held virtually via Teams on a monthly basis for a duration of 1 hour and covers the following areas:

- Risk Management Approach
- Practical Approach to Managing Risk
- Risk Assessment and Scoring
- Datix Risk Management Module

2.8 To date **773** members of staff trained to date since training commenced in 2021. Based on the Risk Management Awareness Training Needs Analysis all attendees completed Training Profile 2.

2.9 Focussed sessions to discuss risk have also been undertaken with Care Group Leads and other departments/directorates as required.

2.10 109 attendees have provided formal feedback (using the URL Code for the Evaluation Form, which was introduced in November 2023). The average rating for the course is 4.80 out of a maximum score of 5.

2.11 100% of the 109 attendees providing formal feedback found that:
- The session provided the right amount of information.
- They gained more confidence and knowledge in risk management having attended.
- They would recommend this training to a colleague.

2.12 98% of the 109 attendees providing formal feedback said they felt more confident to escalate a risk through the organisation.

2.13 Some of the recent comments from the session, received through evaluation, have been included below:
- *"Delivered well and clear".*
- *"training, well rounded, concise and very informative"*
- *"This course was extremely useful being new to risk assessments in" CTM it was the right amount of content/information and well delivered"*

3. Key Risks / Matters for Escalation

3.1 NEW RISKS

Diagnostics, Therapies, Pharmacy and Sciences
- Datix Risk ID 3567 - Capacity of Cellular Pathology Service – Space – new risk escalated to the Organisational Risk Register with a score of 16 in May 2025.

Public Health Directorate
- Datix Risk ID 6179 - High and increasing prevalence of overweight and obesity in children and adults **-** new risk escalated to the Organisational Risk Register with a score of 20 in May 2025.

3.2 CHANGES TO RISKS

Risk Score Increased

There were no risks currently escalated to the Organisational Risk Register had risk scores increased this period.

Risk Score Decreased

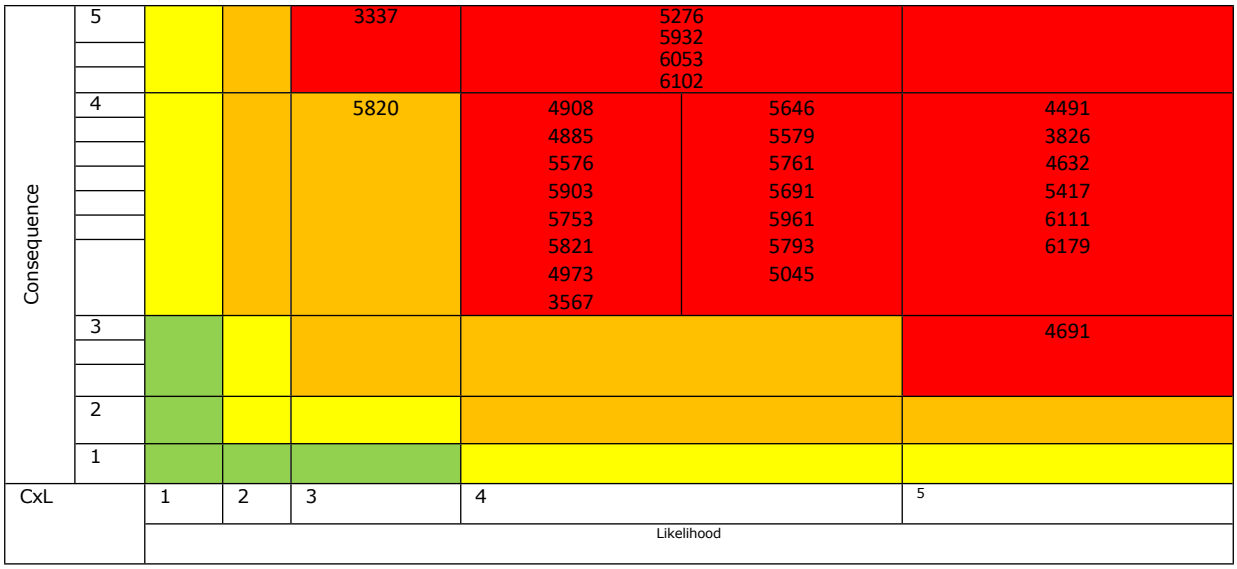
Digital and Data Directorate
- Datix Risk ID – 5226, Risk of damage to records and equipment due to leaking roof in the Williamstown Records Hub. Risk score de-escalated from a 20 to an 8 in May 2025. Repairs completed mid- April 2025. To date, no further leaks have been observed; however, there has not yet been sustained rain to enable

confirmation that all leaks have been stopped. The situation is being monitored on an ongoing basis.

3.3 CLOSED RISKS REMOVED FROM THE ORGANISATIONAL RISK REGISTER

None as assigned to this Committee.

3.4 ORGANISATIONAL RISK REGISTER – VISUAL HEAT MAP BY DATIX RISK ID (RISK RATED 15 AND ABOVE)



3.5 EMERGING RISKS

3.5.1 **The Patient, Care and Safety Directorate** have identified potential challenges in their Legal Service Directorate which will require a detailed review of any associated risk assessments. It is anticipated that updated risks relating to this service area will follow in the next iteration of the Organisational Risk Register.

3.5.2 **The Diagnostics, Therapies, Pharmacy and Sciences Care Group** are reviewing the following risk for escalation to the Organisational Risk Register in July 2025:

- Datix Risk ID 5304 – Air Handling Unit for the Pharmacy Aseptic Production Suite – Medicines Management.

3.5.3 **The Primary, Care & Community Care Group** are assessing a risk in relation to the Welsh General Optometry Service (WGOS), with a few to escalating to the Organisational Risk Register in July 2025.

3.6 Board Assurance Framework – Principal/Strategic risks assigned to this Committee

Risk no	Strategic / Principal Risk	Strategic Goal	Lead(s) for this risk	Assurance committee	Current score
1a	**Sufficient capacity to meet elective demand**	**Improving Care** 	Chief Operating Officer	Quality, Safety & Experience Committee Operational Delivery Committee	**16** (C4xL5)
1b	**Sufficient capacity to meet emergency demand**	**Improving Care** 	Chief Operating Officer	Quality, Safety & Experience Committee Operational Delivery Committee	**20** (C4xL5)
2.	**Ability to deliver improvements which transform care and enhance outcomes**	**Improving Care** 	Executive Dir. Of Nursing, Midwifery / Executive Medical Director	Quality, Safety & Experience Committee Strategic Development Committee	**16** (C4xL4)
3.	**Sufficient workforce to deliver the activity and quality ambitions of the organisation**	**Sustaining our Future** 	Executive Director of People	Operational Delivery Committee Strategic Development Committee	**16** (C4xL4)

4. 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	Not Applicable
	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 Resilient 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))*	Learning, Improvement & Research
	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))*	Safe
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	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: Not required for the Organisational Risk Register. Individual risks may have been subject to QIA.
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: Not required for the organisational Risk Register. Individual risks may have been subject to an Impact Assessment.
Cyfreithiol / Legal	Yes (Include further detail below)	
	See detail captured for each risk	

Enw da / Reputational	Yes (Include further detail below) See detail captured for each risk
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	Yes (Include further detail below) See detail captured for each risk

5. Recommendation

5.1 The Committee are asked to:

- **Review** the risks escalated to the Organisational Risk Register at Appendix 1.
- **Consider** whether the Committee can seek assurance from the report that all that can be done is being done to mitigate the risks.

6. Next Steps

6.1 The Organisational Risk Register will be submitted to the relevant Board and Committees.

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
2	6179	Executive Director of Public Health	Public Health - Health Protection	Executive Director of Public Health	Creating Health & Improving Care	Quality / Complaints / Assurance / Patient Outcomes Impact on the safety – Physical and/or Psychological harm	High and increasing prevalence of overweight and obesity in children and adults.	**If** there is insufficient preventative activity to reduce rates of overweight and obesity **Then** rates of obesity will remain high in CTM . **Resulting in** increased activity/acuity/complexity of patients resulting from obesity, poorer patient outcomes, increasing pressures on services, risk of clinical incidents and continuing financial pressures on the organisation There is also a continued risk from a health and safety perspective for sufficient equipment and capability to move people with extreme BMIs in the event of incidents.	A range of work is currently under way in response to high levels of obesity in CTM including: 1)Grant funded Whole system approach to healthy weight work- building momentum to influence system wide change in our obesogenic environment 2)Adult Weight Management Service – the scale of this is vastly insufficient to make a difference to population level rates of obesity 3)Children and Young People's weight management service – current time-limited funding for Pipyn, preventative family based intervention, ongoing development work to maximise population impact, scale remains small. Proposed future development of a service in line with level 3 of the All-Wales Weight Management Pathway. 4)Healthy pre- and health schools programmes – working to enable educational settings to be healthy weight environments. Current activities are insufficient for population level impact. A new action plan will be published in the Spring/Summer 2025 for Healthy Weight: Healthy Wales, the national strategy for Obesity. This will include actions across 4 domains: -healthy environments -healthy settings, -healthy people, -leadership and enabling change. The Food (Promotion and Presentation) (Wales) Regulations 2025 are due to come into force in 2026 and will introduce some restrictions on the promotion and placement of unhealthy food.	The Healthy Weight Steering Group is currently developing a healthy weight road map for CTMUHB, outlining actions and strategic direction over the short, medium and long term. This will be in line with Healthy Weight: Healthy Wales, and take into consideration health board actions under the new national action plan. There is a business case in place for sustainability and increased capacity for Pipyn (level1+), and a CYP level 3 weight management service. A level 3 weight management service will help improve outcomes for some our most disadvantaged children.	Quality, Safety & Experience Committee. Strategic Development Committee.	20	C4xL5	9 C3xL3	New risk escalated to the Organisational Risk Registar in May 2025.	06.05.2025	06.05.2025	30.06.2025
3	6111	Executive Medical Director	Medical Directorate Function	Medical Directorate Manager	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Medical Examiner Delays	**If:** there continues to be delays in length of time for scrutiny of deaths by the Medical Examiner Service **Then:** death certification will not be completed in a timely manner and so increasing the length of stay of the deceased **Resulting in:** complaints from bereaved relatives due to delayed funerals, inability to view loved ones, and deterioration in condition due to delay and inability to comply with WG bereavement framework and mortuary capacity being overwhelmed	Bereavement database updated to track cases and ensure timely attendance by doctors following scrutiny. Bereavement teams to provide estimated timescales for scrutiny based on database. Daily monitoring of daily occupancy. Funeral directors to be contacted by mortuary teams. All contingency capacity HB wide activated in line with mortuary escalation action card. Use of contracted funeral director staircase if required. Use of medilink sessions to manage post mortem demand.	Plan to improve timely death certification by CTMUHB specific QR code to alert wider staff and reduce delays and education videos from MES to improve accuracy. Continue to improve on communication with families around delays and estimated timescales. Update May 2025 - No change to risk score or mitigation on this review.	Quality, Safety & Experience Committee. Operational Delivery Committee.	20	C4xL5	12 (C4xL3)	↔	05.03.2025	06.05.2025	30.06.2025
4	6053	Chief Operating Officer	Primary Care and Community Care Group	Care Group Service Director	Sustaining Our Future	Service / Business interruption	Failure to secure an alternative Clinical System for GP practices on Vision	**If:** a new supplier is not secured. **Then** there will be a significant risk to the availability of a clinical system/solution to support General Practice service delivery for our GP practices yet to transfer to an alternative provide (EMS). **Resulting in** GP service delivery and patient care being significantly impacted and further impacting on other healthcare services.	Digital Health Care Wales (DHCW) Task force with 4 workstreams set up to manage the incident: Comms & engagement. The company is currently seeking a buyer, process started on Friday, December 13th. DHCW will work with the administrator on the next steps, whatever the outcome of the marketing process. The administrator has advised they are planning to maintain a full service to minimise disruption to practices. Health Boards are working together with DHCW to produce business continuity plans for both HBs and for practices.	Collaboration with DHCE and other Health Boards for Business Continuity Plans - timeframe 27.3.2025. Securing a new Clinical System Provider - timeframe 30.06.2025. Update May 2025 - Digital Health Care Wales (DHCW) are still in negotiations with interested / preferred buyer of the Cededim clinical system. In the meantime HOPC/DHCW and Health Board Digital Leads working on mitigation and business continuity plans.	Quality, Safety & Experience Committee. Operational Delivery Committee.	20	CSxL4	5 (CSxL1)	↔	15.01.2025	06.05.2025	30.06.2025
5	6102	Director of Digital	Central Corporate - Digital & Data	Head of Clinical Admin Transformation	Sustaining Our Future	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Patient Pathways - Working in WPAS Instances.	**If:** A patient is moved between SB WPAS and CT WPAS and their pathway is closed in one before it is opened in the other. **Then:** The pathway will not be automatically re-opened by the systems (this must be manually transacted) and the pathway will remain closed. **Resulting in:** The incorrect ending of the patient pathway, as they will not be visible on the system, which could lead to possible patient harm/ death.	Monitor records/ processes through agreed Standard Operating Procedure's and ensure corrective actions are taken until mitigation is successful. Flagging to users/ management where examples of this not being followed are identified.	Review current business processes and Standard Operating Procedures to clarify the importance of opening the CTM record before closing the Swansea Bay University Health Board record. This process prevents delays in urgent pathway management, as highlighted by flagged dermatology cancer referrals that were discharged on WPAS but not set up on another system at the time of checking. It is anticipated that the target score will not be achieved until CTMUHB have a fully migrated PAS systems and the whole organisation is using a singular PAS system for patient pathways. Update May 2025 - No change to this risk until PAS migration has been completed.	Quality, Safety & Experience Committee. Operational Delivery Committee.	20	CSxL4	5 (CSxL1)	↔	19.02.2025	2.5.2025	30.06.2025
6	5932	Executive Director of Finance Executive Lead for Estates	Central Corporate - Estates	Assistant Director of Planning - (Capital and Estates), Strategic and Operational Planning	Sustaining Our Future	Environmental / Estate / Infrastructure	Roof covering replacement works to resolve identified roof integrity issue and consequent risk of tiles falling internally and externally from weakened roof at POWH Phase 1.	If: the Health Board fails to act upon the recommendations of the findings of the report from the appointed Structural Engineers in relation to the roof area at the POWH. Then: there is a risk of collapse of the roof coverings which could result in the roof coverings falling through the roof void into occupied clinical/non clinical areas and externally from the edges of Phase 1. This risk increases in adverse weather with additional loading on the roof. Resulting in: significant impact/harm to patient, staff and public safety. Healthcare facilities which are not fit for purpose or sustainable for the future. Service delays impacting the patient experience and service performance of the Health Board. Potential legislative challenge and reputational damage. Loss of confidence in the Health Board estate infrastructure across CTM.	Command structure established to manage the critical incident following identification of roof structure failings. Immediate mitigations being considered under 4 key Cells: 1) Discharge Cell - Objectives: The safe but rapid discharge of patients and services from top floor phase 1 POW site and to maintain quality of care and patient safety 2) Decant Cell - Objectives are the safe but rapid decant of patients and services from top floor phase 1 POW site, to maintain quality of care and patient safety and to maintain staff safety and the deployment of the right staff to the right place. 3) Redirect Take - Objective - Reduce demand for inpatient beds on the POW site 4) Estates - focusing on ensuring decant areas are fit for purpose as well as overseeing the plans for the works on the roof. Enabling Support Cells Established: Patient Transport Workforce Digital Facilities Patient Safety Communication In addition barriers are in place around the footpaths to keep pedestrians away from the edge of Phase 1 roofs.	Update April 2025: Removal of Roof Coverings at the Princess of Wales Hospital site in accordance with the recommendations in the structural engineering report of 9th October 2024. Contractor started the roof replacement programme on Monday 11th November. Phase 1 prioritised Maternity and Special Care Baby Unit, these areas are complete and were handed back 13th January, services returned to site in Feb. Contractors have replaced the old tiles above Main Theatres and Wards 9, 10, ITU and Endoscopy are almost complete so risk of falling tiles has reduced considerably with the large area of roof where the old tiles have been removed. Remaining Wards 5, 6, 7 and 8 roof works have started. Full programme including Theatre FEN works and fire compartmentation above vacated wards and depts due to be completed mid August 2025.	Operational Delivery Committee Quality, Safety & Experience Committee Health, Safety & Fire Sub Committee	20	CSxL4	10 (CSxL2)	↔	23.09.2024	06.05.2025	30.06.2025
7	4491	Chief Operating Officer	Deputy Chief Operating Officer - Acute Services.	Deputy Chief Operating Officer - Acute Services.	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to meet the demand for patient care at all points of the patient journey	**IF:** The Health Board is unable to meet the demand upon its services at all stages of the patient journey. **Then:** the Health Board's ability to provide high quality care will be reduced. **Resulting in:** Potential avoidable harm to patients	Controls are in place and include: • Technical list management processes as follows: - Speciality specific plans are in place to ensure patients requiring clinical review are assessed. - All patients identified will be clinically reviewed which will include an assessment of avoidable harm which will be reported and acted upon accordingly. - A process has been implemented to ensure no new sub specialty codes can be added to an unreported list, this will be refined over the coming months. - All unreported lists that appear to require reporting have been added to the RTT reported lists - All unreported lists that are to remain unreported (as they do not form part of the RTT criteria) are being reviewed and will be visible and monitored going forward. • Patients prioritised on clinical need using nationally defined categories • Demand and Capacity Planning being refined in the UHB to assist with longer term planning. • Outsourcing is a fundamental part of the Health Board's plan going forward. • The Health Board will continue to work towards improved capacity for Day Surgery and 23:59 case load. • A Harm Review process is being piloted within Ophthalmology – it will be rolled out to other areas. • The Health Board has taken advice from outside agencies especially the DU when the potential for improvement is found. • Appropriate monitoring at ILG and Health Board levels via scheduled and formal performance meetings with additional audits undertaken when areas of concern are identified Planned Care board established. - The Health Board is exploring working with neighbouring HBs in order to utilise their estate for operating.	Update May 2025: Planned Care -Progress being made towards the >104 week position. There has been continuous improvement against trajectories for elective demand for a range of services including Mental Health and Learning Disabilities. 4 mobile theatres and 2 endoscopy modular units have been opened on Royal Glamorgan Hospital site since the 10th April, to provide additional surgical and diagnostic capacity following the critical incident at POW. Unscheduled Care - Stroke remains on the risk register to closely monitor the temporary centralisation of service and quality of patient journey and outcomes. Stroke Service re-design programme has been established to support development of a longer term sustainable service. Impact on the capacity reduction and resilience across the full CTMUHB system is monitored and managed closely with continuous planning and review of clinical pathways.	Quality, Safety & Experience Committee Operational Delivery Committee	20	C4xL5	12 C4 x L3	↔	13.7.2023	06.05.2025	30.06.2025
8	4632	Executive Director of Therapies and Health Sciences.	Unscheduled Care Group	Head of Strategic Planning and Commissioning	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Provision of an effective and comprehensive stroke service across CTM (encompassing prevention, early intervention, acute care and rehabilitation)	**IF:** changes are not made to improve and align stroke prevention initiatives, early intervention campaigns, and acute and rehabilitation stroke care pathways across CTM **THEN:** avoidable strokes may not be prevented, patients who suffer a stroke may miss the time-window for specialist treatments (thrombolysis, thrombectomy), and patients may not receive timely, high-quality, evidence-based stroke care **RESULTING In:** higher than necessary demand for stroke services, poorer patient outcomes/increased disability, increased length of stay, and poor patient/carer experience. Impact will extend to the need for increased packages of care, increased demand for community health services, and increased carer burden when discharged to the community.	• Executive-led Stroke Strategy Group in place, with targeted task and finish under development. Membership updated to reflect senior Ops changes. • ToR and membership of Strategy Group updated. • Close working amongst executive team to escalate and address operational and clinical issues in relation to stroke pathway • Board briefing to ensure all sighted to challenges • Quarterly briefings to Quality and Safety Committee • Performance data regularly presented to Performance, Planning and Finance Committee • Strong CTM input to regional and national Stroke Programme Boards • Unified, evidence-based pathway developed for thrombolysis • Preparations progressing to prepare for 24/7 thrombectomy service at Bristol and updated RCP guidance on thrombolysis and thrombectomy • Designated senior operational lead for performance and improvement leadership for stroke pathway	Update May 2025 - Update added 21.4.25 - Prior to critical incident and since temporary consolidation of stroke services at RGH, there is no psychology support for stroke patients during any part of the patient pathway. A dedicated psychology support service needs to be included in planning the sustainable service model for stroke within CTM. Care groups are working to ensure a workforce plan and redesign for a sustainable provision. Regular stroke oversight meetings where the risk can be closely monitored and actions taken where appropriate to manage the risk.	Quality, Safety & Experience Committee Operational Delivery Committee	20	C4xL5	12 (C4 x L3)	↔	11.05.2021	06.05.2025	30.06.2025
9	5276	Director of Digital	Central Support Function - Digital and Data	Pathology Directorate Manager	Sustaining Our Future	Business Objectives - Operational Patient safety Digital Healthcare Wales interdependencies	Failure to deliver replacement Laboratory Information Management System, LINC Programme, by summer 2025,	**IF:** the new Laboratory Information Management System (LIMS) service is not fully deployed before the contract for the current LIMS expires in June 2025. **THEN:** operational delivery of pathology services may be severely impacted. **RESULTING IN** potential delays in treatments, affecting the quality and safety of a broad spectrum of clinical services and the potential for financial and workforce impact.	Currently LINC Programme reports progress against timeline to LINC Programme Board and Chief Executive Group. Business continuity options are being explored including extending the contract for the current LIMS to cover any short term gap in provisions. An expert stock take review of the LINC programme has been completed with findings presented to Collaborative Executive Group (CEG) to inform next steps.	Update May 2025 - Phase 1 UAT has now been completed by Digital Health Care Wales (DHCW). They are working with University Health Boards to understand any issues or critical blockers from testing. Replanning options are also being currently looked at e.g. should migration be based on individual specialities/discipline rather than at an individual University Health Board level. DHCW are currently undertaking a procurement activity reviewing the use of Citrix, which is used to deploy LIMS, so activity to explore the mitigation of a potential Citrix contract termination in December is underway.	Quality, Safety & Experience Committee Operational Delivery Committee	20	CSxL4	5 (CSxL1)	↔	26.10.2022	2.5.2025	30.06.2025

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11	3826 Linked to 4839 and 4841 in Bridgend Linked to 4462	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director - Unscheduled Care.	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Emergency Department (ED) Overcrowding	**If:** As a result of exit block due to hospital capacity and process issues patients spend excess amounts of time within the Emergency Department. This is manifested by, but not limited, to significant 12 hour breaches currently in excess of 400 per month. There are also large numbers of patients spending longer than 24hrs and 48hrs within the ED (please see attached information). **Then:** patients are therefore placed in non-clinical areas. **Resulting In:** Failure to deliver Emergency Department Metrics, Poor patient experience, compromising dignity, confidentiality and quality of care. The ability for timely ambulance handover with extensive delays for patients requiring assessment and treatment. Filling assessment spaces compromised the ability to provide timely rapid assessment of majors cases; ambulance arrivals and self presenters. Filling the last resus space compromises the ability to manage an immediate life threatening emergency. Clinicians taking increasing personal risk in management of clinical cases. Environmental issues e.g. limited toilet facilities, limited paediatric space and lack of dedicated space to assess mental health patients. Some of the resulting impact such as limited space has been exacerbated by the impact of the Covid-19 pandemic and the need to ensure appropriate social distancing.	Increased number of nursing staff being rostered over and above establishment. Additional repose mattresses have been purchased with associated equipment. Additional catering and supplies. Incidents generated and attached to this risk. Weekly report highlighting level of above risk being generated. All patients are triaged, assessed and treatment started while waiting to offload. - Escalation of delays to site manager and Director of Operations to support actions to allow ambulance crews to be released. - Rapid test capacity in the POW hot lab has recently increased with a reduction in swab turnaround times. - Expansion of the bed capacity in YS to mitigate against the loss of bed capacity in the care home sector and Maesteg community hospital. - Daily site wide safety meeting to ensure flow and site safety is maintained. - There is now a daily WAST led call (including weekends) with a senior identified leader from the Health Board representing CTM and talking daily through the plans to reduce offload delays across the 3 DGH sites. -Twice weekly meetings with BCBC colleagues to ensure that any delays in discharge are escalated at a senior level to maximise the use of limited care packages/ care home capacity. -Appointment of Clinical Lead and Lead Nurse for Flow appointed Feb 21 - Operational Performance is now monitored through the monthly performance review. Performance review process has been restructured to bring more rigour with a focus on specific operational improvements. - Programme improvement is monitored through the monthly Unscheduled Care Improvement Board, which reports into Management Board.	Update May 2025 - The care group continue to review and monitor targets that will assist with reducing overcrowding, such as 4- and 12-hour ED performance. Care group are reflecting on MAG recommendations to align their targets and meet performance standards. Agree date for implementation of Internal Professional Standards Ongoing monitoring of UTC Pilot at PCH through established programme – extend until the end of April 2025 – seeking recurrent funding Phase 3 of STAMP Programme – a further 3 workshops planned for SDEC/AMU/ACE/ED Ambulatory - 30 April/ 7th May/14th May 2025 Review opportunities for Phase 3 of SDEC at PCH in line with STAMP and securing additional Acute Physicians – locums whilst recruit Review opportunities for 7/7 Acute Medicine with recruitment of Acute Medicine Consultants – Locum whilst recruit Review opportunities to expand Frailty provision at PCH in line with STAMP with additional COTE Consultant – Locum out whilst we recruit ED Patient Tracking in WPAS launch 3 sites Urgent care continues to work at pace through their action plan and senior leadership are monitoring their performance closely, with regular operational meetings.	Quality, Safety & Experience Committee Operational Delivery Committee	20	C4xL5	12 (C4xL3)	↔	24.09.2019	6.05.2025	30.06.2025
12	5417	Chief Operating Officer	Primary Care and Community Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Paediatric Dentistry - General Anaesthetic (GA) theatre list	**If…** Regular additional GA theatre lists (necessary to meet current and future demand) are not made available to the Community Dental Service team for paediatric GA. **Then…** the number of children waiting list for assessment and treatment will continue to increase beyond 1000 by March 2024. **Resulting in…** 1. children waiting increased times for assessment/treatment who have high levels of dental caries and painful teeth requiring extraction, 2. a further increase in the number of children requiring GA, due to long waits for assessment more children need GA when assessed, conversion rate has jumped form 48% to 80%. Children can only wait 8 wks form assessment to treatment therefore there is a large backlog of assessments due to limited GA lists to provide treatment.	Current theatre lists are run on Monday mornings and Friday afternoons and are likely to be cancelled due to bank holidays. This impacts the running of the service, no additional lists are available when lists are missed. There are currently 800+ patients waiting for appointments, with some already waiting for 17 months. Patients are advised to return to their General Dental Practitioner (GDP) if they experience pain, some children are being prescribed multiple courses of antibiotics to ease dental infections that can only be alleviated by tooth extraction. There is a risk these patients will require the removal of more teeth/more require GA when assessed/children will present as an urgent case in Accident and Emergency if left untreated.	Update May 2025 - Prince Charles Hospital (PCH) has confirmed a GA session will run every Friday, this will enable up to 7 patients to be seen p/w dependent on complexity. Still exploring possible use of Vanguard, waiting for the theatres to be utilized by adults patients from the 10 April to understand suitability if theatres are safe for Paediatric use. CDS have started to assess 30 patients p/w in readiness for the Saturday list however will pull down additional assessment clinics in the next few weeks if there is a delay in use of the Vanguard Theatres Confirmation is required as soon as possible due to children can only be assessed 9-10 weeks prior to treatment, additionally other CDS patient lists are currently being cancelled to ensure there is an appropriate cohort for treatment on the Vanguard lists. Currently waiting for secondary care staffing costs to be shared with Service Director to enable costs to be reviewed/signed off.	Quality, Safety & Experience Committee Operational Delivery Committee	20	C4xL5	9 C3xL3	↔	20.04.2023	6.5.2025	30.6.2025
13	5903	Chief Operating Officer	Children & Family Care Group	Care Group Service Director	Improving Care	Statutory Duty, Regulation, Mandatory Requirements.	Unfunded Continuing Care Packages / unfilled packages	**If** the budget is not allocated, to employ additional staff within Children's Continuing Care **Then** agreed packages of care which have clearly identified an unmet need, will remain unfilled **Resulting in** impacts of child and family wellbeing, risk to the child, risk of the unmet need continuing, children with packages for school being prevented from attending. Not meeting health boards obligation against Welsh Government Continuing Care Guidance.	Recruitment activity underway. Temporary posts advertised for Health Care Support Worker - partially successful Risk remains high as staff need to be recruited, inducted and trained SBAR for permanent recruitment escalated to Operational Management Board - no decision to date.	Update May 2025 - Financial allocation being discussed with Care Group which is likely to reduce / remove this risk.	Quality, Safety & Experience Committee Operational Delivery Committee	20	C4xL5	6 (C2xL3)	↔	05.09.2024	06.05.2025	30.6.2025
14	3567	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Care Group Service Director	Improving Care	Quality / Complaints / Assurance / Patient Outcomes	Capacity of Cellular Pathology Service - Space	**If**: there is not enough laboratory and office space for Cellular Pathology to operate the core service safely or support increasing demand, service disaggregation and future Health board changes; **Then:** the service will be unable to work effectively and efficiently in line with Duty of Quality guidance and recognised Health board standards for IP&C, H&S etc. **Resulting in:** - Inability to meet increasing demand - increase in staff stress and compromised well being due to working in suboptimal conditions. - Poor cancer performance and inability to meet expected turnaround times, impacting on Health Board cancer performance - poor quality patient care due to delays in diagnosis or misdiagnosis - Increase in clinical incidents, complaints and potential for reputational damage. - Inability to effectively disaggregate the current SLA with Swansea Bay and repatriate services from Bridgend impacting clinical services across CTM. - inability to support full digital rollout and support regional reporting in line with WG strategic direction - delayed development of advanced scientist dissection to support increasing reporting capacity and delivery of workforce modernisation - loss of tissue leading to Serious incidents and Regulatory non-compliance with HTA and potential compromise of HTA license. - financial risk of outsourcing - threat to strategic regionalisation project due to the scale of the lack of capacity in CTM	SOPs are in place to standardise practice and mitigate risk of variation in practice caused by limitations of the laboratory environment. Controls to reduce the use of reception/dissection as a thoroughfare including signage and demarcation belt. Workflows established to maximize efficiency of limited space. Block and slide filing removed from laboratory area where possible. System of work including check established in dissection to minimize risk of error. IPC and H&S environment inspections undertaken to assess impact of laboratory environment on clinical effectiveness and risk to patients and staff.	Mitigating Action Plan includes: Engagement with estates to review small scale projects to increase laboratory space. Engagement and participation in Regional Scoping group to scope options including estates to look at long term solutions.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL4	C3xL2 6	New risk escalated to the Organisational Risk Register in May 2025.	28.05.2019	06.05.2025	30.06.2025
15	5045	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Access to Neurology Inpatient and Outpatient Services for CTM Residents	**If:** there is no clear direction and commissioning intentions set out in respect of neurology service provision for the residents of RTE; **Then**: existing service pressures in respect of the consultant workforce, availability of diagnostic tests, inpatient demand, care of women on valproate medication, provision of epilepsy specialist nursing services, lack of ante natal epilepsy services and outpatient demand and waiting times will continue; **RESULTING IN**: a risk of harm from late diagnosis; patient condition deterioration; delays starting appropriate treatments, long waiting times; medication issues and potentially sudden unexpected deaths. There is also an issue around reporting of waiting times for neurology patients.	An additional Locum Consultant working out of RGH providing inpatient and outpatient neurology services support. Plan to appoint x3 consultant neurologists within CTM as part of the Neurology Liaison Plan.	Update May 2025 - Neurology capacity pressures remain across CTM and limited access to neurophysiology testing is also an issue. A locum consultant neurologist started in Royal Glamorgan Hospital (RGH) in December 24 and is currently providing inpatient support to RGH and 4 OP clinics per week. This is supporting reducing the OP backlog and improving inpatient support, however, as at end of March 25 there are 1782 patients waiting over 26 weeks for a first op appointment. JMTP bid for neurology consultant posts submitted and awaiting a decision.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL4	8 (C4xL2)	↔	09.3.2022	06.05.2025	30.6.2025
16	5576	Chief Operating Officer	Primary Care and Community Care Group	Care Group Service Director	Sustaining Our Future	Workforce / Organisational Development / Staffing / Competence	Palliative Medicine Staffing	**If** the Health Board are unable to recruit to the vacant Palliative Medicine Consultant post in Ysbyty Cwm Cynon (YCC) for Merthyr/Cynon. **Then.**. there will be a 60% gap in palliative medicine consultant cover. This is in addition to an already understaffed consultant compliment. **Resulting In**.. a negative impact to the delivery of Specialist Palliative Care (SPC) inpatients at YCC. As well as negatively impact on capacity in the other SPC Centres in Royal Glamorgan Hospital and Princess Of Wales Hospital, as remaining Consultants will be required to cover. They are already low as a workforce establishment. Despite this the SPC Centre in YCC will not meet the required standards to retain the SPC status.	Unit is currently open with strict criteria for acceptance End of Life patients only when accepted by a consultant. Limited cover from other SPC centres provided but this individual has now retired, and only remote cover has been secured from other SPC sites going forward. Recruitment in specialist agencies being sought. Additional middle grade cover sought but will have limited impact as not meeting national standards	Update May 2025 - Our current Palliative Care Service is fragile as a result of vacancies within the medical workforce. A request for an immediate emergency service change and focus on redesign of Palliative, End of Life Care model was considered and supported by Executive Leadership Group. Engagement has taken place with Llais and a full communications brief and plan has been drafted for consideration before implementation is started.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL4	8 (C4xL2)	↔	11.10.2023	06.05.2025	30.6.2025
17	5753	Executive Nurse Director / Deputy Chief Executive	Children & Family Care Group	Care Group Service Director	Improving Care	Workforce / Organisational Development / Staffing / Competence	Inadequate Special School Nurse Provision	**If** the Health offer towards the current Special Schools Nursing Model is not increased and Bridgend Local Education Authority (LEA) does not contribute financially to the Service Level Agreement (SLA) in Special Schools **Then t**he Community Children's Nursing (CCN) Service are unable to meet their obligations across the five special schools in CTM and be unable to fulfil their obligation to Rhondda Cynon Taf (RCT) and Merthyr who are the only LEAs who contribute financially into the SLA **Resulting in**, Dissatisfaction and fractured relationships within RCT and Merthyr LEA, inequity of service provision across CTM special schools, risks to the children & young people (CYP), impact on Consultant Led clinics, inability of special school nurse to deliver on School Nursing Framework in Wales part 2 - Nursing in Special Schools and Healthy Child Wales (HCW) part 2, lack of access to continual professional development and peer support for the nurses based in Special Schools, continued issues with recruitment and retention of nursing staff into Special Schools	Mitigation - reviewing SLA at pace with LA, high level meetings with EDON, Nursing Director and Directors of education. Supporting staff, sharing risk across SSN schools. During periods of absence or vacancies; access to a school nurse will not be available in person 5 days per week. However, telephone advice and support will be available. These control measures do not meet expectations of Local Authority. Meetings have been held between Directors of education and Director and Executive Nurse. SBAR has been escalated to Care Group OMB but needs to be escalated to HB OMB (19/02/2025) Engagement between senior nurse and head teachers and support for special school nurses has been given.	Update May 2025 - Special school nursing team remains fragile, 1 LTS ongoing from September, 1 Maternity Leave unsuccessful backfill, 1 staff member just returned from LTS. Increasing demands from schools and uncertainty of agreed roles and responsibilities heighten this fragility. Discussion scheduled for May with Chief Operating Officer (COO) and Executive Director of Nursing and Care Group.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL4	8 (C4xL2)	↔	16.04.2024	06.05.2025	30.6.2025

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18	4973	Chief Operating Officer	Mental Health Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Clinical Medical Cover within CTM Adult Mental Health Services	**If:** CTM Mental Health Service fails to implement adequate senior medical cover across adult in-patient and CMHT services **Then:** the Health Board's ability to provide quality care, a safe environment for patients and a good standard of training for junior doctors will be reduced and potentially compromise the safety of patients and staff **Resulting in**: sub-optimal care to patients, inability to discharge its legal duties under the Mental Health Act, due to insufficient numbers of suitably skilled and experienced Approved Clinicians. Junior doctor supervision will be reduced which may affect future recruitment, patient safety/experience compromised and staff well being will be poor.	Functional inpatient model in place with 3 consultants to cover. Redeployment out of the service and resignation has led to a further depleted workforce and cover will reduce to two consultants from January 2025 with additional middle grade support. Rehabilitation service is at a critically low level with urgent closure of one service needed. Redeployment from inpatients to Rehabilitation of locum has had knock on effect on inpatients. Difficulty recruiting to locum posts due to introduction of rate card and need to have Welsh AC approval. Permission to go out to non-DE has been provided. Weekly cover rota going out to inpatients and rehab wards to ensure all are aware of the cover arrangements. Two PAs recruited to Rehab and IP in Jan/March 2025 which will free up senior time The Adult Directorate is managing medical staffing through "escalated action" procedures with daily scrutiny and communication pressures and counter measures to release the Consultant body. Daily reviews with Retinue on the availability of staff	Substantive jobs which are new posts are being developed and advertised. Substantive and significant programme of work running alongside this in the Medical Workforce Productivity in place. International recruitment drive looking to recruit two Specialty Doctors to Inpatients and Rehab in August 2025. Update 15.4.2025 - Risk reviewed with Adult Directorate Senior Management Team, risk remains with no change at present.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL4	12 (C4xL3)	↔	06.01.2022	15.04.2025	31.05.2025
19	5821	Executive Director of Strategy & Transformation	Central Corporate Directorate - Commissioning	Assistant Director of Transformation, Strategic and Operational Planning	Improving Care	Service / Business interruption	Provision of secondary care immunology services by external provider (this is a service that is not provided by CTM UHB).	If: CTM is unable to secure a new contract with an alternative commissioned provider; Then: CTM residents will have no access to secondary care immunology provision. Resulting in: unacceptable level of clinical risk for both routine and urgent referrals that are currently without any available referral option. Patient experience will be impacted by delays in onward referral for investigation, diagnosis and definitive treatment/management plan. This could lead to both informal and formal concerns being submitted to the health boards.	Working group in place to seek and secure service (meets monthly), although more regular communication and updates is sent in between meetings. Exploration of suitable providers within the NHS and also private providers undertaken. Short term contract being sought for urgent referrals and expected by end July 2024. CTM UHB Referral Management Centre currently maintaining database of both urgent and routine referrals received. CTM GP's have been informed of the challenges currently experienced with immunology provision and delays can be expected.	Update 17.04.2025 - agreement with North Bristol NHS Trust extended to 30/4/25 to all North Bristol Trust to schedule all the new out patient appointments. Wash up meeting planned for May to discuss progress and whether it is something that could be repeated in 25/26 (subject to funding). Funding discussions ongoing. Welsh Government have commenced scoping exercise and has met with all University Health Board commissioning leads in March and will meet with clinical leads this month. Draft report to be submitted to Welsh Government by scoping lead in April.	Quality, Safety & Experience Committee Operational Delivery Committee	16 (Decreased from a 20 to a 16 in February 2025)	C4xL5	4 (C4xL1)	↔	08.07.2024	17.04.2025	30.06.2025
23	5961	Executive Director of Finance Executive Lead for Estates	Central Corporate - Estates	Estates Directorate	Sustaining Our Future	Environmental / Estate / Infrastructure	Remedial roof works to resolve the water ingress at POWH.	If: the Health Board fails to act upon the recommendations of the findings of the report from the appointed Structural Engineers in relation to the roof areas at the POWH Then: water ingress will continue to be a problem. Resulting in: significant impact/harm to patient, staff and public safety. Healthcare facilities which are not fit for purpose or sustainable for the future. Service delays impacting the patient experience and service performance of the Health Board. Potential legislative challenge and reputational damage. Loss of confidence in the Health Board estate infrastructure across CTM.	Command structure established to manage the critical incident following identification of roof structure failings. Immediate mitigations to vacate 1st floor wards & depts. of Phase 1 being managed under 4 key Cells: 1) Discharge Cell - Objectives: The safe but rapid discharge of patients and services from top floor phase 1 POW site and to maintain quality of care and patient safety 2) Decant Cell - Objectives are the safe but rapid decant of patients and services from top floor phase 1 POW site, to maintain quality of care and patient safety and to maintain staff safety and the deployment of the right staff to the right place. Decant plan agreed 15th Oct. 3) Redirect Take - Objective - Reduce demand for inpatient beds on the POW site 4) Estates - focusing on ensuring decant areas are fit for purpose as well as overseeing the plans for the works on the roof. Enabling Support Cells Established: Patient Transport, Workforce, Digital, Facilities, Patient Safety, Communication In addition barriers are in place around the footpaths to keep pedestrians away from the edge of Phase 1 roofs.	Update April 2025: Removal of Roof Coverings at the Princess of Wales Hospital site in accordance with the recommendations in the structural engineering report of 9th October 2024. Contractor has been appointed. Welsh Government funding £26.524m was approved Friday 8th November, contractor started the roof replacement programme on Monday 11th November. Phase 1 has prioritised Maternity and Special Care Baby Unit, roof replaced and handed over on Monday 13th January, services returned to site mid Feb. Full programme including Theatre FEN works and fire compartmentation above vacated wards and depts due to be completed mid August 2025. Water ingress on the Phase 1 areas of the roof is only a risk on areas yet to be completed i.e. ITU, Endoscopy, Wards 5, 6, 7 and 8 but all are vacant and roof works progressing.	Quality, Safety & Experience Committee Operational Delivery Committee Health, Safety & Fire Sub Committee	16	C4xL4	8 (C4xL2)	↔	21.10.2024	06.05.2025	30.06.2025
24	4885	Director of Corporate Governance / Board Secretary	Corporate Governance	Corporate Governance	Improving Care Sustaining our Future	Quality / Complaints / Assurance / Patient Outcomes	Failure to deliver and sustain effective Policy Management System and Process	If: the Health Board fails to maintain an effective policy management process/system to monitor, store and manage the review of policy and procedural documentation Then: there is a risk that staff may act in a manner that is not consistent with strategic and functional expectations. Policies and procedures may not be readily accessible to support decision making and service delivery, and the Health Board may not be protected from litigation if policies and procedures are not regularly reviewed to reflect changes in standards and/or legislation. Resulting in: Policies not being readily available for reference in decision making / emergency situations to support courses of action. Non compliance with new standards and legislative changes leading to possible legal challenge. Limited version control which could impact decision making if there are inconsistent or varying versions of a policy available.	The Policy for the Development, Review and Approval of Organisational Wide Policies is extant and sets out the process to follow. Policy and Procedure advice and guidance is available from the Clinical Policy lead and the Assistant Director of Governance & Risk for non clinical policies. SharePoint Intranet page acts as document library.	Update 30.4.2025 for May 2025 Org RR iteration - a revised "Policy on Policies" has been drafted to simplify the process for development and approval which will shortly be shared for consultation. New policy page on SharePoint in design stages. Baseline position on Central Directorate policy statuses is being collected so that an accurate compliance position can be captured. On track with timescales outlined in the Project Initation Document.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL4	8 (C4xL2)	↔	26.10.2021	30.04.2025	30.06.2025
25	5691 Closed Session due to business sensitivities	Chief Operating Officer	Facilities Directorate	Assistant Director Facilities	Sustaining Our Future	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Detail extracted due to business sensitivities. Full risk received in the Closed Session of the Committee.											
26	5761	Executive Medical Director	Medical Directorate Function	Medical Directorate Manager	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Cross Health Board Data Sharing	If: Digital services across Wales are unable to resolve an ongoing issue with the ability to share patient data in both directions across health boards/trusts Then: Clinical staff across CTM will be unable to provide the safe and effective care to patients using transparent, available data Resulting in: Potential harm to the patients of CTM due to the lack of clinical information available to clinicians when making clinical assessments	For CTM, this is a particular issue in Prince Charles Hospital as there is a lot of patient cross over at the boundary of Aneurin Bevan Health Board. As a health board we continue to raise this as a serious patient safety issue and will continue to press for a solution with Digital Health Care Wales. CTMUHB have asked for alternate options for a quicker solution and timescales to be aligned with these. This has been added as an agenda item for discussion at the next All Wales Medical Director meeting.	Digital Health Care Wales have been working on the ability to share data in both directions so data flows in the Health Board systems – this has been an issue for some time. ABUHB have allocated some project resource to scope, map and plan the work needed, however, resources will need to be allocated by C&V and AB to get the work done. There was a strong commitment from Pan-South East Wales Regional Digital to work closer together and link into a wider regional programme board, this was repeated at the regional planning meeting. Update May 2025 - No change to risk score or mitigation this period. Executive Medical Director to raise risk again at next All Wales Medical Director meeting.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL4	8 C4xL2	↔	26.04.2024	01.05.2025	30.6.2025
27	5646	Chief Operating Officer	Mental Health Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	The impact of "Right Care Right Person" (RCRP) approach.	**If:** South Wales Police (SWP) implement Right Care Right Person **Then:** In some circumstances the Health Board will not be able to routinely call upon SWP to assist with people in mental health crisis or with social care issues, for example, missing patients, welfare checks and supervising people who are detained on S136 Mental Health Act. **Resulting in**: Increased risks to our staff and the people who use our services.	Multi-agency planning meetings have been arranged to review policies. This is an emerging picture and one which the Health Board are developing a fuller mitigation against, it is also a picture which has a gradual phased roll out over the next year. Nurse Director for the Care Group will be drafting a report for Operational Management Board later in the month but timelines have not allowed for this at submission to the Organisational Risk Register.	Update 15.04.2025 - Risk reviewed Phases 3+4 commenced 10/03/25, no significant impact yet, risk reviewed, no change at present. The Care Group will continue to monitor and discuss scoring review at next Mental Health Learning Development Operational Management Board.	Quality, Safety & Experience Committee Mental Health Act Monitoring Committee	16	C4xL4	12 (C3XL4)	↔	08.12.2023	15.04.2025	31.05.2025
28	5579	Executive Director of Public Health	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Head of Nutrition and Dietetics, Therapies, PCH	Creating Health	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Rising childhood obesity rates resulting in an increase in obesity related conditions and poorer health outcomes.	**If** there is no children and young person's weight management service **Then** the Health Board will be unable to support children and young people to manage their overweight and obesity **Resulting in** non-compliance with national standards and pathways, significant risk to patients with increase in childhood obesity rates, obesity related conditions, healthcare costs and no improvement in the health of the most disadvantaged.	Non-finance dependant controls: 1) Level 1 service via PIPYN continues to be delivered in Merthyr (PHW funding until 26) and Taff Ely and Rhondda (Cluster funding until 26) 2) Written first line advice and guidance on the management of referrals available and provided to referrers and shared with families and carers 3)Business case developed submitted and submitted for IMTP consideration. Business case proposes a phased approach at levels 1 and 3 and was developed in collaboration with stakeholders. Finance-dependant controls: 1)Set up service if funding identified via IMTP process.	Update May 2025 - Awaiting formal notification of IMTP investment which will reduce this risk	Quality, Safety & Experience Committee Strategic Development Committee	16	C4xL4	8 C4xL2	↔	13.10.2023	06.05.2025	30.06.2025

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
29	4908	Executive Nurse Director / Deputy Chief Executive	Central Function - Patient, Care and Safety	Assistant Director Quality & Safety	Improving Care	Statutory Duty, Regulation, Mandatory Requirements	Failure to manage Legal cases efficiently and effectively	**If:** The Health Board was unable to sustain ongoing funding for the two temporary Legal Services Officers **Then:** the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. **Resulting in:** Risk to quality and safety of patient care, resulting from lack of capacity to management cases in a efficient and effective manner, which could result in failure to comply with the WRP procedures resulting in financial penalties	The Health Board are developing an action plan in response to the Welsh Risk Pool review, which includes the reviewing structures and workloads New operating model in respect of quality, safety and governance almost fully implemented. New systems and processes, including escalation, implemented to assist to effectively manage cases. The Assistant Director of Concerns & Claims, Head of Legal Services and Legal Services Manager are all carrying case loads to help mitigate this risk. The team are having to apply an objective triage approach across the portfolio of redress, LFERs and Inquests to support the mitigation of this risk.	Update May 2025 - due to a number of challenges identified within the Legal Services Directorate a review is underway which includes a detailed review of any associated risks which will be supported by a recovery plan. This review is being led by the Deputy Director of Nursing. Updated risks will be captured in the next iteration of the Organisational Risk Register.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL4	8 (C4xL2)	↔	02.11.2021	06.05.2025	30.06.2025
36	3337 Linked to RTE Risk 4813 and M&C 4817. Also linked to 4804.	Chief Operating Officer Director of Primary Care and Mental Health Services	Central Support Function: Digital & Data Mental Health Care Group	Lead Infrastructure Architect Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services	Creating Health	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Lack of a Single Electronic Patient Record in Mental Health Services	**If:** Mental Health Services do not have a single integrated clinical information system that captures all patients details. **Then:** Clinical staff may make a decision based on limited patient information available that could cause harm. **Resulting In**: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace.	Control measures updated September 2023. 1. A PID has been developed which outlines the processes, resources and timelines sought - this to be discussed in September Programme Board. 2. The Business Case to be refreshed on the back of the PID once approved. It will need to identify additional staff resource required to progress the disaggregation process to bring all CTMUHB staff who currently use WCCIS via local authority over to CTMUHB WCCIS platform. Requires Programme Board approval. 3. Business case to be progressed following Board approval. 4. A new MHLD Care Group risk will be developed relating to the operational mitigations required in the interim to support safe communication and this will be held by the High Quality Clinical Record group, part of the Inpatient Improvement Programme	Update March 2025 - Update provided by the Director of Digital, confirmed that the implementation period of the Single Record Programme is Jan-July 2027. The programme board will be convened in April 2025 and the tender will be awarded by the end of 2025. Update May 2025 - risk reviewed no change to risk score or mitigation this period.	Quality, Safety & Experience Committee Operational Delivery Committee	15	C5xL3	6	↔	07.11.2018	06.5.2025	30.06.2025
37	4691 Linked to RTE Risks 4803, 4799, 3273 and 3019.	Chief Operating Officer	Mental Health Care Group	Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services	Sustaining Our Future	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	New Mental Health Unit	**IF**: Mental health inpatient environments fall short of the expected design and standards. **Then**: Care delivered may be constrained by the environment, which is critical to reducing patient frustration and incidents as well as presenting more direct risk as a result of compromised observations. **Resulting in**: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace and extended lengths of stay.	A Quality Improvement programme in relation to inpatient care has started and a work stream in relation to Safe and Therapeutic Environments has been established with the aim of optimising the patient experience. Inaugural workshop took place on the 26th April. Assistant Director of Strategic Transformation – Mental Health has commenced in post. This new role will lead a range of strategic programmes including recommencing a capital business case for a new Mental Health Unit. Annual revisiting of all patient ligature risks and completion of Statement of Needs via capital process for any ligature risks assessed as needing resolution. All anti ligature works planned for 2022 – 2023 have now been completed. A scoping document case is to be prepared and submitted to WG. Inpatient Improvement Programme established April 2023	Update 30.4.2025 - Awaiting a feasibility review on Mental Health inpatient space that will support the mitigation for this risk. Care Group Director engaging with the Capital Team on progressing this at present. No change to risk score at this stage.	Quality, Safety & Experience Committee Operational Delivery Committee	15	15 (C3xL5)	6 (C3xL2)	↔	15.06.2021	30.04.2025	31.07.2025
38	5820	Executive Director of Public Health	Public Health Health Protection	Health Protection Team	Improving Care & Creating Health	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Potential inability to deliver all elements of the Health Protection Strategic priorities as a result of reduced allocation of funding.	**IF** as a result of the reduced allocation of Health Protection resource the Health Protection Team has insufficient resources to deliver a safe and sustainable service. **THEN** there may not be sufficient resources to deliver all elements of vaccination and immunisation (which is the first line of defence against infectious disease) in accordance with the NIF. The health board response to infectious disease or environmental hazards will also be significantly hindered and work to address gaps in equity of access will be limited. **RESULTING in** avoidable harm to patients in vulnerable groups and harm to the public as a result of insufficient health protection interventions delivered. This also poses a reputational risk as a consequence	Governance structure agreed in Health Protection. Health Protection Board established. Recruitment underway to Health Protection structure. A series of planning workshops with partners agreed to review resources available, develop Health Protection strategy and highlight ongoing gaps	A workforce structure has been approved by ELG and work to identify gaps is ongoing which will be reviewed once recruitment is complete. Work with partners is ongoing to reduce inefficiencies and develop A collaborative Health Protection (HP) plan based on all resources available to ensure priorities can be clearly defined and delivered. Work with CTM finance is needed to ensure the HB allocation is maximised to support HP priorities. Welsh Government discussions are ongoing with regards to the reduced allocation N/B - Whilst this risk is not scored at a level of 15 and above - the Executive Lead considers this risk to be of a contentious nature that should be escalated to the Board via the Organisational Risk Register. Update February 2025 - This risk has been reviewed by the Local Public Health Team Strategic Group meeting on Tuesday 11th February 2025. As the uplift in Health Protection funding for 2025/2026 still does not bring parity to the funding across Wales and is insufficient to deliver the Health Protection strategic plan, there remains a funding gap. Work is ongoing to establish the impact of the gap and the risk consequence score will be updated accordingly as this work completes. Update 29th April 2025 - Risk reviewed and remains unchanged, next review will be at the PH Strategic Group meeting in May.	Quality, Safety & Experience Committee Strategic Development Committee	12 Please see note in column J	C4xL3	8 (C4xL2)	↔	01.07.2024	29.04.2025	13.05.2025

Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Rating (Target)
5226	Director of Digital	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Risk of damage to records and equipment due to leaking roof in the Williamstown Records Hub	**If:** the paper records stored at Williamstown Records Hub are damaged due to the recurrent water leaks in the roof. **Then:** then they may be damaged beyond repair. **Resulting in:** records not being available for patient care or for legal purposes.	The Estates Directorate have arranged for checks and repairs but roof continues to leak in Library Record Store and above workstations in Library Office. Staff are vigilant and containers are placed to catch known leaks. However, new leaks can occur and unavoidable water damage could occur at any hour during wet weather. Leaks could also cause slips/falls in hard-floor areas.	Update March 2025 - As at 10.2.2025- Repairs have commenced on the southern end of the roof. However, since 6/1/25, 6 new areas of leakage have occurred. On 4 of these occasions, patient records have been water-damaged. @300 records have been affected in total so far, including maternity records which have a 25-year retention period. Work to repair the northern end of the roof is awaited with urgency. Plastic sheeting has been utilised in an attempt to protect notes but it is only possible to do this in small areas. approximately 40% of the Library remains at significant risk. Update May 2025 - Repairs completed mid- April 2025. To date, no further leaks have been observed; however, there has not yet been sustained rain to enable confirmation that all leaks have been stopped. The situation is being monitored on an ongoing basis. The likelihood has been reduced to 2 and it is hoped to reduce this further, if no leaks occur during sustained wet weather.	Quality, Safety & Experience Committee Operational Delivery Committee	8 Risk reduced from a 20 in May 2025	4 (C4xL1)

De-escalation Rationale
Update May 2025 - Repairs completed mid- April 2025. To date, no further leaks have been observed; however, there has not yet been sustained rain to enable confirmation that all leaks have been stopped. The situation is being monitored on an ongoing basis. The likelihood has been reduced to 2 and it is hoped to reduce this further, if no leaks occur during sustained wet weather. Risk will continue to be monitored by the Digital Directorate Function.

Agenda Item
7.2

Quality, Safety & Experience Committee

Highlight Report from the Harm Free Care Agenda

Dyddiad y Cyfarfod / Date of Meeting	20/05/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Richard Hughes, Deputy Executive Director of Nursing
Cyflwynydd yr Adroddiad / Report Presenter	Richard Hughes, Deputy Executive Director of Nursing
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Improving Care Board	30/04/2025	Noted

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taff Morgannwg University Health Board
Datix	Incident Reporting System
ICB	Improving Care Board
MDT	Multi-disciplinary team
QI	Quality Improvement
QSE	Quality, Safety and Experience Committee

1. Introduction

1.1 This report has been prepared to provide the Quality, Safety, and Experience Committee (QSE) with details of the key issues the Harm Free Care initiative considered at its meeting on 05 May 2025.

1.2 The Harm Free Care initiative has made notable progress across its three primary workstreams: Inpatient Falls Reduction, Nutrition and Hydration, and Pressure Damage.

The Inpatient Falls Reduction workstream has concentrated on enhancing audit compliance and integrating multifactorial falls risk assessments, leading to a more holistic approach in identifying and mitigating fall risks.

Meanwhile, the Nutrition and Hydration group, which has been active for over 12 months, has prioritised continuous improvement through policy reviews and, more recently, data analysis, with plans for workshops scheduled in 2025/26. This focus has particularly highlighted incidents related to enteral and parenteral nutrition.

The Pressure Damage workstream has aimed to reduce the incidence of hospital-acquired pressure ulcers by implementing standardised protocols and targeted interventions. Monthly reports and a newly developed dashboard offer a comprehensive overview of pressure ulcer incidents, aiding in the identification of areas requiring improvement.

Overall, these initiatives have significantly enhanced patient safety and the quality of care across various clinical areas.

2. Purpose of this Meeting

2.1 The purpose of this report is to provide an update on the progress and current status of the Harm Free Care initiative, focusing on the three key workstreams: Inpatient Falls Reduction, Nutrition and Hydration, and Pressure Damage. The QSE will review the progress, provide feedback, and discuss future priorities.

3. Highlight Report

Alert / Escalate	• Inpatient Falls Reduction: There is a need to enhance data accessibility, as the dependence on manual extraction and analysis from the DATIX system hinders timely reporting and monitoring. Additionally, standardising the presentation of falls data is fundamental, particularly in relation to bed occupancy rates, to facilitate accurate comparisons across

different wards. Ensuring consistent team engagement poses a challenge with competing care and operational issues being experienced across the health board. Addressing these issues is essential for improving the effectiveness of falls prevention strategies and safeguarding patient safety.

- Nutrition and Hydration: A recent Datix review covering the period from April 2023 to February 2025 highlights various incidents related to nutrition and hydration, indicating areas for meaningful improvements.

  The dataset of 202 incidents reported occurrences, such as allergic reactions (8), gaps in patient assessment (8) and assistance (4), choking incidents (18), and challenges in monitoring fluid balance (8). It also reveals several specific issues with the provision of enteral diets (145), including the failure to supply appropriate special diets and the administration of incorrect feed volumes (5). The prevalence of choking incidents, both in patients with and without dysphagia, calls for a stronger emphasis on thorough assessments and timely referrals to Speech and Language Therapy where required.

  This underlines the importance of ensuring protected mealtimes and prompt transfers to enhance patient care and safety. By focusing on these essential areas, the Harm Free Care agenda will work collaboratively to elevate the quality of nutrition and hydration management, ultimately leading to better patient outcomes and overall satisfaction.

- Pressure Damage: The CTMUHB is facing significant challenges in procuring and managing slide sheets, both washable and single-patient-use types. These issues have led to frequent shortages, inconsistent availability, and higher-than-necessary expenses, impacting equipment availability, operational efficiencies, and patient care. The current system lacks standardised procurement practices, a centralised storage system, and effective tracking, resulting in frequent borrowing between wards and higher costs. Some wards have resorted to ordering directly from companies, bypassing approved procurement channels, further exacerbating the problem.

  A recent cost analysis highlighted inefficiencies in the current washable and single-patient-use slide sheets system. Washable slide sheets are often delayed due to slow returns from laundry, while single-use slide sheets lead to higher long-term costs and increased waste. The lack of a

	centralised equipment tracking system and delivery point exacerbates shortages and misplacements, and there is no standardised fast-track ordering procedure for critical equipment needs. These issues underscore the need for a comprehensive approach to optimise slide sheet procurement and usage, ensuring better operational efficiency and patient care.
Advise	• Inpatient Falls Reduction: Integrating multifactorial falls risk assessments and developing a post-falls assessment checklist are key interventions. These measures lead to a more comprehensive approach to identifying and mitigating fall risks. • Nutrition and Hydration: Reviewing and amending policies and the decision to develop a workshop-based approach with additional training sessions will be the next phase in addressing gaps and ensuring alignment with best practices. • Pressure Damage: The monthly trends indicate a significant rise in device-related pressure ulcer incidents during the summer months (July and August) and January. This seasonal variation underscores the need for further analysis and research, with the potential for increased vigilance and targeted interventions to better understand the rise in reported numbers. Additionally, the differences in care practices among hospitals, as reflected in the rates per 1,000 bed days, this further underscores the importance of the steering group in supporting the standardisation of protocols to ensure consistent and effective prevention and management of pressure ulcers.
Assure	• Nutrition and Hydration: The Prince Charles Hospital Ward 9 and 10 harm-free care QI project summary outlines a comprehensive Quality Improvement (QI) initiative to enhance patient safety at mealtimes on wards 9 and 10 at PCH. The project, which spanned 12 weeks, focused on increasing the percentage of patients receiving the correct therapeutic diets and ensuring staff could safely assist patients with feeding issues. The project assessed five changes that considerably enhanced the safety of food provision and mealtime support. Key recommendations involve the creation of a Therapeutic and Specialist Diet Policy, fostering a culture of protected mealtimes, and implementing standardised terminology and procedures for food textures and dietary needs.

	Leadership and accountability were underscored, with Heads of Nursing responsible for overseeing the implementation of policies, and a new multidisciplinary team (MDT) scrutiny panel tasked with reviewing incidents related to eating and drinking. The project determined that implementing focused leadership and standardised procedures could significantly enhance mealtime safety and establish a sustainable standard across the organisation. • Pressure Damage: The Pressure Ulcer Steering Group is committed to reducing avoidable harm caused by healthcare-acquired pressure injuries. The group's initiatives include monthly monitoring of falls and pressure ulcer rates by ward, implementing best practices, and standardising assurance and learning panels across CTMUHB. These efforts are essential for enhancing patient outcomes. By focusing on developing standardised protocols, fostering a unified approach to assurance and learning panels, and establishing clear criteria for distinguishing between avoidable and unavoidable incidents, the group plays a crucial role in promoting a culture of continuous improvement and accountability.
Inform	• The Pressure Damage workstream minimises hospital-acquired pressure ulcers, ensuring effective prevention and management strategies. The group aims to lower the incidence rate of reported hospital-acquired pressure ulcers per 1,000 bed days. A task and finish group has been established to review current data sources and ensure measurement consistency to support this goal. Monthly reports covering all grades of hospital-acquired pressure ulcers are established, and a dashboard is currently being developed to enhance data accessibility through Datix, triangulation with pressure panels, and safeguarding measures. The group strives for 100% compliance with the investigation and review process within 60 days of a pressure ulcer's discovery, ensuring a timely resolution. Compliance figures are presented through the steering group, alongside the development of a high-level dashboard. Additionally, the availability of appropriate pressure-reducing equipment is closely monitored, and any delays in equipment supply are duly documented and escalated. A scoping exercise has been conducted to assess the availability of equipment and slide sheets, accompanied by a

	cost-comparative SBAR to evaluate single-patient use slide sheets versus reusable, washable options. • The Nutrition and Hydration workstream aims to improve patient care by ensuring proper nutrition and hydration practices. The group reviewed current policies, discussed feedback from medical and allied health professional colleagues, and made necessary amendments. These policies are being prepared for the next Operational Management Board (OMB) meeting. Issues related to the catering bed plan, including compliance concerns and meal distribution processes, were discussed, and actions were taken to address these issues, including setting up meetings with relevant nursing heads. The group proposed developing workshops and training sessions across community and acute sites, focusing on nutrition and hydration procedures. They plan to collaborate with the CTM Learning Academy to create a framework for these sessions. The group reviewed raw data from Datix related to nutrition and hydration incidents, identified potential underreporting, and decided to work on a subset of data for regular analysis. Discussions are planned to link with the Heads of Nursing for the rollout of the catering bed plan in community hospitals. • The Falls workstream is dedicated to reducing inpatient falls and improving patient safety. The steering group focuses on enhancing audit compliance by reviewing documentation to integrate multifactorial falls risk assessments and establishing clear leadership and monitoring arrangements. Emphasis is placed on MDT education and training compliance, with new training opportunities being explored. This includes preparing for the expansion of the audit to include other injuries such as wrist fractures, head injuries, and spinal injuries. The group is also establishing a post-falls assessment checklist, auditing equipment availability and training on its use, and reviewing bed rail risk assessments. They are exploring the capabilities of digital software solutions to enhance learning and communication.
Appendices	None identified.

4. 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	Living Well Aging Well
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 Data to knowledge Learning, improvement and research Whole-systems perspective
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Effective Efficient Equitable Person-centred Timely Safe
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable 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: This is a report on the work being undertaken within the Harm Free Care Agenda. No current recommended service change exists.

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: This is a report on the work being undertaken within the Harm Free Care Agenda. No current recommended service change exists.
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.	

5. Recommendation

5.1 The Quality, Safety and Experience Committee is asked to NOTE the highlights in section 3 of this report. The Harm Free Care initiative has made significant progress across its three primary workstreams: Inpatient Falls Reduction, Nutrition and Hydration, and Pressure Damage.

6. Next Steps

6.1 To further enhance patient safety, it is recommended that multifactorial falls risk assessments be integrated and a post-falls assessment checklist developed. Regular documentation reviews and the implementation of standardised protocols will ensure consistency in falls risk assessments.

6.2 It is advised to review and amend policies and develop a workshop-based approach with additional training sessions. This will address gaps and ensure alignment with best practices. The focus should be on thorough assessments and timely referrals to Speech and Language Therapy where required.

6.3 The monthly trends indicate a significant rise in device-related pressure ulcer incidents during specific months. Further analysis and research are recommended to understand the seasonal variation and implement targeted interventions. Standardising protocols and establishing clear criteria for distinguishing between avoidable and unavoidable incidents will enhance patient outcomes.

6.4 In future meetings, the committee should consider asking for:

6.4.1 Updates on the implementation and effectiveness of the recommended interventions.
6.4.2 Detailed reports on any new trends or emerging issues related to patient safety.
6.4.3 Feedback from staff and patients on the impact of the Harm Free Care initiative.
6.4.4 Progress on any additional training or policy amendments that have been implemented.

Agenda Item
7.3

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Quality, Safety & Experience Committee

Annual Assurance Report on Compliance with the Nurse Staffing Level (Wales) Act

Dyddiad y Cyfarfod / Date of Meeting	20/05/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Tanya Tye, Senior Nurse Professional Practice & Nurse Staffing Lead
Cyflwynydd yr Adroddiad / Report Presenter	Greg Padmore-Dix Executive Director of Nursing
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group /Forum Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
NSLWA	Nurse Staffing Levels Wales Act
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
HB	Health Board
WTE	Whole Time Equivalent
RN	Registered Nurse
HCSW	Health Care Support Worker
SAU	Surgical Assessment Unit
SBAR	Situation, Background, Assessment, Recommendation framework

1. Situation /Background

1.1 The Nurse Staffing Levels (Wales) Act 2016 (hereafter referred to as "the Act") was introduced in March 2016 and came into effect in April 2018 for all acute adult medical and surgical ward areas. From 1st October 2021, the second duty of the Act was extended to include paediatric inpatient wards.

1.2 In accordance with Section 25E of the Act, the Health Board is required to report annually its compliance with maintaining the nurse staffing level in all wards to which Section 25B applies. This annual assurance report covers the period from 6th April 2024 to 5th April 2025.

1.3 The template report has been developed using the nationally agreed-upon and endorsed by the All-Wales Nurse Staffing Programme.

1.4 The Committee is asked to receive and note the following formally:

- The contents of the 2024/2025 Nurse Staffing Levels (Wales) Annual Assurance Report (Appendix A) and the ward staffing levels (Appendix B is available in the documents folder on Admincontrol (not published)).

- The application of the triangulated methodology prescribed under Section 25C of the Act, which outlines the principles for calculating nurse staffing levels.

- A critical incident at Princess of Wales Hospital during the reporting period resulted in the relocation of several wards across the Health Board. Further details are provided in the SBAR (Appendix C), with a summary of the ward relocation listed in (Appendix D available in documents folder on Admincontrol (not published)).

2. Specific Matters for Consideration

2.1 **2024–2025 Annual Assurance Report**: The report outlines the progress made by the Health Board in meeting the statutory requirements of the Act for the period 6th April 2024 to 5th April 2025 (Appendix A).

2.2 **Adult and Paediatric inpatient wards where Section 25B applies**

The table below illustrates the number of wards at the beginning and end of the reporting period from 6th April 2024 to 5th April 2025.

	January 2024	June 2024
Number of Acute Medical inpatient Wards	17	17
Number of Acute Surgical inpatient Wards	15	16
Number of Paediatric inpatient wards	3	3

2.3 Changes Following Acuity Audits: As a result of the acuity audits conducted in January and June 2024, the following changes to nurse staffing levels were implemented (table 1):

Breakdown of staffing costs (proposed Uplifts/ decreases following June 2024 acuity audit)		
Site and Ward	**Additional requirements**	**Financial cost**
RGH Ward 3	Uplift 1 HCSW night	£127,570
PoWH Ward 4	Uplift 2 RN night Decrease 1 HCSW night	I2S scheme using £476,305 of 'out turn' funding savings of £247,249
PoWH Ward 5	Uplift 1 HCSW day and night	£213,677 (I2S scheme)
PoWH Ward 7	Uplift 1 HCSW day and night	£218,095
PoWH ward 8	Uplift 1 HCSW day and night	£218,095
PoWH Ward 9	Uplift 1 HCSW day and night	£218,095
PoWH Ward 10	Uplift 1 HCSW day and night	£206,000
PoWH Ward 11	Uplift 1 HCSW day	£95,915

Royal Glamorgan Hospital (RGH)	Princess of Wales Hospital (PoWH)

2.4 The following will be formally reported in the November 2025 paper, however for noting; following the January 2025 acuity audit the following wards were repurposed or the wards were repurposed into Section 25A wards.

2.5 Ward relocation

PCH (Prince Charles Hospital)
Ward 10 moved to RGH ward 19, following this ward 10 is now used as a surge capacity area.

2.6 Wards repurposed and now fall under Section 25A of the Nurse Staffing Level (Wales) Act (NSLWA 2016)

Site	**Ward**	**Change**
RGH	9	Surgical Assessment Unit (SAU)
RGH	10	Day surgery
RGH	11(PoWH 9)	Day surgery
YGT	Dinas	Was RGH ward 19 changed to rehabilitation

Ysbyty George Thomas Hospital (YGT)

2.7 Ward locations remaining closed following the critical incident

Princess of Wales Hospital
The following wards were closed due to the critical incident Wards 5, 6, 7, 8, 9,10. See Appendix D for additional information.

3. Key Risks / Matters for Escalation

3.1 For the reporting period (6/4/2024 to 5/4/2025) table 1 above shows the staff changes and financial costings for these changes.

3.2 There is a requirement to formally report any impact on safety or quality of care issues, which are attributed to non-compliance with the NSA staffing levels. Specifically, these incidents cover for adult wards (these can be found in Section 25E (2b) of the Annual Assurance Report on compliance with the Nurse Staff Level (Wales) Act Appendix A):

- Hospital-acquired pressure damage (grade 3, 4 and unstageable).
- Falls resulting in serious harm or death (i.e. level 3, 4 and 5 incidents).
- Medication resulting in moderate, severe harm and never events.

There are adjusted definitions cited for paediatric inpatient areas, which include:

- Hospital-acquired pressure damage (grade 3, 4, and unstageable).
- Infiltration/extravasation injuries
- Medication-related moderate, severe and never events.

3.3 In addition, for all Section 25B wards complaints wholly or partially related to nursing care are also reported (Appendix A, section 25E(2a)).

3.4 All incidents and concerns referenced to in this report have been reviewed and assessed by Heads of Nursing and Care group Nurse Directors via relevant internal assurance panel meetings.

4. 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	Not Applicable
	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)*	Not Applicable
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality**	Learning, Improvement & Research
	If more than one applies please list below:

(Duty of Quality Statutory Guidance (gov.wales))	
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Safe
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	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: The NSLWA 2016 is Law and does not impact quality
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): NEUTRAL Outcome for Welsh Language (delete as appropriate): NEUTRAL documents for patients are available in welsh language if required.	If no, please include rationale below:
Cyfreithiol / Legal	Yes (Include further detail below)	
	This report is the assurance the Health Board is complying with the NSLWA 2016	
Enw da / Reputational	Yes (Include further detail below)	
	To ensure compliance with the NSLWA 2016, therefore proposed changes may have some reputational impact	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	Due to the changes to patient acuity and dependency there will be some financial impact due to the need to source additional staffing as and when risk assessed as doing so.	

5. Conclusion

5.1 In summary, the reporting year 20024-2025 has presented significant challenges due to the critical incident declared at Princess of Wales. This situation has necessitated several ward relocations throughout the Health Board, as well as the repurposing of wards into Section 25A areas.

5.2 The use of the Safecare system has started to be used in the Safe2start meetings, specifically supporting the deployment of staff, mitigation of professional judgment decisions, and the identification and management of red flags raised by the clinical teams.

5.3 Recruitment and retention of staff has been a focus in this reporting period with the following highlights

- Lateral move scheme supporting 33 individuals to remain in the health board in areas where they have an interest, with another 59 applications at various stages in the lateral move scheme.
- A total of 137.01 WTE staff recruited through the streamlining scheme.

6. Recommendation

6.1 The Quality, Safety & Experience Committee is asked to **NOTE** the annual assurance report 2024-2025:

- Assurance that the statutory requirements for section 25B wards have been completed
- Ongoing review of ward moves following the Princess of Wales Critical incident and support to the senior nursing team on the creation of new templates when wards relocate.

7. Next Steps

7.1 Assurance period 2025-2026

- Continue to support staff in embedding SafeCare into their daily roles and in raising professional judgements/ red flags to mitigate risk.
- once-for-Wales approach to reporting. Collaborate with colleagues across Wales to establish a unified approach to reporting that will benefit all regions.
- Collaborate with the attraction and retention leads to enhance nurse recruitment through student streamlining and a lateral move scheme.
- Support unscheduled care and planned care following the critical incident in Princess of Wales Hospital.

Annual Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act: Report for Board/Delegated Committee			
Health board/trust	Cwm Taf Morgannwg University Health Board (CTMUHB)		
Date annual assurance report is presented to Board	This report is to be presented to Board 29th May 2025 (NB: Include data from April 6th 2024- April 5th 2025) This annual report refers only to year 2024/2025 but this report forms part of the 3 yearly assurance report that will be presented to Welsh Government in October 2027 for the reporting period from April 2024- April 2027.		
	Adult acute medical inpatient wards	**Adult acute surgical inpatient wards**	**Paediatric inpatient wards**
During the last year the lowest and highest number of wards	Lowest 16- Highest 17	Lowest 13- Highest 17	3
During the last year the number of occasions (wards where section 25B applies) where the nurse staffing level has been reviewed/ recalculated outside the bi-annual calculation periods	Although no calculations occurred outside the biannual acuity audits, 9 medical wards were relocated due to a critical incident at Princess of Wales Hospital. This resulted in one medical ward being reclassified from Section 25B to Section 25A, as its remit changed to a rehabilitation ward	Although no calculations occurred outside the biannual acuity audits, 10 surgical wards were relocated due to a critical incident at Princess of Wales Hospital. Following the January 2025 acuity audit, five surgical wards were reclassified from Section 25B to Section 25A, as their primary purpose changed to day surgery or rehabilitation.	0
The process and methodology used to calculate the nurse staffing level.	The Nurse Staffing Levels (Wales) Act 2016 (hereafter referred to as "the Act") came into effect in April 2018 for Adult Acute Medical and Surgical inpatient wards. From 1st October 2021, the second duty of the Act was extended to include paediatric inpatient wards. These wards will be referred to as Section 25B wards Section 25B requires Health Boards/ Trusts to calculate and take reasonable steps to maintain the nurse staffing level in all of these wards. The calculation is undertaken bi-annually in January and June with an annual paper being presented in November combining both audit results into one paper and a May paper presented to Board which forms part of the three-year report into Welsh Government. These reports are as per agreement within the once-for-Wales approach. The triangulated methodology, as outlined in Section 25C of the Act, sets out the principles for calculating nurse staffing levels.		

	January and June 2024 Staffing calculations For the Biannual acuity audits in 2024 each Section 25B ward was analysed using the data captured from various digital systems including SafeCare and Datix. The data below was reviewed in collaboration with the Ward Sister, Senior Nurse, and Lead Nurse responsible for the ward, as well as the Heads of Nursing from each acute hospital and Care Group Nurse Directors, to generate the report. The templates were discussed and ratified by the Ward Sister/Charge Nurse, senior nurses, Heads of Nursing and the Care Group Nurse Directors with the final templates endorsed by the Executive Director of Nursing full details are in Appendix B **Key areas of data capture:** • Current nurse staff availability, including staff not included in the core roster such as supervisory ward manager. • Patient acuity data for the month of January and June 2024. • six months (falls, medication errors, pressure damage, and serious incidents, including paediatric-specific infiltration and extravasation). Since June 2024, work has been ongoing with Care Group Nurse Directors to ensure data captured is sufficiently detailed to support in-depth triangulation for staffing decisions. • Workforce-related metric data, mandatory training compliance, vacancies, recruitment and sickness. • Information relating to patient flow, patient acuity and care quality metrics via the IT performance reporting system Datix and SafeCare (that allows information to be available to the Ward Managers, Heads of Nursing and Care Group Nurse Directors) for review. • Financial data confirming that all workforce models under the Nurse Staffing Act include a 26.9% uplift, with the supernumerary Band 7 Ward Sister/Charge Nurse factored into the ward's overall workforce plan. A critical incident at the Princess of Wales Hospital (PoWH) was declared in October 2024, due to this incident a number of wards had to move locations across site and across the Health Board one of these wards moved from Section 25B to Section 25A of the Act. As a result of the January 2025 acuity audit, a further five surgical wards were moved from Section 25B to Section 25A of the Act. This was due to changes in their primary purpose, shifting from acute surgical wards to day surgery or Surgical Assessment Unit (SAU) formats (full details of all PoWH ward moves are available in Appendix C)
Informing patients	The statutory guidance states that “Local Health Boards (LHBs) and Trusts “must make arrangements to inform patients of the nurse staffing level” (paragraph 20). The statutory requirements are to inform patients of the nurse staffing levels by ensuring that the most up-to-date information is displayed on wards in relation to the staffing levels agreed. To ensure transparency and consistency across Wales and to ensure compliance with this guidance, bilingual poster templates are displayed either outside or inside the ward entrance for all 25B wards that are included in the Act including

	Paediatrics. These are audited for compliance and shared with the senior nursing teams The template identifies the information of the nurse staffing numbers calculated for the identified period and the date the calculation was undertaken and signed off by the designated person. Following the June 2024 bi-annual acuity audit and calculation all eligible wards were issued the new templates, these are displayed with the responsibility to ensure they are completed correctly with oversight given to ward sister/ charge nurse and Senior nurses to ensure compliance. Paediatric inpatient wards have paediatric specific templates which were issued following the June 2024 bi-annual acuity audit and are being used within CTMUHB, these are updated following each acuity audit. All Section 25B wards have patient information leaflets available which informs patients and relatives with the information relating to the Nurse Staffing Levels (Wales) Act 2016. Information posters explaining the purpose of the Act and a Frequently Asked Questions leaflet (available in standard and easy-read versions) can be provided to answer any more detailed questions. A child and young person friendly poster are visible on all Paediatric inpatient wards. To ensure all the information is readily at hand, there is a shared drive for nurse staffing act resources which is available for staff across CTMUHB to access through the SharePoint system. The annual assurance report was presented to Board on 30th May 2024 and an annual paper to Board in 28th November 2024, the All Wales Nurse Staffing Programme have updated the informing patient posters and these will be used following this paper being presented to Board in May 2025.

Section 25E (2a) Extent to which the nurse staffing level has been maintained

As the nurse staffing level is defined under the NSLWA as comprising of both the planned roster *and* the required establishment, this section should provide assurance of the extent to which the planned roster has been maintained *and* how the required establishments for Section 25B wards have been achieved/maintained during the period of this annual report

Extent to which the required establishment has been maintained within <u>adult acute medical and surgical wards.</u> NB: First cycle: spring 2024 following January audit Second cycle: autumn 2024: following June audit		**Period Covered: -** 06/04/2024-05/04/2025		
		Number of Wards:	**RN (WTE)**	**HCSW (WTE)**
	Required establishment (WTE) of adult acute medical and surgical wards <u>calculated</u> during first cycle (May)	**31**	**619.32**	**493.60**
	WTE of required establishment of adult acute medical and surgical wards <u>funded</u> following first (May) calculation cycle	**31**	**619.32**	**493.60**
	Required establishment (WTE) of adult acute medical and surgical wards <u>calculated</u> during second calculation cycle (Nov)	**32**	**635.30**	**523.75**

	WTE of required establishment of adult acute medical and surgical wards funded following second (Nov) calculation cycle	**32**	**635.30**	**523.75**
	WTE Supernumerary band 7 sister/charge nurse (funded but excluded from planned roster)	**WTE: 32**		
	Accompanying narrative: As mentioned, during this reporting period the Health Board declared a critical incident at the Princess of Wales Hospital (PoWH) site in October 2024, which impacted a number of wards, including 13 Section 25B ward areas. To ensure the safety of patients and staff, the affected wards were relocated both on-site and off-site. These relocations were physical moves only, with an agreement that a full acuity audit would be conducted in January 2025, allowing time for any service changes to be embedded. In instances where bed numbers decreased, the funded establishment remained unchanged, with additional staff deployed as needed to cover vacancies during this interim period. A full breakdown of the ward moves is provided in Appendix C. Following the January 2025 acuity audit, one medical ward and five surgical wards were reclassified as Section 25A areas. This reclassification was due to changes in ward function and activity. As part of the wider response to the critical incident and to maintain patient flow and service continuity, six wards were repurposed as Section 25A areas in January 2025. As a result, the total number of wards under Section 25B of the Act is now 26. In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within the data for this report.			
Extent to which the required establishment has been maintained within paediatric inpatient wards NB: First cycle: spring 2024 following January audit		**Period Covered 06/04/2024-05/04/2025**		
		Number of Wards:	**RN (WTE)**	**HCSW (WTE)**
	Required establishment (WTE) of paediatric inpatient wards calculated during first cycle (May)	**3**	**93.81**	**19.1**
	WTE of required establishment of paediatric inpatient wards funded following first (May) calculation cycle	**3**	**93.81**	**19.1**

Second cycle: autumn 2024: following June audit	**Required establishment (WTE) of paediatric inpatient wards calculated during second calculation cycle (Nov)**	**3**	**94.01**	**20.31**
	WTE of required establishment of paediatric inpatient wards funded following second (Nov) calculation cycle	**3**	**94.01**	**20.31**
	WTE Supernumerary band 7 sister/charge nurse (funded but excluded from planned roster)	**WTE: 3**		

Accompanying narrative:

The nurse staffing levels were calculated using the triangulated methodology and compared to the current funded establishments to determine any workforce gaps. There has been no change from the initial calculation; however, please note the following update for

Princess of Wales Hospital (PoWH):
A Band 4 Nursery Nurse has been added to the calculation, and 0.61 WTE Registered Nurse has been deducted to support the workforce during the spring/summer months (March–September). This adjustment is based on an anticipated reduction in patient activity and acuity during these months, as evidenced by trends in previous years. Staffing levels will be increased again during the winter months to accommodate the predicted rise in acuity. This seasonal variation will be operationally managed through careful planning of annual leave and other staffing considerations.

Prince Charles Hospital:
Has fully recruited into existing vacancies, and current staffing levels are appropriate for the acuity and dependency of their paediatric patients.

It is important to note that, following the critical incident at Princess of Wales Hospital, Royal Glamorgan Hospital had to relocate their Paediatric Assessment Unit (PAU) into their Outpatients Department. As a result, the remaining two units experienced increased admissions, due to Royal Glamorgan Hospital being unable to surge capacity into their PAU during peak times.

Paediatric services continue to support the Health Board's student streamlining and recruitment events, both internally and externally, throughout the year.

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of

additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within the data for this report.

Extent to which the planned roster has been maintained within <u>adult acute medical and surgical wards</u>

	Total number of shifts	Shifts where planned roster met and appropriate	Shifts where planned roster met but not appropriate	Shifts where planned roster not met but appropriate	Shifts where planned roster not met and not appropriate	Data completeness
TOTAL	31420	17000 (49%)	3929 (15%)	6303 (24%)	2962 (8%)	95%

Accompanying narrative:

This is the first year the HB has managed to pull this data from the SafeCare system therefore unable to compare to previous years. This shows a data completeness of 95%, there is work being undertaken in relation to the classification of shifts to ensure the data is assured. Where there has been shifts where planned roster has not been met all appropriate steps have been taken to ensure staffing levels were maintained whether by redeployment of staff or asking the supernumerary Band 7 to work within the numbers or having additional temporary staffing supporting the shift.

Commented [T1]: Trying to pull this data

Extent to which the planned roster has been maintained within <u>paediatric inpatient wards</u>

	Total number of shifts	Shifts where planned roster met and appropriate	Shifts where planned roster met but not appropriate	Shifts where planned roster not met but appropriate	Shifts where planned roster not met and not appropriate	Data completeness
TOTAL	5638	2057(42%)	127 (14%)	3131 (31%)	172 (9%)	96 %

Accompanying narrative:

This is the first year the HB has managed to pull this data from the SafeCare system therefore unable to compare to previous years. This shows a data completeness of 96%, there is work being undertaken in relation to the classification of shifts to ensure the data is assured. Where there has been shifts where planned roster has not been met all appropriate

	steps have been taken to ensure staffing levels were maintained whether by redeployment of staff or asking the supernumerary Band 7 to work within the numbers or having additional temporary staffing supporting the shift.
Process & systems for capturing data on the extent to which the planned roster has been maintained on wards where section 25B applies.	NHS Wales is committed to utilising a national informatics system that can be used as a central repository for collating data to evidence the extent to which the nurse staffing levels have been maintained and to provide assurance that all reasonable steps have been taken to maintain the nurse staffing levels required. Extensive work has been undertaken across NHS Wales to implement a national informatics system to enable health boards/trust to meet the reporting requirements of the Act and follow the Once for Wales approach to ensure consistency. Each health board/trust committed to implementing RL Datix (formally Allocates) Safecare system, with each organisation having implemented this system to their section 25B wards. CTMUHB can confirm that all requirements of 'the Act' have been met during this reporting period. 'All reasonable steps' described in the statutory guidance have been utilised. The Health Board also hold daily safe2start huddles as well as monthly establishment meetings to review nursing workforce establishments attended by Workforce, Rostering, Nursing teams and finance colleagues. CTMUHB continue to embed SafeCare into the daily routine on an almost 'live' basis with more work around the escalation/ use of raising of red flags and professional judgements which provides greater understanding of ward activity, this supports staffing decisions and reporting requirements. The recording of patient acuity using the Welsh Levels of Care is embedded in practice with scrutiny undertaken if required, sessions are set up on a monthly basis for training and areas can ask for additional support if required.
Process for maintaining the Nurse staffing level	**Strategic/ Corporate steps to taken to maintain staffing levels** • Continued recruitment into identified vacancies across the Health Board. • Roster Management – All rosters are completed in line with policy and are developed to ensure the appropriate number of staff are rostered, underpinned by a suite of rostering metrics. • Roster Approval Process – All nurse rosters are subject to an approval process monitored by senior nurses to ensure safe and effective rostering. • Ward Managers and off-ward staff are deployed "into numbers" to meet the planned roster once all other options have been exhausted. • Staff numbers are enhanced via temporary staffing solutions, including redeployment from other areas within the organisation, overtime, bank, or agency staff. • The Health Board continues to participate in student nurse streamlining events and hosts local recruitment events both in-person and online to promote itself as an employer of choice. CTMUHB successfully recruited 137.01 WTE nurses through the streamlining process (September 2024: 99.48 FTE | March 2025: 37.53 FTE).

	• The Health Board launched a Lateral Move Scheme to support internal staff transfers for Band 5 Nurses and Band 2 Healthcare Support Workers. This has enabled the retention of 33 nurses, with a further 60 in process **Operational steps taken to maintain staffing levels** • Robust daily systems of staff planning and reviews of patient flow and acuity are in place on each acute site via "Safe2Start" meetings. These inform 24-hour staffing plans, with risks assessed and managed accordingly. Within Paediatrics, staff are deployed across sites to ensure appropriate clinical skills are available when risks are identified. • A clear escalation process to manage staffing deficits is outlined in the Health Board's Operating Framework and Nurse Staffing Escalation Policy. • Staff are signposted to well-being support mechanisms and facilities. • Deployment of supernumerary Ward Sister/Charge Nurse to undertake direct care delivery when required. • The SafeCare system is used to deploy staff, including Ward Managers and Senior Nurses, to mitigate professional judgments and red flags raised by clinical staff. • Enhanced overtime payment rates are offered to substantive staff for defined periods to increase workforce capacity. The NSLWA statutory guidance requires that the Health Board takes 'all reasonable steps' to maintain its staffing levels and this includes strategic/ corporate as well as operational steps. The Nursing Staffing Levels (Wales) Act (2016) Operating Framework and Escalation Policy for the Health Board supports the process of calculation and maintenance of nursing staffing levels in all S25B wards (including Paediatric inpatient wards) and the actions that are taken to review, record and escalate where nurse staffing levels are not maintained. **Strategic/ Corporate/ Heads of Nursing responsibilities to maintain staffing levels** • The Heads of Nursing chair monthly workforce meetings to review current ward vacancies and recruitment plans. The Allocate/Rostering Team provides data and scrutiny of ward rosters to assess compliance with efficiency and key metrics, as outlined in the Rostering Policy. • All nurse rosters are reviewed and approved by the Senior Nurse Team to ensure safe and effective staffing. • These meetings are attended by the Nurse Staffing Lead, Finance, and Workforce colleagues. **Ward level responsibilities to maintain staffing levels** Since November 2019, the All Wales Executive Director of Nursing Group has implemented a guidance document outlining what constitutes 'All Reasonable Steps' to support decision-making in maintaining safe staffing levels. This is a statutory requirement under the Act.

	Within CTMUHB, there are well-established daily operational processes for reviewing staffing levels and making risk-based decisions regarding staff deployment. Every acute hospital holds Safe2start meetings three times daily to review staffing. Following risk assessments, staff are deployed where possible using professional judgment and in line with the 'All Reasonable Steps' guidance. The SafeCare IT system is used to: • Record staff moves • Flag professional judgment calls • Highlight red flags related to staffing risks • These are addressed through mitigation actions by senior nursing staff, providing documented evidence of efforts to reduce or manage identified risks.

Section 25E(2b) Impact on care due to not maintaining the nurse staffing levels on adult acute medical and surgical inpatient wards

Incidents of patient harm with reference to quality indicators and complaints about nursing care	Avoidable hospital acquired pressure damage (grade 3, 4 and unstageable).	Falls resulting in moderate harm, serious harm or death (i.e. level 3, 4 and 5 incidents).	Medication administration errors resulting in moderate harm, severe harm, death & never events (i.e. level 3, 4, 5 and never events incidents).	Any complaints received about nursing care (Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR))
	TOTAL	TOTAL	TOTAL	TOTAL
Number of incidents/complaints closed during the current reporting period. (Please note these may include incidents/complaints opened prior to this reporting period).	18	1	2	21
Number of incidents/ complaints occurring when the nurse staffing level (planned roster) had not been maintained	3	0	2	1
Number of those incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor	3	0	0	1

Number of incidents/complaints occurring when the nurse staffing level (planned roster) had been maintained	15	1	0	20
Number of those incidents/complaints when the nurse staffing level was deemed to have been a contributing factor, even when planned roster had been maintained.	0	1	0	0

The following information has been attained from the business intelligence team who have gathered the data from the datix system for the annual period 6th April 2024- 5th April 2025, using the levels of harm and asking for the Closed cases.

Reportable Pressure Damage (Grade 3, 4 and unstageable)
There has been a total of 18 reportable Hospital acquired pressure ulcers during the reporting period 2024-2025, the Head of Nursing undertake scrutiny panels for Pressure ulcers where these are discussed and deemed avoidable/ unavoidable any lessons learnt from these incidents are shared with the wider teams not only on the specific DGH site but across the Health Board. There were 3 instances where nurse staffing levels were an attributing factor, lessons learned have been shared through Professional Forum Group (PFG) and through training sessions, ward staff attend the scrutiny panels to be able to see the process

Reporting Falls (Resulting in moderate, severe harm or death)
There has been 1 reportable falls during the reporting period 2024- 2025, this fall occurred where nurse staffing had been maintained however this was a contributing factor, staff involved in this incident have reflected and lessons learned have been shared for further learning across CTMUHB.

Reportable medication errors (level 3,4,5 and Never events)
There have been 2 reportable medication errors which have been investigated through internal process and taken to scrutiny panel, planned roster was not met however it was not deemed to be an attributing factor. Any lesson learnt from these incidents have been shared wider across the Health Board

Reportable complaints about nursing care (managed under PTR)
There have been 21 reportable complaints about nursing care and managed under the PTR process, these have been investigated through internal process and any lesson learnt from these incidents have been shared wider across the Health Board. 1 of these complaints have been linked as nurse staffing levels not being met as a contributing factor.
The changes to the data provided for the above table is because there has been training for staff and improved use of the Nurse staffing question in the investigations and Datix module.

Based on a review of the Health Boards/Trusts first 3 yearly reports and feedback from operational leads on their experience completing the reports; an SBAR was presented to the Executive Nurse Directors and CNO in 2021, which included a series of recommendations to improve and refine the reporting process. Following this a sub-group of the All-Wales Nurse Staffing Group was set up to improve and refine the reporting process to standardise reporting

and be in line with the Duty of Candour set out in the Quality & Engagement Act (2020), with the aim of broadening the scope of incidences of harm to provide more meaningful data, by including moderate risk falls and medication administration error incidents.

The work of the Reporting Sub-Group included a review of the measures for the adult medical and surgical inpatient wards and these were presented to the Executive Nurse Directors in August 2023. The changes to the adult ward's measures were agreed, with the intention that the amended measures come into effect at the beginning of the next reporting period i.e. April 2024.
Since EDoNs agreed the recommendations in August 2023 it became apparent that the way data is being captured on Datix to meet the reporting requirements of the Duty of Candour (DoC), which came into force in April 2023, may impact our data collection under the duties of the NSLWA.

Previously, we anticipated that the changes in the reporting criteria to include moderate levels of harm would increase overall reporting, however, following this clarification this anticipated increase may not be seen.
It must be noted that previous NSLWA reports have reported on the actual harm sustained without validation, as opposed to the number of incidents found to be resulting from an act or omission when in receipt of NHS Care. To align with patient safety incident reporting to Welsh Government all future NSLWA reports, as from April 2024, will report on closed patient safety incidents which have been validated with a level of harm moderate or above (as per patient safety incident definition) and whether the nurse staffing levels contributed to the incident.
The quality indicators for the adults in-patient wards will be as follows:

- Avoidable hospital acquired pressure damage (grade 3, 4 and unstageable).
- Falls resulting in moderate harm, serious harm or death (i.e. level 3, 4 and 5 incidents).
- Medication administration errors resulting in moderate harm, severe harm, death & never events (i.e. level 3, 4, 5 and never events incidents).
- Any complaints received about nursing care (Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR))

The data to be reported for each of the above will be:

- Number of incidents/complaints closed during the current reporting period. (Please note these may include incidents/complaints opened prior to this reporting period).
- Number of incidents/ complaints occurring when the nurse staffing level (planned roster) had not been maintained
- Number of those incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor
- Number of incidents/complaints occurring when the nurse staffing level (planned roster) had been maintained
- Number of those incidents/complaints when the nurse staffing level was deemed to have been a contributing factor, even when planned roster had been maintained.

Section 25E(2b) Impact on care due to not maintaining the nurse staffing levels on paediatric inpatient wards					
Incidents of patient harm with reference to quality indicators and complaints about nursing care	**Avoidable hospital acquired pressure damage (grade 3, 4 and unstageable).**	**Falls resulting in moderate harm, serious harm or death (i.e. level 3, 4 and 5 incidents).**	**Medication administration errors resulting in moderate harm, severe harm, death & never events (i.e. level 3, 4, 5 and never events incidents).**	**infiltration and extravasation injuries**	**Any complaints received about nursing care (NOTE: Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR)**
	TOTAL	**TOTAL**	**TOTAL**	**TOTAL**	**TOTAL**
Number of incidents/complaints closed during the current reporting period. (Please note these may include incidents/complaints opened prior to this reporting period).	0	0	1	3	5
Number of incidents/ complaints occurring when the nurse staffing level (planned roster) had not been maintained	0	0	0	2	0
Number of those incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor	0	0	0	0	0
Number of incidents/complaints occurring when the nurse staffing level (planned roster) had been maintained	0	0	0	1	5

Number of those incidents/complaints when the nurse staffing level was deemed to have been a contributing factor, even when planned roster had been maintained.	0	0	1	0	0

Reportable medication errors (level 3,4,5 and Never events)
One of the incidents under medication errors, nurse staffing was maintained however it was considered to be a contributory factor, learning has been shared across the care group

Reportable infiltration and extravasation incidents
There were three incidents, two of these when the planned roster was not maintained but staffing was not deemed to be a contributory factor and one of these occurred when staffing was maintained but again staffing was not a contributory factor. Lessons have been shared across the Health Board.

The work of the Reporting Sub-Group, mentioned previously, included the measures for the paediatric inpatient wards and these were presented to the Executive Nurse Directors in August 2023, along with the amended measures for the adult medical and surgical wards. The changes to the paediatric measures were agreed, with the intention that the amended measures come into effect at the beginning of the next reporting period i.e. April 2024.

The work of the Reporting Sub-Group, mentioned previously, included the measures for the paediatric inpatient wards and these were presented to the Executive Nurse Directors in August 2023, along with the amended measures for the adult medical and surgical wards. The changes to the paediatric measures were agreed, with the intention that the amended measures come into effect at the beginning of the next reporting period i.e. April 2024.

The quality indicators for the paediatric inpatient wards will be as follows:

- Avoidable hospital acquired pressure damage (grade 3, 4 and unstageable).
- Falls resulting in moderate harm, serious harm or death (i.e. level 3, 4 and 5 incidents).
- Medication administration errors resulting in moderate harm, severe harm, death & never events (i.e. level 3, 4, 5 and never events incidents).
- Infiltration and extravasation injuries
- Any complaints received about nursing care (Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR))

The data to be reported for each of the above will be:

- Number of incidents/complaints closed during the current reporting period. (Please note these may include incidents/complaints opened prior to this reporting period).
- Number of incidents/ complaints occurring when the nurse staffing level (planned roster) had not been maintained

	• Number of those incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor • Number of incidents/complaints occurring when the nurse staffing level (planned roster) had been maintained • Number of those incidents/complaints when the nurse staffing level was deemed to have been a contributing factor, even when planned roster had been maintained.
	Section 25E (2c) Actions taken if the nurse staffing level is not maintained (or maintained but not appropriate *)
Actions taken if the nurse staffing level <u>was not</u> maintained in wards where section 25B applies	As discussed, all reasonable steps are implemented to mitigate/ reduce risk where the nurse staffing level has not been maintained, due to the demand for services it is not always possible to close beds as a way to mitigate the risk. Teams on the Acute District General Hospital (DGH) sites conduct Safe2start meetings three times daily to review staffing, assess risks, and implement plans to support roster maintenance and ensure patient safety. The SafeCare system provides a bird's-eye view of staffing across the site, allowing for more informed and responsive decisions. Senior nurse leadership is available 24 hours a day, 7 days a week, ensuring that professional decisions can be made at any time of day. The Health Board has established a learning repository, where any relevant events are uploaded for shared learning across the organisation. In cases where medication errors occur, teams are invited to a review panel, where the incident is discussed. This promotes transparency and gives staff an opportunity to engage with the review process and learn from the event.
	Section 25A: Duty to have regard to provide sufficient nurses
Requirements of Section 25A (NB: Section 25A refers to the Health Boards/Trusts overarching responsibility to ensure appropriate nurse staffing levels in any area where nursing services are provided or commissioned, not only wards where section 25B applies)	Due regard has been given to review and ensuring sufficient nurses are within Section 25A areas in the HB: - • Ward sister/ charge nurses in the Community hospitals undertake regular meetings with the lead nurses and Heads of nursing. • Group Nurse Directors maintain oversight of their respective areas, with senior nursing teams escalating risks, identifying gaps, and reviewing staffing levels accordingly. • Within CTMUHB Mental Health Services, is currently undertaking an establishment review across the directorate. Where staffing levels are identified as being below the agreed level, these are escalated following the appropriate process. • Section 25A Adult Ward areas, Emergency and Outpatient Departments, undergo monthly establishment reviews with staffing levels discussed and escalated with senior nurses and Heads of Nursing • Ongoing education and training for nursing staff across the Health Board ensures they have the required skills and knowledge to perform their role effectively. Some staff are also supported to undertake further education modules to their areas.

	The All-Wales Nurse Staffing Programme have just commissioned a Section 25A work stream to develop Operational Guidance for section 25A areas which the nurse staffing lead is part of the membership.
	Conclusion & Recommendations
	In summary, there has been continued support for the Nurse Staffing Levels (Wales) Act 2016 during the period 2024-2025. The Heads of Nursing conduct the biannual triangulated reviews and review staffing on a monthly basis during establishment Meetings. Temporary funding for some areas have continued at a cost pressure whilst further work is undertaken to remodel wards to ensure patients and clinical areas are able to provide the correct level of care. **Highlights of reporting period** • The SafeCare system has been rolled out to all Section 25B areas, with implementation in Community Hospital wards, Maternity, and Mental Health services commencing in March 2024. • An All Wales review of the specific Datix question related to the Nurse Staffing Act has been completed. This has resulted in a revised set of questions, due to go live in April 2024. These changes aim to provide more robust and complete data regarding reportable incidents and complaints. Further work is underway to develop an All Wales Nurse Staffing Report from Datix, promoting consistent reporting across Wales. • 137.01 WTE nurses have been recruited through the student streamlining process. • 33 nurses have successfully used the Lateral Move Scheme, with an additional 59 currently in process. **Next steps for 2025-2026** • To continue to promote the use of SafeCare to enhance daily staffing meetings on the acute sites. • Working in partnership with Workforce and Organisational development colleagues, gain an insight and understanding of the themes that underpin the obstacles to staff retention. This will include analysis data from Exit interviews, staff feedback and staff surveys. • Develop a coherent recruitment strategy for both the short and medium term, aligned with the Health Board Integrated Medium Term Plan and Cwm Taf 2030: Our Health Our Future strategy. • Following the Princess of Wales critical incident, some Care Groups have reorganised wards to ensure patient flow and staffing is accurate. • Continue collaboration with Care Groups to ensure biannual acuity audits accurately capture patient acuity and dependency levels, enabling appropriate staffing levels and support efforts to recruit and retain staff.

Agenda Item
7.3 Appendix C

Quality, Safety & Experience Committee

SBAR on Section 25B ward moves outside of biannual acuity audit

Dyddiad y Cyfarfod / Date of Meeting	20/05/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	Tanya Tye Senior Nurse Professional Practice & Nurse Staffing Act Lead
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group /Forum Individuals	**Date**	**Outcome**

Acronyms / Glossary of Terms	
NSLWA	Nurse Staffing Levels (Wales) Act 2016
Section 25B (S25B)	Inpatient Adult Acute Medical and Surgical Wards and Inpatient Paediatric wards
Section 25A (S25A)	Any area within the Health Board where nursing care is undertaken
PoWH	Princess of Wales Hospital
RGH	Royal Glamorgan Hospital
PCH	Prince Charles Hospital
YGT	Ysbyty George Thomas Hospital
PAU	Paediatric Assessment Unit
DSU	Day Surgery Unit

1. Situation /Background

1.1 In October 2024, a critical incident was reported at the Princess of Wales Hospital (PoWH), necessitating the relocation of inpatient wards, including 12 wards covered under Section 25B of the Nurse Staffing Levels (Wales) Act 2016.

1.2 The affected wards and their respective relocations are detailed in the table below. A comprehensive analysis of the impact on nurse staffing levels and the associated costs is provided in Appendix A.

Site	Ward	New location
Princess of Wales Hospital (PoWH)		
PoWH	5	RGH 19
PoWH	6	PoWH 16
PoWH	7	RGH 15
PoWH	8	PoWH 19
PoWH	9	RGH 11
PoWH	10	PoWH 18
PoWH	11	RGH 18
PoWH	16	PoWH 21
PoWH	18	RGH 2
Royal Glamorgan Hospital (RGH)		
RGH	2	RGH 9
RGH	3	RGH 16
RGH	9	RGH 7
RGH	15	RGH 19 is now on RGH Ward 1
RGH	19	RGH 3
Section 25A wards		
RGH	11	The Day Surgery Unit (DSU) ward is now closed (temporarily)
RGH	18	The Paediatric Assessment Unit (PAU) is temporarily closed
PoWH	21	Glanrhyd Hospital, Angelton ward 3
PoWH	19	Ysbyty George Thomas Hospital (YGT) Fernhill ward
RGH	1	Unfunded/ established ward areas is closed
RGH	20	YGT Dinas ward (was Section 25B now Section 25A)

2. Specific Matters for Consideration

2.1 The ward relocations are temporary and have been implemented in response to the critical incident at Princess of Wales Hospital. Any further changes involving Section 25B wards will be documented and reported as set out in the requirements of the Nurse Staffing Levels (Wales) Act 2016 (NSLWA).

3. Key Risks / Matters for Escalation

3.1 The critical incident may lead to temporary adjustments in the wards' capacity and staffing levels, which may have financial implications and affect funding for the affected wards.

3.2 For the initial ward relocations, no financial impact was observed since there were no changes to staffing establishments; only physical moves of the wards took place. The senior nursing teams will assess acuity and staffing levels during the biannual acuity audit in January 2025. Any changes that may incur financial costs will be identified at that time.

4. Assessment

Objectives / Strategy		
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Not Applicable If more than one applies please list below:	
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable 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)*	Not Applicable 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))*	Not Applicable 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))*	Safe If more than one applies please list below:	
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable 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: ☐ Outcome:	No: ☒ If no, please include the rationale below: This is a paper to highlight the changes made following the critical

		incident, therefore this is just to update the board No impact on Quality of care
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):	If no, please include the rationale below: The Changes have no impact on Equality and Welsh Language
Cyfreithiol / Legal	Yes (Include further detail below)	
	There is a legal requirement under the Nurse Staff Levels (Wales) Act to report any changes to the 25B wards within the Health Board	
Enw da / Reputational	Yes (Include further detail below)	
	To ensure compliance with the Nurse Staffing Levels (Wales) Act	
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.	
	No Additional resources are needed at present	

5. Recommendations

5.1 Ward templates will be issued to all Section 25B wards affected by the Hospital incident; this is to ensure continued compliance with Section 25E of the NSLWA (2016)

5.2 The Heads of Nursing/ lead nurses/ senior nurses are to notify the Health Board's Nurse Staffing Lead of any further changes to ward locations, bed numbers or staffing numbers.

This should ensure:

- Timely updates to staffing templates
- Accurate documentation of changes
- Compliance with statutory reporting requirements under the Nurse Staffing Levels (Wales) Act 2016

5.3 The January 2025 biannual acuity audit will incorporate all section 25B wards in their temporary ward locations, which have been a result of the critical incident. Any changes will be reported in line with the NSLWA operational guidance.

6. Next Steps

6.1 January 2025 biannual acuity audit has now been completed. Staffing levels for each Section 25B ward will be calculated using the triangulated methodology, incorporating permanent and temporary ward locations.

6.2 Following the January Biannual acuity audit, a paper will be written to outline any changes. These will be formally reported in the November 2025 Board paper, informing of any changes to ward staffing levels. These changes are to include rationale, costings, and whether these are temporary or permanent changes. An interim report will be written for the Executive Director of Nursing to share with the Executive Leadership Team.

6.3 Heads of nursing to continue to notify the Nurse Staffing Act Lead of any changes to ward locations, bed numbers and/or staffing as set out in the Nurse Staffing Levels Wales Act 2016.

Agenda Item	8.1.1

Unapproved Minutes of the Quality, Safety & Experience Committee

Date and Time of Meeting	Tuesday 25 March 2025 at 9:00am
Venue	Virtually via Microsoft Teams

Members Present	Carolyn Donoghue	Independent Member (Committee Chair)
	Hayley Proctor	Independent Member
	Patsy Roseblade	Independent Member
	Helen Lentle	Independent Member
In Attendance	Greg Dix	Executive Director of Nursing/Deputy CEO (In part)
	Lauren Edwards	Executive Director of Allied Health Professionals & Health Sciences
	Philip Daniels	Executive Director of Public Health
	Hywel Daniel	Executive Director for People (In part)
	Sallie Davies	Deputy Medical Director
	Julie Denley	Deputy Chief Operating Officer
	Richard Hughes	Deputy Director of Nursing
	Kellie Jenkins-Forrester	Head of Concerns & Business Intelligence
	Emma James	Care Group Nurse Director – Unscheduled Care
	Sarah Follows	Unscheduled care group - service Director (In part)
	Owen Weeks	Medical Director - Unscheduled Care (In part)
	Suzanne Hardacre	Director of Midwifery
	Mohamed Elnasharty	Medical Director – Children & Families Care Group
	Sharon O'Brien	Care Group Nurse Director – Planned Care
	Ana Llewellyn	Care Group Nurse Director – Mental Health & Learning Disabilities
	Lucie Owen	Care Group Nurse Director – Primary Care & Community
	Hannah Wilton	Chief Pharmacist
	Nigel Downes	Assistant Director of Quality & Safety

	Paul Gimson	Assistant Director of Improvement Culture Capability & Delivery
	Becky Gammon	Assistant Director of Nursing
	Gaynor Jones	RCN Convenor/Staff Side Representative
	Claire Taylor	Action Regional Director, Llais Cymru
	Gareth Watts	Director of Corporate Governance / Board Secretary
	Emma Walters	Head of Corporate Governance & Board Business (Secretariat)
Meeting Observers	Sophie Bassett	Lead Nurse, Mental Health

Agenda Item	Meeting Business
1.	**PRELIMINARY MATTERS**
1.1	**Welcome and Introductions**
	The Committee Chair welcomed everyone to the meeting, particularly those joining for the first time, those observing and colleagues participating for specific agenda items. The format of the proceedings in its virtual form were also noted. Members noted that the meeting would be recorded to aid the Committee Secretariat in ensuring the accuracy of scrutiny related discussions and decisions made during the meeting. Members noted that the recording would be destroyed once the minutes had been confirmed as accurate. Members confirmed they were happy to proceed.
1.2	**Apologies for Absence**
	Apologies for absence were received from: • Kath Palmer, Vice Chair; • Dom Hurford, Executive Medical Director; • Gethin Hughes, Chief Operating Officer; • Cally Hamblyn, Assistant Director of Governance & Risk; • Stephen Sarasin, Care Group Clinical Director, Planned Care
1.3	**Declarations of Interest**
	There were no interests declared.
2.	**CONSENT AGENDA BUSINESS**
2.1	There were no items Members wished to move from the consent agenda to the main agenda for discussion.
3.	**COMMITTEE GOVERNANCE ARRANGEMENTS**
3.1	**Action Log**
	The action log was received and noted. Members supported the actions proposed for closure.
3.2	**Matters Arising Not Captured on the Action Log**
	There were no matters arising.
4.	**STAFF AND SERVICE USER EXPERIENCE**

4.1	**Shared Listening & Learning Story – Care received at the Snowdrop Breast Centre**
	K. Jenkins-Forrester shared a presentation which outlined her personal experience regarding care and treatment received at the Snowdrop Breast Centre. The Committee Chair extended her thanks to K Jenkins-Forrester for sharing her personal story.. S O'Brien also extended her thanks to K Jenkins-Forrester for sharing her story with such honesty and recognised this would not have been easy to do. S O'Brien advised that she would share the positive feedback received with the Snowdrop Breast Centre Team and added that the Multi-Professional Team recognised that the Centre, being away from the main acute hospital site, was having a significant impact on efficient and timely care and had improved the experiences for patients. In relation to the concerns identified regarding communication of histology results, S O Brien advised that she would share this feedback with team members. S O'Brien advised that she welcomed the dedicated theatre that had been put into place for patients requiring breast surgery alongside the dedicated recovery unit which had a positive impact on patient experience The Committee Chair once again extended her thanks to K Jenkins-Forrester for sharing the story and added that it was interesting to hear from a patient perspective of the matters that were deemed to be important for them, for example, communication and hospital environment, and added that it was important to ensure these lessons were shared with other areas and used as a standard to drive towards.
Resolution:	The Listening & Learning story was NOTED.
Action:	Positive feedback to be shared with the Team at the Snowdrop Breast Centre along with the concerns identified regarding communication of histology results
5.	**SETTING THE SCENE – SERVICE DELIVERY**
5.1	**Thematic Spotlight Presentation – Stroke Unit Temporary Centralisation** E. James shared the presentation and highlighted the key matters for Members attention. The Committee Chair thanked E. James and noted the triangulation of information from data, patient stories, and staff feedback, emphasising the difference between statistics and staff experiences. The Committee Chair noted that significant work had been undertaken in this area, and thanks were extended to colleagues for their efforts. P. Roseblade sought clarity on acute stroke admissions, and E. James explained that Ward 20, staffed by the Stroke Team from Princess of Wales Hospital, were receiving all acute admissions due to transport challenges. Ward 19, staffed by Prince Charles Hospital staff, were taking rehabilitation

	patients, which has caused some dissatisfaction among staff used to acute care. Concerns were raised about patient risk at Royal Glamorgan Hospital due to staff turnover. E. James acknowledged the risk and mentioned ongoing Demand & Capacity modelling for acute stroke, sub-acute stroke, and community beds. Members noted that recommendations would be made in collaboration with stroke nursing and medical teams. Members noted the rehabilitation patients stepping down from Ward 20 to Ward 19, with early mobilization and ongoing rehabilitation support potentially moving to community beds or home. The Committee noted that priority was being placed on retaining skilled staff at their base site. H. Proctor addressed risks to stroke patients, emphasising the importance of Multi-Disciplinary Team support and the creation of a dedicated rehabilitation space at the Princess of Wales Hospital. Concerns about the temporary arrangements' longevity were discussed, with ongoing monitoring and evaluation needed. L. Edwards welcomed feedback and suggested feeding these concerns into the Allied Health Professionals leadership group to address service inequities. G Jones advised that she assumed that as the staff were moving back to Prince Charles Hospital, and with the repatriation of staff from Ysbyty George Thomas, the Health Board would still be compliant with the nurse staffing act. E James confirmed that this was correct, and the staffing ratios were being met given that the team at Prince Charles Hospital opted to move to Royal Glamorgan Hospital as a collective, which meant that the stroke unit was over resourced as a result of the bed base reduction of the therapy space. Members noted that this would be reviewed through the Nurse Staffing Act. O Weeks referred to medical staffing and provided assurance that adverts had been placed, with active recruitment being undertaken to recruit stroke physicians, with all avenues being explored for permanent stroke physician staff to limit the reliance on the use of locums. Members noted this was part of the reason why a temporary relocation was undertaken whilst the team were trying to recruit into roles. H Lentle extended her thanks to E James for sharing the presentation and advised that it was evident that this was clearly a complex situation. H Lentle queried whether this was a matter the Committee wished to escalate to the Board regarding the inequity and post code lottery that was raised by H Proctor. H Lentle advised that it would be helpful if Independent Members were provided with a timescale for resolving the issues highlighted. The Committee Chair advised that this needed to be included in the alert/escalate section of the highlight report to Board.

	L Edwards advised that steps would be taken to ensure this feedback was fed into the leadership team and agreed to present an update report back to a future meeting of the Committee for further discussion. J Denley advised that this needed to be noted as a risk as part of the work being undertaken to reassess services returning to the Princess of Wales Hospital and what the proposed solution was in terms of operations moving forwards. G Watts advised that he would draft the highlight report to Board and advised that given the proximity of this Committee to the March Board, the Highlight report from this meeting would be presented to the May Board, by which time the team may be able to provide a more substantive update in regard to progress made. The Committee Chair advised that she fully appreciated the work that had been undertaken by E James and the team given the complexities of the position and recognised that regional solutions were also being worked through. The Committee Chair referred to lessons learnt and advised that when discussions were being held on the relocation of services from Prince Charles Hospital, focus was mostly placed on issues regarding the medical model which was felt to be unsustainable, and added that she personally felt that she did not have enough oversight of what the move would mean for all of the other teams involved with this service, and added that it would be helpful to hear staff views as to how things felt now within the service.
Resolution:	The presentation was **NOTED.**
Actions:	Concerns raised regarding the service inequity and the potential risk to patients to be fed into the Allied Health Professionals Group. Concerns raised regarding service inequity and the potential risk to patients to be included in the alert/escalate section of the Highlight Report to Board. Report to be presented to a future meeting to outline progress made in this area.
5.2	**Report from the Clinical Executives**
	G. Dix and Clinical Executive colleagues presented the report and highlighted the key matters for Members attention. P Roseblade made reference to the Risk Register which proposed to reduce the risk score from 20 to 12 of the adult weight management service risk, which would result in this risk being removed from the risk register being presented at Board and Committee level. She queried why the risk score was being reduced given the update provided by P Daniels regarding the adult weight management service. P Daniels advised that whilst changes had been made within the service, he agreed that the risk score needed to remain at 20 for the current time.

	The Committee Chair advised that there were some risks within the risk register where the risk had been reduced, despite no change in outcomes, and added that she felt the risk scores were being reduced prematurely in some areas. G Jones referred to the update provided by P Daniels in regard to the increase in the number of patients testing positive for HIV and queried whether this was because of more testing being undertaken or because of more patients presenting with symptoms. P Daniels advised that testing was in place, with individuals being tested for HIV in a variety of settings and added that a review was being undertaken as to why an increase was being seen. Members noted that numbers were still quite low, with five people testing positive in the last quarter. P Daniels advised that there was awareness that the use of contraceptives had changed since Covid and added that a fast-track programme was in place to raise awareness of HIV amongst young people. Members noted that the demographics of people presenting with HIV had also changed, with an increase being seen in middle aged women presenting with HIV.
Resolution:	The report was **NOTED.**
5.3.	**Care Group Highlight Report** The Chair invited the Care Group Leads to present their respective reports, requesting them to focus solely on the areas highlighted in the alert/escalate section.
5.3a	**Children & Families Care Group Highlight Report**
	S. Hardacre presented the report and highlighted the key matters for Members' attention. P Roseblade advised that there was a significant amount of data contained within the report on Maternity and Neonates, and advised that she struggled to understand if the data included within the report was positive or negative and added that she felt it did not answer the "so what" question from a lay person perspective, which needed to be highlighted within the report. S Hardacre agreed to provide some narrative explanation against the data within the next iteration of the report. S Hardacre advised that the data was showing that the Health Board's outcomes were comparable nationally and advised a report was being presented to the In Committee session following this meeting which outlines a deeper dive into the metrics reported. The Committee Chair agreed with the comments that had been made by P Roseblade and advised that Independent Members needed to be provided with the conclusions that could be drawn from the data in regards to how the Health Board were performing in a range of areas, for example, the reasons behind the rise in Caesarean section rates and whether this was a national issue or just local to the Health Board. S Hardacre advised that the C-Section rates for CTM were comparable nationally and added that some detailed information on this had been included in the report for discussion at In Committee following this meeting. S Hardacre advised that she would ensure that some additional narrative was included in the next iteration of the report on key themes.

Resolution:	The report was NOTED.
Action:	Next iteration of the report to include a narrative explanation of the data to enable Independent Members to draw conclusions as to how the Health Board were performing in a number of areas.
5.3b	**Unscheduled Care Group Highlight Report**
	E James presented the report and highlighted the key matters for Members attention. Members noted the positive update provided by E James in regard to the move of the medical day unit and the significant improvements that had been made regarding incident management. Members noted the positive experiences that had been achieved regarding the opening of two wards at Ysbyty George Thomas during the critical incident at the Princess of Wales Hospital. Members noted that because of capital works, the bed base would soon be increasing to 58 and noted that positive feedback was being received from patients and staff regarding the ward and hospital environment. E James advised that work was being undertaken with the Patient Experience Team to highlight the positive comments that had been received which could be shared with families of patients who may require transfer into Ysbyty George Thomas. In response to a suggestion made by E James, the Committee Chair advised that a spotlight on this positive development would be welcomed by Members at a future meeting.
Resolution:	The report was NOTED.
Action:	Spotlight presentation to be presented to a future meeting in relation to the positive experiences that had been achieved regarding the opening of two wards at Ysbyty George Thomas during the critical incident at the Princess of Wales Hospital.
5.3c	**Planned Care Group Highlight Report**
	S O Brien presented the report and highlighted the key matters for Members attention. The Committee Chair welcomed the use of the QR codes and agreed that this could be something that could be rolled out into other areas. P Roseblade referred some terminology contained within the advise section of report which was quite clinical, regarding the never event relating to a wrong site block and the avoidable pressure damage marked as unstageable and queried whether this level of detail was required. P Roseblade added that if this level of detail was required, then an explanation was required as to what each item meant given that this was a public facing document. S O'Brien advised that she would be happy to remove reference to these matters in future iterations of the report.
Resolution:	The report was NOTED.
Action:	Future iterations of the report to not include reference to clinical matters if an explanation was not being provided to make the matters clearer to members of the public
5.3d	**Mental Health & Learning Disabilities Care Group Highlight Report**

	A Llewellyn presented the report and highlighted the key matters for Members attention. Members noted that whilst medical staffing remained a challenge for the care group, the care group director daily oversight of the position had now been stood down given that the system of monitoring, oversight and allocation of medical resource had significantly improved alongside a small reduction in vacancies. Members noted that the Directorate were now managing the oversight of their medical staffing issues and noted that at present the Care Group were not proposing to reduce the risk score as medical staffing challenges remained in place. L Edwards reminded Members that a Regulation 28 had been received regarding the Electronic Clinical Record and welcomed the update provided that work was progressing in relation to the procurement exercise. L Edwards also welcomed the news that the In-Patient Improvement Board was being stood down as a result of the progress made and the sustained changes that were being seen, which had been recognised by Healthcare Inspectorate Wales in further inspections.
Resolution:	The report was NOTED.
5.3e	**Primary & Community Care Group Highlight Report**
	L Owen presented the report and highlighted the key matters for Members attention. P Roseblade referred to the Paediatric General Anaesthetic Dental Lists and sought clarity as to whether there was any indication as to when this would be resolved. L Owen advised that an update on this would be included in the detailed report being presented to the May meeting of the Committee and added that at present an exact date for resolution could not be provided as the position was dependent on theatre list availability, which could then be impacted by other factors such as major trauma. In response to a query raised by P Roseblade as to whether the issues would take months or years to resolve, L Owen advised that it was most likely this would take years to resolve as opposed to months, give the numbers of patients currently awaiting treatment. P Roseblade sought clarity as to whether any verbal feedback was received following the unannounced prison visit undertaken by HM Inspectorate of Prisons on the 13 January 2025. L Owen advised that whilst positive verbal feedback was received, there were some challenges identified which the Care Group were already aware of and added that the service was awaiting receipt of a final formal report. Members noted that no immediate make safes were identified at verbal feedback stage. The Committee Chair referred to the update provide on page 4 of the report regarding Optometry - WGOS 4 Monitoring Services- Implementation and sought confirmation as to the timelines of ensuring a robust plan was in place in order to progress the work. L Owen added that further progress had been made since this report was drafted and advised that meetings had now taken place with Planned Care regarding the process and a plan had now been submitted to Welsh Government.

Resolution:	The report was NOTED.
5.3f	**Diagnostics, Therapies, Pharmacy & Sciences Care Group Highlight Report**
	H. Wilton presented the report and highlighted the key matters for Committee attention. The Committee Chair extended her thanks to H Wilton for presenting the report and advised she was pleased to hear of the compliment received from a patient appreciative of the work undertaken 'behind the scenes' in the Cellular Pathology department to ensure patients receive their results. H Proctor referred to the patient complaint that was received in relation to the new weight management drug, which linked back to the update provide by P Daniels earlier in the meeting. The Health Board is trying to manage this group of patients within our population, and this matter needs to be supported by people with expertise with a really strong shared decision management tool and behaviour change model as opposed to the drug being easily accessed through primary care. H Proctor advised that she felt uneasy with the current position particularly as this has wider implications for the population and the Health Board. P Daniels advised that he shared the concerns expressed by H Proctor and added that he was anecdotally hearing that some patients were ordering this drug via high street pharmacies privately, with no screening process in place to manage this, which was concerning given the long-term implications of this drug were not yet known. P Daniels advised he welcomed the approach being taken in Wales in ensuring that specialist input was being put into place. The Committee Chair advised that this would need to be an area of focus moving forward and suggested that the concerns raised should be included in the alert/escalate section of the highlight report to Board. H Wilton agreed with the comments made and added that she felt that Welsh Government had taken the correct approach and advised that it would be important to caveat that there was a third of the population that were eligible for and needed this treatment. Members noted that the capacity to see these patients within the specialist weight management service was insufficient and H Wilton advised that she fully supports this remaining on the risk register as it was concerning. Members noted that any new patients requiring access to this drug will be required to have a video consultation with a pharmacist prior to prescribing. P Roseblade referred the update provided within the alert section of report regarding Allied Health Professionals and the concerns regarding the higher than average number of clinical incidents, which did not triangulate with the update provided as part of the presentation on stroke services, which implied that the number of incidents was on par with other areas. The Committee Chair requested further clarity on the discrepancies identified and asked for an

	update to be presented to the next meeting L Edwards advised that she would be happy to ensure further detail on clarity was provided at the next meeting.
Resolution:	The report was NOTED.
Action:	Further clarity to be provided regarding the discrepancies highlighted in relation to the higher than average number of clinical incidents being reported within stroke services which did not correlate with the update provided on stroke services earlier in the meeting
6.	**DELIVERING OUR PLAN**
6.1	**Patient Safety, Quality and Experience Dashboard**
	N Downes presented the report and highlighted the key matters for Members attention. P Roseblade referred the criteria or threshold for the nationally reportable incidents, which changed around two years ago and was actually raised, and added that the Health Board at that time made the decision that it would continue to report against the previous NRI level as well as the new nationally reportable level that is submitted up to Welsh Government. P Roseblade advised that she could no longer see this comparison included within this report. N Downes advised that when he commenced in post there were locally reportable incidents, which were phased out in September 2023, with the Health Board now only required to report against nationally reportable incidents. N Downes advised that he would be happy to provide some further clarity on this for the next meeting if required. N Downes advised that the Duty of Candour was brought into being in April 2024 which was helping to identify matters that would have previously been reported as locally reportable incidents. The Committee Chair advised that she would welcome an update on this at the next meeting which identifies whether the locally reportable incidents were now being picked up via the Duty of Candour. The Committee Chair advised that the report referred to in the Ombudsman report was shared with her for information .
Resolution:	The report was **NOTED.**
Actions:	Update to be provided at the next meeting which identifies whether the locally reportable incidents were now being picked up via the Duty of Candour. Ombudsman report to be shared with Committee Members for information and awareness.
6.2	**Safe Care Partnership 2 and developing a Quality Management System** P. Gimson present the report and highlighted the key matters for Members attention. The Committee Chair extended her thanks to P Gimson for presenting the report which she found to be helpful in terms of highlighting and bringing together a number of strands of work.
Resolution:	**ENDORSED**

7.	GOVERNANCE, RISK AND ASSURANCE
7.1	**Organisational Risk Register – Risks Assigned to the Quality & Safety Committee**
	The following questions were raised ahead of the meeting together with the responses received: *Question: I note the number of staff trained is increasing but it would be good to know whether it is at an appropriate level or what percentage of people needing training have completed it.* *Response: the following response was provided by G Watts during the meeting – G Watts advised that as risk management training was not part of statutory and mandatory training, there was no specific key performance indicator, however, a targeted approach was being taken to train staff who were involved in risk management, with work being undertaken with Care Groups to achieve this.* *Question: Risk 6102 - has this risk just come to light. Are we aware of incidents of harm?* *Response: This risk came to light in January 2025 when our Medical Records team identified an issue with the patient pathway. Specifically, a patient's pathway was closed on our Swansea Bay University Health Board (SBUHB) instance of PAS before the continuing record in Cwm Taf Morgannwg (CTM) PAS was set up. This situation involved a Dermatology medical secretary who was following the clinician's instructions to bring a patient initially seen in Princess of Wales (POW) Hospital to a follow-up clinic in Royal Glamorgan Hospital (RGH). We discovered the issue when we were asked to register the patient on the CT PAS.* *As of now, I am not aware of any instances of harm occurring due to this oversight. However, due to the current operating arrangement of two PAS systems, this is still an active risk across any specialty that is managing patients across our two PAS instances.* Risk 5276 - needs to be updated (no response provided to this question). *Question: Risk 5045 it would be good to understand the rationale and the risk around CTM taking over the waiting list* *Response: We are working on a SBAR to cover this – I thought the following points would be helpful to cover the immediate ask:* • *C&VUHB are commissioned via the LTA to provide this service on behalf of CTMUHB (the only thing that is slightly different is that the C&V service provide some clinics from CTM sites) and therefore it is consistent with other specialties and appropriate for C&VUHB to report the performance as it is no different to any other service commissioned via an LTA.*

- *If responsibility for the neuro service does transfer across to CTMUHB then it sets a precedent for any other services struggling with long waits commissioned from C&V (or other HBs) to be potentially transferred back.*
- *Taking over the service but continuing to rely on C&VUHB consultants to run the service does come with risks. If it did go ahead this would need to be done with a robust SLA in place which clearly sets out the roles and responsibilities of both organisations and the service would need to closely manage the contract.*
- *Financially there would be no funding released from the LTA in the short/medium term unless CTMUHB also took back the backlog and patients on active pathways from C&VUHB, if C&VUHB continued to manage the backlog and active patients CTMUHB would continue to pay C&VUHB for this activity via the LTA until all RCT CTM residents were discharged.*
- *The LTA advises that any change or cessation requires 6 months formal notice – formal process being via commissioning teams not service to service discussions.*
- *If the reporting were CTMUHB responsibility it would increase the internal viability in terms of the significant waits and pressures within the Neuro service, however, as CTMUHB is responsible for either providing or commissioning a service on behalf of its residents there is scope to internally communicate it in this way that could help attract more visibility without having to transfer responsibility.*
- *There have been long standing suggestions that the funding given to C&VUHB does not cover the cost of covering the neurology service to RCT CTM residents. It has been agreed at Director of Finance level that CTMUHB and C&VUHB will work together to update and refresh the LTA arrangements across all specialties via an LTA rebasing exercise which would also cover neurology which does give a route to resolving the funding issue longer term*

G. Watts presented the report and highlighted the key matters for Members attention and advised that some questions were raised by the Committee Chair ahead of the meeting, which he would circulate to all Members of the Committee following this meeting together with the responses received.

P Roseblade referred the risk relating to Ophthalmology (risk 4103) and advised that a focussed report was presented to the January 2025 meeting of the Operational Delivery Committee in relation to Ophthalmology and added that she did not get the impression from that report, or from the activity data within the performance report that Ophthalmology was yet in a position to reduce the risk score from 20 to 12, which had resulted in this risk being removed from the risk register being reported at Committee level, which she found concerning. P Roseblade added that whilst she recognised that there was significant work being undertaken to address the position, she could not yet see the results of this work.

The Committee Chair advised that she also had concerns regarding the risk score reduction against risk 4071, which related to cancer targets, and it appeared that an assumption was being made that whilst a significant amount

	of work was being undertaken to address the risk which was likely to be effective, therefore the risk of failing to meet the target was lowered. The Committee Chair advised that she was unsure whether this was appropriate given that targets were still not being met, and the impact of the work being undertaken was not yet being seen. P Daniels referred to discussions held earlier in the meeting in regards to the weight management risk and requested that given the discussions held, the risk score remained at 20, with a further review of the risk to be undertaken ahead of the next meeting, particularly given the discussions in regards to the weight loss drug and the impacts this will have on the weight management service in terms of demand. P Daniels advised that demand was not where it was expected to be for the level 2 service and added that for the level 3 service demand was significant, which needed to be taken into consideration. The Committee Chair advised that it would be helpful to obtain the views of the Chief Operating Officer as to how the risks were currently being assessed. P Roseblade added that she was concerned that risks were being reduced to a level that was taking them out of the Committee's view. H Daniel advised that there were differences between what would be classed as a risk, what would be classed as an issue and what would be classed as a performance metric and added that caution needed to be taken that the risk register was not being used as a tool to manage performance. H Daniel advised that this would need to be talked through further in an alternative setting, focussing on what are we looking to manage via our risk register versus how we get assurance on particular issues via performance reporting and other sources. H Daniel added that it could be the case that having mitigating actions in place, does, by definition, reduce a risk. The Committee Chair recognised the points raised by H Daniel and added that this is how she thought the approach was, but she felt that further clarity was required on the approach being taken. G Watts advised that he would be happy to review the reduction in risk score regarding the wight management risk and the request made by P Daniels to revert the risk score back to 20. G Watts added that given that this was a jointly owned risk, this would need to be discussed and agreed further with L Edwards, Executive Director for Allied Health Professionals and Health Sciences. G Watts advised that regarding the points raised by H Daniel, he would agree that further consideration needed to be given to the distinction between risks and issues and agreed that a further discussion on this would need to be undertaken in an alternative setting/forum.
Resolution:	The report was REVIEWED and CONSIDERED.
Action:	Review to be undertaken of the reduction in the risk score for risk 5462 Adult Weight Management Service and the request made for the risk score to be reverted back to 20
7.2	**Coroners inquest – Case Activity & Lessons Learned**

N. Downes presented the report and highlighted key updates for Members attention.

G Dix advised that it would be important for the Committee to be mindful that there had been a significant increase in inquests being received by the Health Board as result of the increase in capacity within the coroner's office, which did not match the capacity available within the Health Board's legal team. Members noted that an Organisational Change Process was being undertaken by N Downes to better align capacity to address Inquests, Claims and Redress cases, and noted that the Team were trying to keep pace with the work, with discussions being held with Legal & Risk services to determine what support they could provide against some of the backlog cases. G Dix advised that the Team remained fragile, with some changes in leadership and agency staff had been brought in to provide support as case handlers and added that the new Team structure could be presented to the Committee in due course. G Dix advised that most Regulation 28 cases relate to Unscheduled Care.

In relation to the increase in cases, the Committee Chair sought clarity as to the reasons behind the increase in cases. G Dix advised that the increase in cases was as a result of there being a significant backlog within the coroner's office which meant that they had increased their capacity to address the backlog, which was then impacting on the workload of the Health Board's Claims and Inquests Team.

P Roseblade commented that the issuing of Regulation 28 reports was previously rare, with one report being received not even once a year at one stage and added that these reports appeared to be issued more regularly, which she found to be concerning given the seriousness of these reports. With regard to the reasons behind this increase, P Roseblade sought clarity as to whether this was as a result of there being a change in threshold for the Coroner, or whether this was as a result of the Health service being so stretched, that requirement outweighs capacity in a number of areas which meant that standards were not always where we would want them to be.

G Dix advised that there was something around threshold and added that the Team RAG rates the cases and were often surprised when a Regulation 28 was received, which may not have been the case in previous years. G Dix added that the organisation was also stretched as a system, with care lapses regrettably being seen, resulting in incidents occurring. Members noted that the increase in inquests were also having an impact on the numbers of Regulation 28's being received. G Dix advised that receiving a Regulation 28 was serious and added that the Health Board needed to do all that it could to prevent any future deaths.

P Roseblade advised when looking at the Regulation 28 report listed within the report, she recalled the Chief Operating Officer providing an update at a previous Committee meeting that the Health Board did not undertake corridor care, and queried whether the case outlined within the report was a historical case. In relation to corridor care, G Dix advised that the Health Board regrettably still had patients in the corridors being cared for, but these patients were generally in chairs and not trolleys, which was a practice previously

	undertaken at Prince Charles Hospital and ceased a few years ago. Members noted that patients were being cared for by nurses who were aligned to ensuring that patients were being kept as safe as possible. The Committee Chair advised that she felt that the report could be slightly misleading, given that patients were still being cared for in corridors, particularly as assurance had previously been provided to Independent Members that patients were not being cared for in corridors. G Dix apologised that Members had found this to be misleading and advised that whilst the Health Board did not have patients with high acuity waiting on trolleys in corridors, there were still some patients in chairs waiting in corridors for treatment. The Committee Chair advised that it would be helpful if Members could be provided with more clarity on this moving forward, with a clear statement required as to the exact current position. G Jones advised that she felt the term corridor care was not the correct term to use and added that the Royal College of Nursing was currently undertaking a significant campaign regarding patients who were being cared for in appropriate areas and added that there was awareness that in order to free up space in the Emergency Departments, extra beds sometimes needed to be put into place in inappropriate areas. Members noted that the term corridor care covered a wide range of inappropriate areas, which included bays and treatment rooms. E James provided further clarity in that some patients who were being assessed at triage were deemed fit to sit and would be considered suitable to receive ambulant levels of care. Members noted that the only site where patients were receiving this level of care was in Princess of Wales Hospital and noted that the Senior Care Group Team were working with the site-based team on a capital piece of work to create an ambulatory area within the Hospital. In response to the question raised by P Roseblade as to whether the case referred to within the report was historical, N Downes confirmed that the patient sadly passed away in April 2022. N Downes added that on reviewing the cases being presented to inquest this coming month, these related to patients who had passed away between two and four years prior.
Resolution:	The report was NOTED.
7.3	**Health, Safety & Fire Sub Committee Highlight Report – 24 January 2025** H. Daniel presented the report and highlighted the matters contained within the alert/escalate section of the report.
Resolution	The Committee NOTED the report.
8.	**CONSENT AGENDA**
8.1	**FOR APPROVAL**
8.1.1	**Unconfirmed Minutes of the meeting held on 21 January 2025** The Minutes were APPROVED
8.1.2	**Unconfirmed Minutes of the In Committee meeting held on 21 January 2025**

	The Minutes were APPROVED
8.1.3	**Asbestos Management Plan** The Management plan was was APPROVED.
8.1.4	**Medical Gases Management Policy** R Hughes advised Members that following the last meeting of the Operational Management Board, some minor amendments were requested in regards to this policy. In this respect, Committee Members agreed to defer this to the May meeting for final approval.
8.1.5	**Water Safety Plan** The Water Safety Plan was APPROVED.
8.2	**FOR NOTING**
8.2.1	**Non-Routine Committee Business (Forward Plan)** The Committee NOTED the forward plan.
8.2.2	**Committee Annual Cycle of Business 2025** The Annual Cycle of Business was NOTED.
8.2.3	**Healthcare Inspectorate Wales Improvement Plan Tracker Report** The report was NOTED. The following question was raised ahead of the meeting, as outlined below together with the response received Question: 8.2.3 HIW action tracker- I am concerned about the number of actions which have not had any update in December or February. I appreciate that this may be due to operational pressures, but can we be assured that they will be updated for the May meeting? Response: in response to the HIW Tracker I can confirm that when we reviewed this submission, we were also concerned about the number of actions that did not have an update, and my team has sent out some targeted email communication on this. In addition, my team is also arranging for us both to go out to the Nurse Directors / Senior Nurse meetings to do a focussed session on the tracker and how we are using it for assurance purposes so I hope these actions will result in an improvement in May and the meetings thereafter. Greg as Exec Lead is also aware of the action we plan to take and if no improvements are identified in the next month or so then we will escalate to him accordingly.
8.2.4	**Cwm Taf Morgannwg University Health Board (CTMUHB) National Clinical Audit Programme Quarter 3 Update 2024-25** The report was NOTED.
8.2.5	**Cwm Taf Morgannwg University Health Board (CTMUHB) Clinical Audit Forward Plan for 2025-26** The plan was NOTED.
8.2.6	**Organ Donation Sub Committee Highlight Report** The report was NOTED.
9.	**CLOSE OUT BUSINESS**
9.1	**Committee Highlight Report to Board - Verbal** Members noted that this report would be drafted by the Senior Corporate Governance Lead outside the meeting.

9.2	**Meeting Feedback** The Committee Chair advised that she would welcome feedback from colleagues outside the meeting and added that she had found the Care Group Highlight reports to be excellent and well presented, which allowed Members to focus on specific areas.
9.3	**Any Other Business** There was no other business to report.
10.	**Private / Closed Session Business** The following items would be discussed at the In Committee session immediately following the meeting: • Organisational Risk Register - Closed Risks • Maternity Incidents Princess of Wales Hospital
11.	**DATE AND TIME OF NEXT MEETING** The next meeting take place on Tuesday 20 May 2025 at 9:00am.

Agenda Item	8.1.2

Unapproved Minutes of the In Committee Quality, Safety & Experience Committee

Date and Time of Meeting	Tuesday 25 March 2025 at 12:00pm
Venue	Virtually via Microsoft Teams

Members Present	Carolyn Donoghue	Independent Member (Committee Chair)
	Hayley Proctor	Independent Member
	Patsy Roseblade	Independent Member
	Helen Lentle	Independent Member
In attendance	Greg Dix	Executive Director of Nursing
	Lauren Edwards	Executive Director of Allied Health Professionals & Health Sciences
	Philip Daniels	Executive Director of Public Health
	Gethin Hughes	Chief Operating Officer
	Sallie Davies	Deputy Medical Director
	Richard Hughes	Deputy Director of Nursing
	Nigel Downes	Assistant Director of Quality & Safety
	Suzanne Hardacre	Director of Midwifery & Nursing
	Mohamed Elnasharty	Medical Director – Children & Families Care Group
	Gareth Watts	Director of Corporate Governance / Board Secretary
	Emma Walters	Head of Corporate Governance & Board Business (Secretariat)

Agenda Item	Meeting Business
1.	**PRELIMINARY MATTERS**
1.1	**Welcome and Introductions**
	The Committee Chair welcomed everyone to the meeting.
1.2	**Apologies for Absence**
	Apologies were received from: • Kath Palmer, Vice Chair • Dom Hurford, Executive Medical Director; • Gethin Hughes, Chief Operating Officer; • Cally Hamblyn, Assistant Director of Governance & Risk •
1.3	**Declarations of Interest**
	There were no interests declared.

2.	**MAIN AGENDA**
2.1	**Organisational Risk Register – CLOSED RISKS** G. Watts presented the report and highlighted the key matters for Members' attention.
Resolution:	The report was NOTED.
2.2	**Maternity Incident at Princess of Wales Hospital** S Hardacre presented the report which provided an update in relation to a cluster of incidents that had occurred at the Princess of Wales Hospital within Maternity services. The Committee noted that immediate make safes had been put into place with learning identified, which had led to some immediate changes being implemented. Following detailed discussion, the Committee Chair extended her thanks to S Hardacre for presenting the report and advised that she felt assured that transparency was in place and detailed actions had been taken as a result of the incidents.
Resolution:	The report was NOTED.
3.	**ANY OTHER BUSINESS**
3.1	There was no other business discussed.
4.	**DATE AND TIME OF NEXT IN COMMITTEE SESSION - TO BE CONFIRMED**

Agenda Item
8.1.3

Quality, Safety & Experience Committee

RATIFICATION OF CHAIRS ACTION: MEDICAL GASES MANAGEMENT POLICY

Dyddiad y Cyfarfod / Date of Meeting	20/05/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Emma Walters, Head of Corporate Governance & Board Business
Cyflwynydd yr Adroddiad / Report Presenter	Gareth Watts, Director of Corporate Governance/Board Secretary
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Approval

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Operational Management Board	19/03/2025	Approved
Chairs Urgent Action	15/04/2025	Approved

Acronyms / Glossary of Terms	

1. Situation /Background

1.1 The purpose of the report is to present the Medical Gases Management Policy which has been endorsed for implementation by the Operational Management Board and approved via Chairs Urgent Action by the Quality, Safety & Experience Committee.

1.2 A request seeking urgent support for approval of the Policy was circulated on the 10 April 2025, following agreement with the Quality, Safety & Experience Committee Chair. This resulted in the following responses indicating support from Committee Ims and Executive Directors:

- Carolyn Donoghue (Committee Chair)
- Lauren Edwards, Executive Director Allied Health Professionals and Health Sciences
- Hayley Proctor – Independent Member
- Patsy Roseblade – Independent Member

This was approved on the 15 April 2025 and the Assistant Head of Assets Governance and Technical Services was notified. Further changes to the policy were requested by the Deputy Director of Nursing and these have been reflected in the final version of the policy which is attached.

2. Specific Matters for Consideration

2.1 The purpose of this document is to specify Cwm Taf Morgannwg University Health Board's (CTMUHB's) Policy for the management of the Medical Gas Pipeline Systems (MGPS) and medical gas in pressurised cylinders.

This Policy has been developed to introduce a structured Procedure and Reporting Schedule for the Management and Control of Medical Gases in compliance with current Guidelines Health Technical Memorandum (WHTM 02-01).

This Policy covers all aspects in the safe use and operation of Medical Gases throughout CTMUHB. It is not limited solely to the Pipeline System. Although not exhaustive it includes:

- Central plant
- Pipeline systems
- Cylinder manifolds
- Cylinder use, transportation and storage

3. Key Risks / Matters for Escalation

3.1 Due to the Quality, Safety & Experience Committee not meeting until the 20 May 2025, Chairs Urgent Action was sought for approval of this policy in response to a Healthcare Inspectorate Wales inspection, in which this policy would have been pertinent to the audit.

4. 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: Inspiring People	
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Living Well	
	If more than one applies please list below: Growing Well	
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 More Equal 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))*	Culture and Valuing People	
	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)	No - Not Applicable	
	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: This is a statutory requirement, summarising of activity and achievements

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: This is a statutory requirement, summarising of activity and achievements
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
	This is a statutory requirement, summarising of activity and achievements	
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.	

5. Recommendation

4.1 The Quality, Safety & Experience Committee is asked to **RATIFY** the **APPROVAL** of the Medical Gases Management Policy via Chair's Urgent Action as set out above.

6. Next Steps Following Approval the Policy will be published on the Health Board's intranet site.

Medical Gases Management Policy

Document Type:	Non Clinical Organisational Wide Policy
Ref:	EST005
Author:	Christopher Lewis – Assistant Head of Assets, Governance and Technical Services
Executive Sponsor:	Executive Director of Finance & Procurement
Approved By:	**Quality & Safety Committee**
Approval / Effective Date:	(dd/mm/yyyy)
Review Date:	(dd/mm/2027)
Version:	4.0

Target Audience:

People who need to know about this document in detail	Operational Estates Managers, Estates Officers, Contractors and anyone involved in the management of medical gas pipeline systems in Health Board premises with responsibilities set out in Section 5.
People who need to have a broad understanding of this document	All Estates staff, Heads of Nursing, Senior Facilities Managers, Service Managers, ILG Directors
People who need to know that this document exists	All staff

Integrated Impact Assessment:

Equality Impact Assessment Date & Outcome	**Date: 05/07/24** **Outcome: No impacts**
Welsh Language Standard	No
Date of approval by Equality Team:	N/A
Aligns to the following Wellbeing of Future Generation Act Objective	Provide high quality, evidence based, and accessible care

CONTENTS

INTRODUCTION

The purpose of this document is to specify Cwm Taf Morgannwg University Health Board's (CTMUHB's) Policy for the management of the Medical Gas Pipeline Systems (MGPS) and medical gas in pressurised cylinders.

This Policy has been developed to introduce a structured Procedure and Reporting Schedule for the Management and Control of Medical Gases in compliance with current Guidelines Health Technical Memorandum (WHTM 02-01).

This Policy covers all aspects in the safe use and operation of Medical Gases throughout CTMUHB. It is not limited solely to the Pipeline System. Although not exhaustive it includes:

- Central plant
- Pipeline systems
- Cylinder manifolds
- Cylinder use, transportation and storage

1. POLICY STATEMENT

The Policy specifies the management responsibilities for ensuring compliance with NHS Health Technical Memorandum WHTM 02-01, safe systems of work, the reduction of hazards in the working and patient environments and day to day management of medical gas systems within the CTMUHB.

Procedures for normal operation, maintenance and emergency actions are detailed in appendices of this Policy.

No work or testing that could affect security of supply of medical gases shall take place without:

- The formal approval of the Designated Nursing Officer / Designated Medical Officer (DNO) (DMO) of the area(s) that will be affected.
- Being the subject of an appropriate Permit to Work (Issued by an Authorised Person (MGPS).

A Competent Person (MGPS) carrying out the work and subject to the requirements and limitations of that Permit-to Work and in accordance with an approved procedure.

2. SCOPE OF POLICY

The Medical Gas Pipeline System (MGPS) together with portable cylinders, compressors, and suction units, which provide gas or vacuum, form an integral part of the systems supporting the CTMUHB's clinical activities.

This Policy is intended for use by the University Health Board and their contractors involved with medical gas systems and related equipment as defined in WHTM 02-01. It applies throughout the CTMUHB to all fixed medical gas pipeline systems.

Medical gases piped to a Clinical Engineering Department are included, as is a medical compressed air supply to a Sterile Services Unit (for the express purpose of testing the operation of air-powered surgical tools).

Other systems not covered by this policy include:

- Stand alone compressors
- Piped Pathology (Path lab) systems
- Dental laboratory systems
- Stand alone Dental vacuum systems

Stand alone mobile units (Eg. MRI Scanners) are not included within this policy but will be reviewed on a case by case basis by the Medical Gas AP.

Compressed gas and vacuum supplies to general engineering workshops and Pathology Departments shall be separate from the general MGPS and are NOT included in this Policy.

The operation of the medical and surgical equipment connected to the terminal units is **NOT** covered by this Policy and is the responsibility of clinical and medical staff.

The safe use of cylinders, transportation and storage is covered by the Medical Gas Cylinder policy.

3. DEFINITIONS

AGSS – Anaesthetic Gas Scavenging Systems

AP – Authorised Person

AVSU - Area Valve Service Unit

BS / ISO – British Standard / International Standardisation Organisation

COO – Chief Operating Officer

CP – Competent Person

CTMUHB – Cwm Taf Morgannwg University Health Board

DMO - Designated Medical Officer

DNO – Designated Nursing Officer

EFA – Estates & Facilities Alert

IPC – Infection Prevention & Control

MGPS – Medical Gas Pipeline System

MRI – Magnetic Resonance Imaging

PUWER – Provision & Use of Work Equipment Regulations

QC(MGPS) – Quality Controller (Medical Gas Pipeline System)

SESN – Specialist Estates Services Notification

SOM – Senior Operations Manager

WHTM – Welsh Health Technical Memorandum

4. AIMS AND OBJECTIVES

This Policy has been developed to introduce a structured Procedure and Reporting Schedule for the Management and Control of Medical Gases in compliance with current Guidelines within Welsh Health Technical Memorandum (WHTM 02-01).

The objective is to ensure the organisation takes all reasonable precautions to ensure Medical Gases are managed correctly for the safety of patients and staff.

5. RESPONSIBILITIES

It is the responsibility of the Board to ensure that the organisation meets its legal obligations under the current WHTM standards. As set out in S.13

The Board must ensure adequate funds and resources are available to meet the organisation's medical gas requirements and review the effectiveness of the Policy yearly and personnel under their control to whom medical gas responsibilities have been assigned.

5.1 Chief Executive

The Chief Executive of Cwm Taf Morgannwg University Health Board has the ultimate management responsibility for ensuring that an effective policy for managing medical gases is in place and to ensure that arrangements are in place for operations to be conducted only by Authorised or approved personnel.

The Chief Executive will nominate a designated person (Designated Person MGPS) to discharge their duties in respect of the MGPS.

The Chief Executive, on the recommendation of the Chief Pharmacist, will appoint a Quality Control Pharmacist with MGPS responsibilities, in writing.

5.2 Director (Designated Person MGPS) with Nominated Responsibility for Medical Gases Policy – Director of Finance

The Director of Finance is responsible for leading all Medical Gas pipeline issues

will assist the Chief Executive and Board in their responsibilities regarding medical gas management.

As Designated Person they will ensure:

- There is an overarching Medical Gas Management policy in place for the UHB.
- The development and implementation of the Medical Gas Management Policy and procedures in line with WHTM02-01 and the organisation's Risk Management Strategy.
- A medical gas group is set up to address medical gas concerns/issues and compliance to WHTM 02-01.
- An Authorised Engineer is appointed.
- The organisation obtains competent advice regarding medical gas safety from either within or external sources where appropriate.
- Nominate suitable individuals for formal assessment to the AE MGPS, following the guidelines set out in WHTM 02-01.
- Authorised persons are appointed in writing on the recommendation of the Authorising Engineer (MGPS) following formal assessment, ensuring the day to day management of the MGPS is delegated to the appointed AP MGPS.
- A procedure is in place for the supervision of contractors carrying out work in the organisation's premises.
- Where other responsibilities relating to the management of medical gases within the UHB are identified, which are outside of the remit of the policy lead, these will be noted within this overarching policy and those responsible will be made aware by reference within this policy.
- If required a coordinating AP should be appointed in writing by the DP.

5.2.1 Authorising Engineer (MGPS)

The Authorising Engineer provides advice and guidance for the UHB in maintaining the required standard laid down in WHTM 02-01 by:

- Recommending to the DP (MGPS) those persons who, through individual assessment, are suitable to be Authorised Persons (MGPS).
- Through assessment ensure that all Authorised Persons (MGPS) have satisfactorily completed an appropriate training course and are deemed competent to carry out the specified work.
- Following appointment ensure that all Authorised Persons (MGPS) are re-assessed every three years and have attended a refresher or other training course prior to such re-assessments.
- Conduct an annual audit and review of the management systems of the MGPS, including the Permit to Work System.
- Monitor the implementation of this Policy and associated procedures.

5.2.2 Authorised Person (MGPS)

The Authorised Person(s) is responsible for assisting the HB in maintaining the required standard laid down in WHTM 02-01:

- Ensuring that the MGPS is operated safely and efficiently in accordance with the statutory requirements and guidelines.
- Responsible for the Permit to Work System, including the issue of Permits-to-Work to Competent Persons (MGPS) for all servicing, repair, alteration and extension work carried out on the existing MGPS.
- Responsible for the supervision of the work carried out by Competent Persons (MGPS) and for the standard of that work (a Register of Competent Persons (MGPS) must be kept).
- Ensure that the MGPS maintenance specification and schedule of equipment (including all plant, manifolds, pipe work, valves, terminal units and alarm systems) are kept up to date.
- Liaise closely with designated nursing/medical officers, the Quality Controller (MGPS) and others, who need to be informed of any proposed interruption or testing of the MGPS to ensure clinical needs are met.
- Provide technical advice and liaise closely with clinical engineering for the purchase of any medical equipment which will be connected to the MGPS, in order to avoid insufficient capacity and inadequate flow rates.
- Ensure maintenance of MGPS services within the University Health Board is in accordance with the WHTM 02.01 and manufacturers.
- Provide advice on the provision and/or replacement of MGPS central plant and associated systems.
- Ensure training of CP's is conducted (additional staff may be trained if required) and/or transfer of MGPS information, as is needed for the efficient and safe operation of the MGPS.
- Assess and formally appoint in-house CP's in writing.
- AP to ensure that contractors are suitably qualified.
- Contractors employed to work on medical gas systems for the University Health Board must be registered to BS ISO 9001/BS ISO 13485. All medical gas contract staff must comply with the requirements of WHTM 02-01.

5.2.3 Competent Person (MGPS)

The duties and responsibilities of the Competent Person (MGPS) are to:

- Carry out work on the MGPS in accordance with approved maintenance specifications; and their training.
- Carry out repair, alteration or extension work, as directed by and Authorised Person (MGPS) in accordance with the Permit to Work System and WHTM 02-01.
- Perform engineering tests appropriate to all work carried out and inform the Authorised Person (MGPS) of all test results.
- Immediately report any non-conformance's to the AP

5.3 Director with Nominated Responsibility within the Medical Gases Policy – Chief Operating Officer (COO)

The Chief Operating Officer (COO) is responsible through the Pharmacy lead/Chief Pharmacist for ensuring the HB has sufficient supply and quality of medical gases. Also that through the Chief pharmacist the HB has access to a quality controller(s), and that sufficient porters are trained in medical gases safety as per WHTM 02-01 requirements.

5.3.1 Chief Pharmacist

- The Chief Pharmacist can recommend appointment of a QC(MGPS) tester to the Chief Executive.
- Inclusion on the QC(MGPS) register is sufficient to qualify an individual to act as a QC(MGPS) tester for any hospital site. (WHTM 02-02 Part B, 7.58, page 46).
- The Chief Pharmacist has the authority to specify who is allowed to operate on the sites and should decide this in conjunction with the AP (who should contact the QC(MGPS) when testing is required).
- QC is responsible for maintain all accurate records for testing work carried out. The Chief Pharmacist will ensure accurate records are maintained.
- To ensure there is a process in places to ensure ALL cylinders are replaced before their allotted expiry date.
- The Chief Pharmacist is responsible for ensuring only medical gas cylinders are kept in the medical gas cylinder stores.

5.3.2 Quality Controller (MGPS)

The duties and responsibilities of the Quality Controller (MGPS) are to:

- Assume responsibility for the quality control of the medical gases at the terminal units.
- Liaise with the Authorised Person (MGPS) in carrying out specific quality and identity tests on the MGPS in accordance with the Permit to Work System and relevant Pharmacopoeia Standards.
- Maintain records of calibration of test equipment.
- Quarterly testing of the medical air system.
- Respond and support in a timely manner, plan and/or emergency work.

5.3.3 Manager responsible for Porters

It is the responsibility of Portering Managers (or Facilities Managers / Heads of Facilities as appropriate) to ensure the following duties are undertaken by suitably trained staff:

- To ensure all designated porters are suitably trained.
- Porters training is provided by the medical devices training team in years 1,4 and 7 etc. Years 2 and 3 etc (refreshers) are provided by suitably trained Portering staff.

- Porters training risk sits under Facilities directorate and Facilities are responsible for Designated Porter compliance
- Facilities are responsible for reporting of Designated Porter training compliance.
- Replacing all appropriate cylinders when the central medical gas alarm panel indicates.
- Ensuring that the manifold areas and store rooms are kept clean and tidy.
- Providing appropriate tools and personal protective equipment.
- Ensuring that all cylinders are supported and secured.
- Ensuring designated porters lock stores and manifold rooms after use.
- Replacing the Emergency Supply Manifold ESM cylinders before the cylinder expiry date.
- The management and condition of the cylinder store (reporting of faults).
- Complete cylinder change log book for each manifold.

5.3.4 Portering Staff (Porter Services)

All Porters should have specialist training in the identification and safe handling and storage of medical gas cylinders, including relevant manual handling training. They will undertake the following duties:

- Deliver full (in date) gas cylinders from the Cylinder Stores, as appropriate to wards, and theatres and manifold rooms and return empty (or no longer required) cylinders to these stores.
- Connect to and remove from cylinders, medical equipment regulators (or regulator / flow meter combinations) and manifold tailpipes as requested by clinical staff.
- Any identified faulty (e.g. leaking) cylinders should be labelled with fault details and placed in the "medical gas cylinder isolation store".
- Ensure that all cylinders removed from store for use are within the 3-year fill / refill timescale specified by the gas supplier.
- Work safely at all times, using the appropriate personal protective and manual handling equipment, which is provided and maintained by the Portering Manager (Manual Handling Equipment by Pharmacy).
- Personal protective or manual handling equipment found to be missing, or defective in any way, must be reported immediately to the Portering Supervisor.
- Storage Facilities: It is the responsibility of Portering to ensure that the following cylinder storage conditions are met or reported if not available / in compliance.
    - Ensure all cylinders are stored in the specified locations in the medical gas store.
    - Storage of any non-medical gas cylinders in the main store should be reported to the porting supervisor immediately.
    - F, HX, G and J-size cylinders, full or empty, being securely restrained

in an upright manner by safety chains (where provided). The presence of cylinders for which no secure storage is available must be reported immediately to the Portering Supervisor by the Portering staff.

- Smaller cylinders being stored horizontally on racks, suitably protected to prevent damage to cylinder paint-work
- Protective clothing must be worn when moving cylinders.
- The store being kept clean, dry and free from flammable materials and other rubbish.
- The area around the store being kept free of combustible material, including dried vegetation.
- Transport cylinders safely using the appropriate trolley provided in accordance with their training.

5.3.5 Clinical Engineering

All medical gas flow meter, regulators (except main plant) and vacuum controllers are maintained by the Clinical Engineering Department.

Purchase of new Medical Gas related equipment must be discussed and agreed with Medical Gas APs prior to purchase. (New Equipment Request Form is to be used, included in App E)**.**

Porter training is provided by the medical devices training team (part of Clinical Engineering) in years 1,4 and 7 etc. Years 2 and 3 etc (refreshers) are provided by suitably trained Portering staff.

5.4 Director with Nominated Responsibility within the Gases Policy – Director of Nursing

The Director of Nursing is responsible for ensuring the provision for every ward/department to have a trained Designated Nursing Officer and for its General Nursing staff to be suitable trained according to WHTM 02-01

5.4.1 Senior Duty Ward / Department Nurse (Designated Nursing Officer)

Designated Nursing Officer (DNO) training is the responsibility of the Patient Care & Safety Directorate. The DNO training risk sits under the Patient Care & Safety Directorate who are responsible for their compliance and reporting of compliance.

Work will be carried out only after formal approval from the senior duty nurse in charge of the Ward / Department who will carry out the role of the DNO (MGPS).

5.4.2 Duties of the Designated Nursing / Medical Officer (DNO/DMO)

Designated Medical Officer (DMO) training is the responsibility of the Patient Care

& Safety Directorate. The DMO training risk sits under the Patient Care & Safety Directorate who are responsible for their compliance and reporting of compliance.

Give appropriate approval after any necessary consultation, for planned interruption to the supply by signing the relevant sections of the Permit to Work Form.

Inform clinical colleagues of any changes to medical gas availability.

For the purposes of MGPS work at ward level, have jurisdiction over all MGPS work, in their area of responsibility. This will include all planned and emergency local work.

If the shutdown or emergency work involves more than one area, the Senior Nurse or Senior Medical Officer for the site must be informed.

A Senior Nurse or Senior Medical Officer will outside normal working hours sign emergency Permits-to-Work for local work only.

The DNO/DMO shall familiarise themselves with the location of the Area Valve Service Unit (AVSU) and the medical gas alarm panel. The DNO/DMO should be aware of the alarms, and ensure all staff are aware of the locations and how to isolate the medical gasses for their area in the event of a serious incident such as fire.

Training of the DNO/DMO in operational and safety aspects of the MGPS should take place on a regular basis (as detailed in WHTM 02-01).

Accountable for any cylinder stocks in their Ward or Department. Keeping these to a minimum and replacing the cylinders before the cylinder expiry date has been reached. Also to provide stock control information to Pharmacy when requested.

Ensure all medical gas cylinders are stored in accordance with the WHTM 02-01 guidelines, and in line with fire policy/procedures.

5.4.3 General Nursing Staff: Medical Gas Safety training for nursing staff is available as an eLearning module and is managed through ESR. Medical gas training risk sits under the Patient Care & Safety Directorate and the Patient Care & Safety Directorate are responsible for their compliance and reporting of compliance. Staff will need to be competent in the safe use of medical gas and will be expected to attend a medical gas safety course every 3 years:

- Be aware of the maximum permissible quantity of cylinders allowed on the ward/department.
- Understand the UHB's rules for handling, moving and the storage of cylinders.
- Check the expiry date on the cylinder.
- Define a medical gas, especially in the context of its role as a medicine.
- Describe the dangers of medical gases and take appropriate precautions to ensure safety during their use.

- Identify a range of medical gas cylinders by size, valve type and colour-coding.
- Prepare a medical gas cylinder for use, connect it to a piece of medical equipment and, when empty, take the cylinder out of use, with due regard to any relevant local labelling requirements.
- Identify faulty and incident cylinders and take appropriate action.
- Identify and operate medical gas pipeline terminal units and flexible, colour-coded hoses.
- Ensure contaminated cylinders are cleaned prior to removal as per IPC guidelines.
- If a known vacuum system contamination event occurs at ward or department level, then the Authorised Person (AP MGPS) must be informed immediately.

5.5 Medical Gas Advisory Group

The Group will report to the Health, Safety and Risk Committee and the Estates and Capital Governance Board.

The Group is responsible for reviewing and updating the medical gas policy. Reviewing and mitigating against risks associated with the provision, installation and use of Medical Gas Pipeline Systems (MGPS), Anaesthetic Gas Scavenging Systems (AGSS) and vacuum systems. It is responsible for reviewing and addressing any medical gas related safety alerts. It will also raise awareness of issues around the procurement, storage and use of medical gases.

Quarterly training reports will be produced by the responsible directorate for the Medical Gas Advisory Group as follows:

- DNO / DMO, General Nursing – Patient Care & Safety Directorate Leads
- Designated Porters – Facilities Directorate
- APs / CPs – Estates Department
- Quality Controller (MGPS) – Pharmacy Department

These reports will be forwarded to the relevant director for action if required.

The group will undertake an annual review of the Terms Of Reference and arrange for external audit/risk assessment of all medical gases systems, installations and procedures.

Membership of the group will comprise:

- Head of Assets Governance and Technical Services (Chair)
- Estates and Facilities Compliance Manager
- Authorised Persons (MGPS) (Senior Operations Manager (SOM))
- Competent Persons (MGPS)
- Nominated Nursing or Medical Representative
- Quality Control Pharmacist (or nominated Pharmacist representing CTMUHB)

- Portering Manager / Head of Facilities
- Clinical Engineering Manager
- Medical Devices Training Manager
- Senior Fire Officer
- Authorising Engineer
- Anaesthetist
- Other department leads that receives medical gases, i.e. Dental, Maternity, Paediatrics, Localities & Primary Care

Additional experienced parties will also be invited as appropriate, to participate in the review process.

This Policy shall be reviewed by the Medical Gas Compliance Group annually or more frequently if new guidance is issued.

5.5.1 Links to other groups

Cylinder Management Group

Ventilation Safety Group

6. INFORMATION, INSTRUCTION AND TRAINING

- It is essential for the safety of patients that no person should operate, or work on any part of the MGPS unless adequately trained or supervised. Medical gas training is a requirement under the following (This list is not exhaustive):
- WHTM02-01 (Part A & B) Medical Gas Pipeline Systems
- Health and Safety at Work etc. Act 1974
- Management of Health and Safety at Work Regulations 1999
- Provision and Use of Work Equipment Regulations (PUWER) 1998
- CTMUHB Medical Gas Policy

Medical Gas Safety – Designated Nursing/Medical Officer

All ward/department managers, where there is a pipeline or wall supply of medical Gas - (Frequency of this training is every 3 years- Mandated)

Designated Nursing / Medical Officer (DNO/DMO) training is the responsibility of the Patient Care & Safety Directorate. The DNO/DMO training delivery sits under the Care Groups, with Patient Care & Safety Directorate responsible for monitoring DMO/DNO training compliance.

Medical Gas Safety - General Nursing Staff

Required by all qualified nursing staff, who handle Medical Gas cylinders and wall flowmeters (including Oxygen, medical Air, Carbon Dioxide, Nitrous oxide and Entonox. (Frequency of this training is every 3 years Mandated)

Medical Gas Safety training for nursing staff is available as an eLearning module and is managed through ESR. Medical gas training risk sits under the Patient Care & Safety Directorate and the Patient Care & Safety Directorate are responsible for their compliance and reporting of compliance.

Medical Gas Safety – Designated Porter

Portering staff who move, handle medical gas cylinders including the manifold room (Frequency of this training is annually-Mandated. Year 1 is provided by the Medical Devices Training Team and refreshers in year 2 and 3 will be provided by suitably trained portering staff)

Appointed -Authorised Person Estates Staff

Medical Gas Safety – Authorised Persons (Frequency of this training is every 3 years) Assessment & Appointment

Appointed – Competent Person- Estates / Contractors

Medical Gas Safety – Authorised Persons (Frequency of this training is every 3 years) Assessment & Appointment

Appointed - Quality Controller

Medical Gas Safety – Quality Controller

(Frequency of this training is every 5 years) Assessment

Records of Training

The ward/department manager is responsible for ensuring their staff are suitably trained and current within the set timescales and maintaining records of their staff training, should they need to be provided to any auditing body.

For compliance monitoring purposes, competencies have been created within ESR for General Nursing Staff, Designated Nursing Officer and Designated Porter, each competency has a lifespan equivalent to the required refresher period detailed above.

Quarterly training reports will be produced for the Medical Gas Advisory Group, showing compliance for DNO / DMO, General Nursing Staff and Designated Porters. These reports will be forwarded to the relevant director for action if required.

Training records will be monitored by the Medical Gas Compliance Group for:

- **Authorised Person** (AP) MGPS

  Completion of approved training to required, set out in WHTM 02-01.

- **Competent Person** (CP) MGPS Estates / Contractors

  Completion of approved training as set out in WHTM 02-01.

- **Quality Controller** (QC) MGPS

  Completion of appropriate training as set out in WHTM 02-01.

- **Designated Porters** and Portering service Supervisors (or Facilities Support Managers)

  Training in safe use of medical gases, both piped and in cylinders

  Practical training in storage, transport, handling and change-over of gas cylinders

- **Designated Nursing and Medical Officers** (DNO)(DMO) MGPS

7. PROCEDURE

This Policy is supported with procedures. These will be relevant to each Department and listed under Responsibilities (Section 5).

8. REVIEW, MONITORING AND AUDIT ARRANGEMENTS

8.1 Monitoring & Audit

The Organisation will monitor the level of compliance in respect of the management of medical gases through a scorecard system. The scorecard will report the level of compliance based on the core requirements of WHTM 02-01.

The scorecard will be completed by the Medical Gas compliance group and overseen and updated by the Facilities Governance Section.

8.2 Audit of Installations

The Authorising Engineer (MGPS) will undertake an annual audit and review of the management systems of the MGPS, including the Permit-to-Work system at all relevant CTMUHB sites.

9. IMPLEMENTATION/POLICY COMPLIANCE

It is the policy of the organisation to comply with NHS, Welsh Government, UK statutory and other legislative requirements in relation to the use and management of energy. The legislation and Health Service guidance documents that must be considered in the development and maintenance of this policy are listed in section 13 – Main Relevant Legislation / Standards.

10. RETENTION OR ARCHIVING

In line with the CTMUHB's Policy on Records all Engineering / Building records will be kept for the lifetime of the premises. All other records will be retained in line with the relevant Department requirements, if not dictated by the CTMUHB's Policy.

11. NON CONFORMANCE

There is a requirement of all staff to comply with the provisions of the Medical Gases Management Policy and, where requested, to demonstrate such compliance.

12. EQUALITY IMPACT ASSESSMENT STATEMENT

This policy has been screened for relevance to Equality. No potential negative impact has been identified.

13. MAIN RELEVANT LEGISLATION / STANDARDS

The main Guidance Document for piped Medical Gases in the NHS is WHTM 02-01. Other Legislation and guidance relative to Medical Gases are listed below:

13.1 Statutory requirements relevant to Medical Gas Systems

- Health and Safety at Work etc. Act, 1974
- Management of Health and Safety at Work Regulations, 1999
- Provision and Use of Work Equipment Regulations 1998
- Personal Protective Equipment at Work Regulations, 1992
- Manual Handling Operation Regulations, 1992
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations, 2013
- Control of Substances Hazardous to Health (COSHH) Regulations, 2002
- Pressure Equipment Regulations 1999
- Pressure Systems Safety Regulations, 2000
- Highly Flammable Liquid and Liquid Petroleum Gas Regulations, 1972
- Medicines Act, 1968
- Electromagnetic Compatibility Regulations 1992

- Electricity at Work Regulations, 1989

13.2 Other Guidance Applicable to Medical Gas systems

- Welsh Health Technical Memorandum WHTM 02-01 Medical Gas Pipeline Systems.
- Part A Volume 1, Design, Installation, Validation and Verification
- Part B Volume 2, Operational Management
- Supplement No 1 HTM 20-22 "Dental Compressed Air and Vacuum Systems" 2003
- Supplement No 2 HTM 20-22 "Piped Medical Gases in Ambulance Vehicles" 1997
- European Pharmacopoeia Standards for medical gases, including medical compressed air.
- CTMUHB Fire Policy
- CTMUHB Workplace Safety and Health Policy
- CTMUHB Medical Device Management Policy
- CTMUHB Cylinder Policy

Appendix A - Emergency Procedures

Appendix A1 - Isolation of Medical Gases by DNO/DMO in charge of Ward / Dept in event of fire.

Appendix A2 - Total or Partial Failure of Medical Gas Supply

Appendix A3 - Real or suspected contamination of Medical Gas Supply Appendix A4 - Contamination of Medical Vacuum System

Appendix A5 – Management of Medical Gas Alerts (All medical gas related alerts shall be shared and reviewed at the Medical Gases Advisory group)

Appendix A6 – Emergency Response to Increased Demand for Oxygen

Appendix A1 - Isolation of Medical Gases by DNO/DMO or Senior Nurse in charge of Ward / Department in the event of fire

In the event of a fire situation involving or likely to involve the MGPS or in the event of a fire situation which necessitates the area being evacuated.

The **DNO/DMO or Senior Nurse in charge** at the time of the incident:

- Must satisfy themselves that all piped Medical Gas dependent patients attached to the pipeline system have been placed on a secondary supply (cylinder).
- Isolating the medical gas supply to the 'affected' area (as per training).
- They must be sure the isolation of the piped gases is to the fire affected area only, and not to any other area which may have piped medical gas dependent patients attached. (Instruction attached as Appendix D)
- In all instances of fires or suspected fires the requirements of the CTMUHB's Fire Policy / Procedure should be followed until the Fire Service attend the site when the Senior Brigade Officer will assume full control of the situation and areas affected.
- If there are patients dependent on piped Medical gas services this must be made known to the responding Senior Brigade Officer.
- If piped gases have been isolated this must be made known to the Senior Brigade Officer.
- Inform Authorised Person (MGPS) and Senior Operations Manager at the earliest opportunity that emergency AVSU valve has been closed.

At the end of the fire incident the NDO/DMO, Senior Nurse In Charge, must complete fire incident form as per the Fire Policy.

Appendix A2 - Total or Partial Failure of Medical Gas Supply, need to engage with the Authorised Person (AP) medical gases

In these circumstances:

The person discovering the failure will inform the Estates Help Desk (Out of hours Estates on call engineer via switchboard) immediately.

The switchboard will inform Portering Services and the Authorised Person (AP) (MGPS), the Estates Engineer on call and the Estates Senior Operations Manager, who should be told the floor level, department, room number(s), the gas or gases involved and if patient ventilators are in use. As a precautionary measure, the AP will also notify porter services and critical areas that a failure has occurred on part of the system, so that they are prepared in the event of the fault extending to their departments. These departments will also be telephoned as a matter of course, if it is immediately evident that the fault is affecting the whole medical gas system.

It is the responsibility of the DNO/DMO or Senior Nurse in Charge to check which patients may have been put at risk by the failure and, if necessary, to arrange immediate emergency medical action.

The DNO/DMO or Senior Nurse in Charge will notify the relevant Senior Manager immediately, when a total or partial failure of medical gas occurs

Depending on the reason for the failure and its possible duration, the Authorised Person (MGPS) will decide the most appropriate method of long-term emergency gas provision. Nursing and medical staff should attempt to reduce gas consumption to a minimum during the emergency.

Portering staff will be required to monitor / replenish cylinders at any emergency stations and at plant room emergency supply manifolds.

The Duty Porter (Porter Services Supervisor or Facilities Support Manager) should inform the pharmacist if additional cylinders are required.

The Authorised Person (MGPS) will liaise with the Competent Person (MGPS) to complete emergency repairs needed to re-instate the gas supply, using the Permit to Work system.

The AP will liaise with the QC to complete emergency repairs needed.

In situations where it is envisaged that there will be long term loss of oxygen or medical air supply, the relevant Directorate Manager will liaise with clinical colleagues, including the Nursing Manager, the Medical Director and the Authorised Person (MGPS) on the need for transfer of critically ill patients to other hospitals, as department closure may be warranted in extreme circumstances.

In general, in the event of failure of nitrous oxide to the Theatres, the Theatre staff need to be informed immediately. If the failure is to be long-term, additional cylinders should be arranged via Pharmacy.

When the supply is fully restored, the Authorised Person (MGPS) will complete an Incident Report Form and carry out where appropriate a full investigation involving all relevant parties resulting in a final report with actions to minimise risk of re-occurrence as soon as reasonably practical and within 7 days of the incident

Appendix A3 - Real or Suspected Contamination of a Medical Gas Supply

This may be evidenced by unusual smells or fumes coming from equipment connected to a terminal unit.

It is not unusual for a smell to be noticed when using "plastic" equipment hoses to deliver gas to a patient. This smell usually disappears rapidly after first use of the hose and will generally be familiar to operatives.

However, if either operatives or patients complain of any unusual or strong smell from equipment, the situation must be treated seriously and immediate action taken to ascertain the cause. Where it is obvious that the smell is coming from the pipeline rather than a piece of connected equipment, the gas supply must not be used. In this event the fault should be treated as a complete gas failure to that area and the actions described in Appendix A3 taken immediately. It is very important that if such an incident occurs the switchboard (coordinated by the AP) advises all departments of the problem, especially those involved with critical care.

Where an item of medical equipment is involved advice must be obtained from the Clinical Engineering Department. Clearance for re-use of MGPS can only be given by the Quality Controller after any necessary purging and sampling for purity.

Appendix A4 - Contamination of the Medical Vacuum System

Contamination of the medical vacuum system may be detected through routine maintenance inspection and evidenced by the presence of liquid in the Medical Gas Plant room on-line bacteria filter drain flask. The Infection Prevention & Control Team should be notified immediately and should advise on any additional precautions to effect filter change safely.

If a known contamination event occurs at ward or department level, then the Authorised Person (AP MGPS) must be informed immediately.

It is the responsibility of the Competent Person (MGPS) to change the filter in accordance with the approved procedure (set out in WHTM 02-01, Part B,

Appendix D, pages 137 & 138) and any additional advice from the Infection Control Department.

If the contamination is due to system misuse, the Authorised Person (MGPS) must complete an Incident Report Form and report facts by phone to the appropriate Nurse Manager so that remedial action can be taken after due investigation.

Decontamination of pipe work (if necessary) should be carried out in accordance with the procedure described in WHTM 02-01 **BEFORE** filters are changed.

Appendix A5 – Management of Medical Gas Alerts

- (All medical gas related alerts shall be shared and reviewed at the Medical Gases Advisory group)
- Patient Safety Alerts may be issued by Department of Health or Welsh Government. Estates and facilities alerts (EFA) and Specialist Estates Services Notifications (SESN) issued by NHS Wales Shared Services Partnership. From time to time, these alerts may relate to medical gas safety matters.
- Within Cwm Taf Morgannwg UHB medical gas related alerts are received by Chief Executive Officer (also usually copied to the MGPS Designated Person, Chief Pharmacist and Assistant Director of Estates).
- When such an alert is received, response to the alert is managed by Central Patient Care and Safety Team progress recorded through the Datix system.

It is to be disseminated to the members of the Medical Gases Advisory Group for relevant action. Progress is reported and recorded at this group.

Appendix A6 – Emergency Response to Increased Demand for Oxygen

Users are advised to refer to the following NHS Wales guidance advice:

- SESN 20/19 The COVID-19 Pandemic and actions necessary to mitigate it's effect on the performance of Healthcare Cryogenic Liquid Oxygen System
- WG SES EFA 2020 004 – COVID-19 Response – Oxygen Supply and Fire Safety

Procedures and principles set out in these documents would be common to other gases, therefore the same considerations would be given to other medical gases.

Appendix B - Permit to Work System

The System applies to all work on a Medical Gas Pipeline System (MGPS) with the exceptions of routine changing of cylinders, recharging of liquid oxygen vessels, emergency valve closure and the commissioning of new systems, medical air quarterly testing.

Day to day management responsibility of a MGPS resides with an Authorised Person. (AP) (MGPS)

It is the duty of the AP (MGPS) to co-ordinate work on the MGPS and obtain the full co-operation of the relevant medical and nursing staff to ensure that clinical needs are met.

The Competent Person (CP) (MGPS) is the maintenance person or contractor who carries out approved work on the system.

The DNO/DMO in charge of Ward/ Dept gives written permission for work on the MGPS to take place and written acceptance of the tested system back into use.

The Quality Controller (QC) is usually a Pharmacist with overall responsibility for quality control (identity and purity) of the medical gases supplied to patients.

Before work on the MGPS is agreed, the AP (MGPS) must assign a HAZARD level to the job.

A **HIGH** hazard level implies the job carries risks to the MGPS of cross connection and pollution. (Cutting or brazing of the pipe work).

A **LOW** hazard level applies to all other work.

Bacterial hazard permit - Is required for changing of bacteria filters on the central medical vacuum plant / system. The permit to work and associated standard operating procedures are documented in WHTM 02-01 Part B, Appendix D

Each level of hazard attracts a series of engineering and/or pharmaceutical tests, which must be completed before the system is taken back into use.

The Permit to Work Form is a triplicate document, a consecutively numbered booklet, which is held by the AP (MGPS). Copies of the Permit are retained by the AP (MGPS).

Appendix C - Actions in the Event of an MGPS Alarm

Central high level alarm systems are under continuous observation, usually by switchboard. Local pressure alarms, are also in place to provide assurance of gas availability via the piped system, everyone must be vigilant in observation and reporting of alarms

Instructions are kept with the Switchboard staff to confirm the personnel to be contacted in event of each of the medical gas alarms being activated.

Alarm panels will be found in various departments and wards and staff should familiarise themselves with the significance of the colour displays on these panels. The panels associated with each gas and the alarms displayed are illustrated below.

On detection of a local alarm indication e.g. in a ward area, the DNO/DMO or Senior Nurse should contact the Estates Help Desk (Ext 73210 or 54000 in Bridgend region. See Appendix D below) to confirm that a fault has been signalled and that the Estates Dept. are aware of the situation. Outside normal hours the Estates On Call Engineer will be informed (Via Switchboard).

Each alarm panel will be fitted with a "MUTE" push button which, when pressed, will silence the audible alarm for approximately 15 minutes. The audible alarm will also be cancelled automatically when the fault is cleared. The diagrams below show the actions that should be taken at each level of alarm.

Note: Disabling the alarm system, other than when due authorisation has been obtained from an Authorised Person (MGPS), is absolutely forbidden, AS THIS ACTION MAY COMPROMISE PATIENT SAFETY.

In the event of a Plant alarm condition on the following systems, it is the responsibility of the Duty Telephonist (or Porters at some sites outside normal working hours) to inform the appropriate staff as follows;

NWH = Normal Working Hours

ONWH = Outside Normal Working Hours

i). Medical Air / Surgical air plant

Alarm indication	Action (telephonist to inform)
NORMAL	No action to be taken
PLANT FAULT	**NWH** – Authorised Person (MGPS) **ONWH** – Estates On Call Engineer
PLANT EMERGENCY	**NWH** – Authorised Person (MGPS) **ONWH** - Estates On Call Engineer
RESERVE LOW	**NWH** – Porter services supervisor **ONWH** – Porter services
PRESSURE FAULT	**NWH** – Authorised Person (MGPS) **ONWH** – Estates On Call Engineer

ii). Medical Vacuum

Alarm indication	Action (telephonist to inform)
NORMAL	No action to be taken
PLANT FAULT	**NWH** – Authorised Person (MGPS) **ONWH** - Estates On Call Engineer
PLANT EMERGENCY	**NWH** – Authorised Person (MGPS) **ONWH** - Estates On Call Engineer
PRESSURE FAULT	**NWH** – Authorised Person (MGPS) **ONWH** - Estates On Call Engineer

iii). Medical Gas Manifolds N2O / Entonox / Oxygen

Alarm indication	Action (telephonist to inform)
NORMAL	No action to be taken
CHANGE CYLINDERS	**NWH** – Porter services supervisor **ONWH** - Porter services
CHANGE CYLINDERS IMMEDIATELY	**NWH** – Porter services supervisor **ONWH** - Porter services
RESERVE LOW	**NWH** – Porter services supervisor **ONWH** - Porter services
PRESSURE FAULT	**NWH** – Authorised Person (MGPS)

NB No "Reserve Low" indication for Nitrous Oxide or Entonox

iv). VIE with VIE Backup

Alarm indication	Action (telephonist to inform)
NORMAL	No action to be taken
LIQUID OXYGEN LOW	**NWH** – Authorised Person (MGPS)
REFILL OXYGEN IMMEDIATELY	**NWH** – Authorised Person (MGPS) **ONWH** - Estates On Call Engineer
RESERVE LOW	**NWH** – Authorised Person (MGPS)
PRESSURE FAULT	**NWH** – Authorised Person (MGPS)

v). VIE with Cylinder Manifold Backup

Alarm indication	Action (telephonist to inform)
NORMAL	No action to be taken
LIQUID OXYGEN LOW	**NWH** – Authorised Person (MGPS)
REFILL OXYGEN IMMEDIATELY	**NWH** – Authorised Person (MGPS) **ONWH** - Estates On Call Engineer
CHANGE CYLINDERS	**NWH** – Porter services supervisor **ONWH** - Porter services
PRESSURE FAULT	**NWH** – Authorised Person (MGPS)

vi). Panel Indication (all alarm panels)

Alarm indication	Action (telephonist to inform)
POWER ON	No action to be taken
SYSTEM FAULT	**NWH** – Authorised Person (MGPS) **ONWH** - Estates On Call Engineer

Appendix D - Useful Contacts

Estates Help Desk	Tel: 73210.
Bridgend Estates Help Desk	Tel: 5400.
Porter services supervisor or Designated porter	Tel or bleep Via switchboard
Pharmacy	Tel or via Switchboard out of hours
Senior Operations Manager (SOM)	Out of Hours via Switchboard
Authorised Person (AP)	Normal Hours via Estates Help Desk (giving site details)
Estates On Call Engineer (all hours emergency)	Via Switchboard
Specialist MGPS Contractor	Contacted via SOM or AP
Medical gas cylinder orders, BOC Gases	Tel No 0800 111 333
Liquid Oxygen BOC Gases	Tel No. 0800 111 333

Key-holders

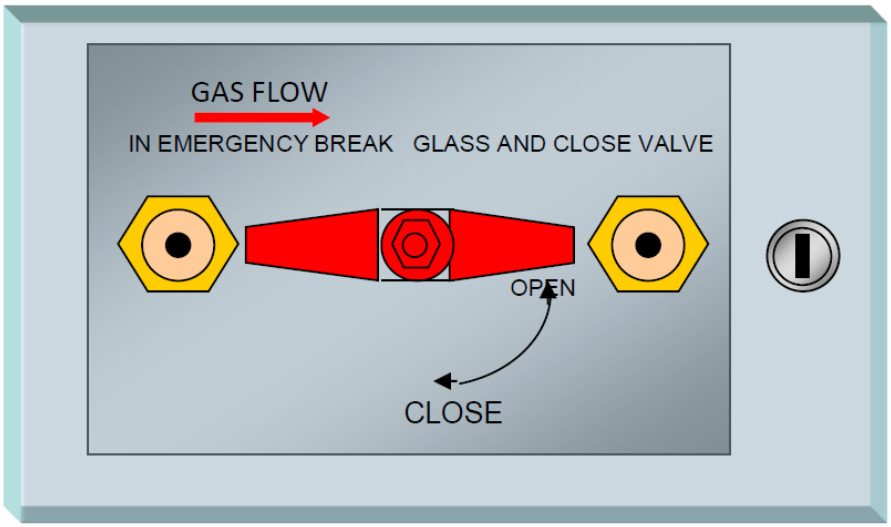
Depending on site contact Porters and Authorised Person for the site via switchboard

Key Holder	**Person**	**Locations**	**Tel No.**
Oxygen (VIE) compound	Authorised Person MGPS (AP)	YCR, YCC, PCH, RGH, POW, MCH	Via relevant switchboard
Nitrous oxide manifold room	Porter services supervisor or designated porter /Estates	PCH, RGH, POW	Via relevant switchboard
Compressed air / vacuum plant room	Estates	YCR, YCC, PCH, RGH, POW	Via relevant switchboard
Entonox manifold room	Porter services supervisor or designated porter /Estates	YCR, YCC, PCH, RGH, POW	Via relevant switchboard
Main cylinder store	Porter services supervisor or designated porter /Estates	PCH, RGH, POW, MCH, Glanrhyd	Via relevant switchboard
Oxygen manifold room	Porter services supervisor or designated porter /Estates	PCH, RGH, YCC, Glanrhyd	Via relevant switchboard
Medical gas system valve boxes	Operational Manager’s Office	Estates Dept.	Via relevant switchboard

Appendix E - Emergency Isolation of an Area Valve Service Unit (AVSU)

The location of AVSUs varies from department to department, in some instances they are located near nurse stations, whereas in other areas they are located or near the entrance to the ward or department. In some instances, more than one AVSU will control a ward (such as ITU, CCU, SCBU and theatres etc).

Staff must make themselves aware of the location of the AVSUs under their remit of responsibility, the gases, the areas they control and their method of operation.



Typical Area Valve Service Unit in open (ON) condition

Emergency Gas Isolation

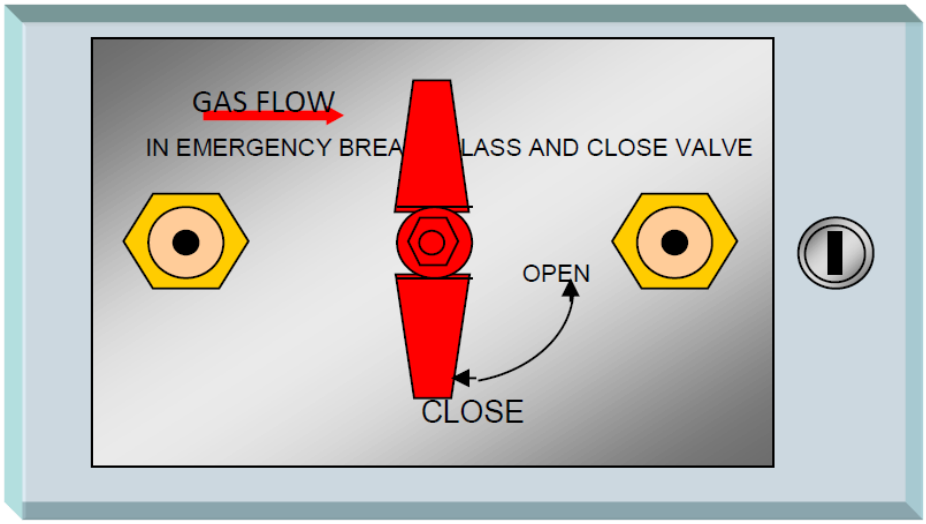
Medical gases must be isolated in the event of a fire or major gas leak. Isolation of the gases and AVSU/scan only be performed by the senior clinical staff member in charge of the ward or department – only after making sure patients are safe and supported

Before Isolation:

- Identify the gas(es) to be isolated
- Check that gas supplies are not in use and that no patients are connected or dependent on the Medical Gas Piped System (MGPS) to be isolated.
- Break the glass or pull the ring of the AVSU panel for the gas(es) to be isolated
- Clear any remaining glass or debris from the AVSU panel
- Close valve/s by rotating the valve handle in the direction of the arrow until the handle is in the **vertical** position.
- The local "low pressure" alarm may activate once the valve is closed or shortly after
- Ensure these actions are reported to your Authorised Person – MGPS – Estates Department

Do not reinstate any medical gas(es) systems following isolations without firstly consulting your Authorised Person – MGPS.

Isolation of medical gases can kill – always ensure that essential life support is maintained first prior to any isolations.



Typical AVSU in closed (OFF) position

Quality, Safety & Experience Committee – Non Routine Committee Business Forward Plan

(1st January 2025 to the 31st December 2025)

This forward plan is only to be used for one-off Adhoc items that do not require inclusion as routine business on the Annual Committee Cycle of Business.

Date of Request	Origin of Request	Requestor	Item Summary / Title	Nature of Request	Lead Officer	Executive Lead	Intended Meeting Date	Status
	Request made by the Quality & Safety Committee Chair	Committee Chair	Annual Quality Work Plan	The Annual Quality Report was presented for endorsing by Board at the July Q&SC and this was endorsed at July Board. Annual Quality work plan to be presented to the a future meeting of the Committee	Executive Director of Nursing/Executive Director of Allied Health Professionals and Health Sciences	Executive Director of Nursing/Executive Director of Allied Health Professionals and Health Sciences	To be agreed	**Propose to Close** The summary of the Annual Quality Work Plan will be provided in the forthcoming July Quality and Safety Executive (QSE) meeting. The objective is to align this component with the forthcoming Duty of Quality Annual Report. Additionally, the Quality Strategy is scheduled for revision during the current financial year, and efforts will be made to ensure that the reporting for Duty of Quality is integrated with the Quality Strategy, facilitating ongoing reporting and assurance.
16 May 2024	Request made at agenda planning session for this item to be added to the agenda	Executive Director of Nursing	Nursing & Midwifery Plan	Nursing & Midwifery Plan received at the May 2024 meeting. Agreed at May 2024 meeting that annual updates on progress would be included in the Clinical Executives report.	Executive Director of Nursing	Executive Director of Nursing	20 May 2025 – **Now 22 July 2025**	**In progress** Was due to be presented to the May 2025 meeting of the Committee. This will now be presented to the meeting taking place on the 22 July 2025
16 May 2024	Suggested at the 16 May 2024 meeting that report would be presented to a future meeting on this item	Chief Operating Officer	CTM Escalation Policy	Suggested at the 16 May 2024 meeting that report would be presented to a future meeting on this item	Chief Operating Officer	Chief Operating Officer	18 September 2024	**In progress** Following discussion with the Chief Operating Officers Business Team, this Policy is in the process of being reviewed and updated and will be available for circulation in **late 2025.**
14 August 2024	Request received by email for this to be presented as a spotlight presentation to a future	Senior Nurse Acute Deterioration and Outreach Services	Spotlight Presentation Decision Making	Case presentation to highlight the need for more resource in end-	Senior Nurse Acute Deterioration and Outreach Services	Executive Medical Director	25 March 2025	**In progress** Consideration being given to governance reporting routes for

	meeting of the Committee		around ACP/DNACPR/TEP	of-life education and training				RADAR. In this respect this item may be removed from to forward plan for Quality, Safety & Experience Committee
24 September 2024	Request received by email from the Assistant Head of Assets Governance and Technical Services	Assistant Head of Assets Governance and Technical Services	Estates Policies	Estates Policies for approval: • Asbestos Management Plan • Water Safety Plan • Medical Gases Policy	Assistant Head of Assets Governance and Technical Services	Executive Director of Finance	19 November 2024	**On agenda** Medical Gases Management Policy approved via Chairs Urgent Action. Ratification of Chairs Urgent Action report on agenda for May meeting
21 January 2025	Item identified as future report at the meeting held on 21 January 2025	Primary Care & Community Care Group Nurse Director	Progress report on Dental Services	To be presented to the Committee for information and awareness	Primary Care & Community Care Group Nurse Director	Chief Operating Officer	20 May 2025	**On agenda** Report is on the agenda for the May 2025 meeting
18 February 2025	Committee referral made by the Audit, Risk & Assurance Committee at its meeting on 13 February 2025	Executive Medical Director	Details of the medical negligence claims from the losses and special payments report	A detailed discussion required on the reasons for the increases in medical negligence claims with the appropriate execs all being present to answer questions and provide assurance to the committee.	Assistant Director of Quality & Safety	Executive Director of Nursing	20 May 2025 – **Now 22 July 2025**	**In progress** Was due to be presented to the May 2025 meeting of the Committee. This will now be presented to the July meeting.
11 March 2025	Request made by an Independent Member at the January 2025 QSEC for this report to added to future meeting agenda's	Executive Director of Nursing	WAST Produced Quality Report	USC Care Group to provide a report on the joint working with WAST looking at the People's Experience and Quality of care as this is work that is undertaken jointly with the central team and sits within USC portfolio.	USC Care Group Nurse Director	Executive Director of Nursing	20 May 2025 – **Now 22 July 2025**	**In progress** Agreed that this agenda item is put on hold until the new USC DoN is appointed. Agreed that this item will be deferred until July QSEC with any urgent issues being provided through the USC Care Group highlight report; Matter will be kept under review regarding frequency of reporting and the report requirements will be made to allow for regular updates to be provided by the Care Group in respect of the joint working with WAST looking at the

								People's Experience and Quality of Care
10 April 2025	Request made at the agenda planning session held on 10 April 2025	Committee Chair	Stroke Services Progress Report	Stroke Services report to be presented to the July meeting of the Committee	Executive Director of Allied Health Professionals & Healthcare Sciences	Allied Health Professionals & Healthcare Sciences	22 July 2025	**In progress**
Completed Items								
11 November 2024	Request received by email from the Assistant Director of Improvement	Assistant Director of Improvement	Quality Management Systems	To be presented to the Committee for information and awareness	Assistant Director of Improvement	Executive Director of Nursing	25 March 2025	**Completed** Received and discussed at the meeting held on 25 March 2025
24 September 2024	Request received by email from the Assistant Head of Assets Governance and Technical Services	Assistant Head of Assets Governance and Technical Services	Estates Policies	Estates Policies for approval: • Asbestos Management Plan • Water Safety Plan • Medical Gases Policy	Assistant Head of Assets Governance and Technical Services	Executive Director of Finance	19 November 2024	**Completed** Asbestos Management Plan and Water Safety Plan approved at the meeting held on 25 March 2025
11 February 2025	Request made at the agenda planning session held on 11 February for this to be added to the agenda	Unscheduled Care Group	Spotlight presentation on Stroke Services	To be presented to the Committee for discussion and assurance	Unscheduled Care Group Nurse Director	Executive Director of Nursing	25 March 2025	**Completed** Received and discussed at the 25 March 2025 meeting

Quality, Safety & Experience Committee – Annual Cycle of Committee Business

(1st January 2025 to the 31st December 2025)

The Annual Cycle of Committee Business has been developed to help plan the management of Committee matters and facilitate the management of agendas and committee business. The Annual Cycle of Committee Business will be complemented by a "Non-Routine Committee Business (Forward Plan)" for 'one-off' Adhoc items raised during the course of meetings.

The role of the Committee is set out in CTMUHB's standing orders and the Terms of Reference, both of which are available here: Standing Orders & Standing Financial Instructions - Cwm Taf Morgannwg University Health Board (nhs.wales)

The Quality, Safety & Experience Committee meets at **least 6 times per annum**.

Committee Chair:	**Committee Vice Chair**	**Executive Leads for Agenda Planning**
• Carolyn Donoghue, IM University	• Kath Palmer, Vice Chair	• Greg Dix, Executive Nurse Director / Deputy CEO

CTMUHB Committee Business:

Items of Business	Executive Lead / Or External Representative	Reporting Frequency	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Consent Agenda	Main Agenda
Committee Governance Arrangements																
1. Action Log	Director of Corporate Governance / Board Secretary	All Regular Meetings	✓		✓		✓		✓		✓		✓		✓ If all actions are complete	✓ If there are actions in progress / overdue actions
2. Minutes of the previous meeting (Public and Closed Session)	Director of Corporate Governance / Board Secretary	All Regular Meetings	✓		✓		✓		✓		✓		✓		✓	X
3. Non-Routine Committee Business (Forward Plan)	Director of Corporate Governance / Board Secretary	All Regular Meetings	✓		✓		✓		✓		✓		✓		✓	X
4. Annual Cycle of Business	Director of Corporate Governance / Board Secretary	All Regular Meetings	✓		✓		✓		✓		✓		✓		✓ Except for the annual review in November	✓ Annual Review only
5. Committee Annual Report	Director of Corporate Governance / Board Secretary	Annually					✓								X	✓
6. Outcome of Annual Committee Self-Assessment	Director of Corporate Governance / Board Secretary	Annually					✓								X	✓
7. Terms of Reference Review	Director of Corporate Governance / Board Secretary	Annually					✓ Defer to Sept 25				✓				X	✓

Items of Business	Executive Lead / Or External Representative	Reporting Frequency	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Consent Agenda	Main Agenda
Staff and Service User Experience																
8. Shared Listening & Learning Story	Executive Director of Nursing / Deputy CEO	All Regular Meetings													X	
9. Outcome reports - Executive and Independent Member Patient Safety Walkabouts	Executive Director of Nursing / Deputy CEO	Twice per annum.			To be deferred to the May meeting											
Setting the Scene – Service Delivery																
10. Thematic Spotlight Presentation	Lead Clinical Executive	All Regular Meetings													X	
11. Report from the Clinical Executives	Clinical Executives	All Regular Meetings													X	
12. Care Group Highlight Reports	Care Group Nurse Directors/Care Group Medical Directors	All Regular Meetings													X	
Delivering our Plan																
13. Quality Dashboard Report	Executive Nurse Director / Deputy Chief Executive	All Regular Meetings													X	
14. Stroke Services Progress Report *(also captured in the regular Unscheduled Care, Care Group report – it has been agreed that updates on Stroke Services can now be included in the Unscheduled Care Group Highlight Report moving forwards with no separate report required)*	Executive Director of Therapies & Health Science / Chief Operating Officer	Twice per annum													X	
Governance, Risk and Assurance																
15. Organisational Risk Register – Risks Assigned to Quality & Safety Committee	Director of Corporate Governance	All Regular Meetings													X	
16. Health Inspectorate Wales (HIW) Audit Tracker Report	Director of Corporate Governance & Executive Nurse Director / Deputy Chief Executive	All Regular Meetings	**(consent)**		**(consent)**		**(consent)**		**(main)**		**(consent)**		**(main)**			**(to be added to the main agenda on a 6 monthly basis)**

Items of Business	Executive Lead / Or External Representative	Reporting Frequency	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Consent Agenda	Main Agenda
Governance, Risk and Assurance Contd.																
17. Coroner's Inquest – Case Activity & Lessons Learned	Executive Medical Director Executive Nurse Director / Deputy Chief Executive	Bi Annually													X	
18. Mortality Indicators and Mortality Reviews	Executive Medical Director	Bi Annually													X	
19. Continuing Healthcare (CHC) and Funded Nursing Care (FNC) Activity.	Executive Nurse Director / Deputy Chief Executive	Annually			To be deferred to the May meeting										X	
20. Infection, Prevention & Control Annual Report	Executive Nurse Director / Deputy Chief Executive	Annually													X	
21. Infection, Prevention & Control Strategy Implementation Plan	Executive Nurse Director / Deputy Chief Executive	Annually													X	
22. Putting Things Right Annual Report	Executive Nurse Director / Deputy Chief Executive	Annually														X
23. Non Clinical Policies for approval	Executive Portfolio determined.	As and when required														X
24. Clinical Policies Highlight Report	Executive Medical Director	Bi-Annually														X
25. Safeguarding & Public Protection Annual Report	Executive Nurse Director / Deputy Chief Executive	Annually														X
26. Nurse Staffing Levels Wales Act 2016	Executive Nurse Director / Deputy Chief Executive	Twice per Annum														X
27. Medicines Management *(Including Controlled Drugs Local Intelligence Network (CDLIN) / Prescribing Annual Report) Prescribing errors captured in quality dashboard)*	Executive Medical Director	Annually plus exception reporting													X	
28. Oversight on the delivery of the R&D Strategy	Executive Nurse Director / Deputy Chief Executive	Bi Annually					Defer to July									
29. Cancer Services Annual Report	Executive Medical Director	Annually														X

Items of Business	Executive Lead / Or External Representative	Reporting Frequency	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Consent Agenda	Main Agenda
Governance, Risk and Assurance Contd.																
30. RADAR Committee Highlight Annual Report	Executive Medical Director	Annually plus exception reporting			Removed from the March agenda whilst reporting arrangements are being finalised											X
31. Clinical Audit Quarterly Report	Executive Medical Director	Quarterly														X
32. Clinical Audit Annual Plan	Executive Medical Director	Annually														X
33. Clinical Education Annual Report	Executive Nurse Director / Deputy Chief Executive	Annually														X
34. Individual Patient Funding Request Annual Report	Executive Director of Strategy & Transformation	Annually														X
35. Radiation Safety Committee Annual and Mid-Year Updates	Executive Director of Therapies & Health Science	Bi Annually			To be deferred to the May meeting											X
36. Ombudsman's Annual Letter and Annual Report	Executive Director of Nursing / Deputy Chief Executive	Annually														X
37. Human Tissue Authority Act Progress Report	Executive Medical Director	Bi Annually														X
38. CTM Carers End of Year Progress Report	Executive Director of Nursing / Deputy Chief Executive	Annually														X
39. Health, Safety & Fire Sub Committee Highlight Reports	Executive Director of People	All meetings following a Sub Committee													Unless there is an area for escalation	X
40. Health, Safety & Fire Sub Committee Annual Committee Report	Executive Director of People	Annually					Defer to July 25									X
41. Organ Donation Sub Committee Highlight Reports	Executive Medical Director	All meetings following a Sub Committee					Defer to July 25								Unless there is an area for escalation	X
42. Organ Donation Sub Committee Annual Committee Report	Executive Medical Director	Annually					Defer to July 25									X

Items of Business	Executive Lead / Or External Representative	Reporting Frequency	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Consent Agenda	Main Agenda
Governance, Risk and Assurance Contd.																
43. Hosted Organisations Quality, Safety & Experience Updates	JCC Chief Commissioner NIAW Programme Director	TBD													Unless there is an area for escalation	X
44. Anti-Microbial Resistance reports	Executive Medical Director	Twice Per Annum														
45. Harm Free Care Update	Executive Director of Nursing	Twice Per Annum													**X**	
46. Annual Duty of Quality Report	Executive Director of Nursing	Annually					Defer to July								**X**	
47. Research & Development, Innovation & Improvement	Executive Director of Nursing	Bi Annually													**X**	
48. Patient Experience Forum Update	Executive Director of Nursing	Bi Annually													**X**	

Agenda Item
8.2.3

Quality, Safety & Experience Committee

Clinical Policies Highlight Report

Dyddiad y Cyfarfod / Date of Meeting	20/05/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	Dr David Deekollu, Assistant Medical Director Quality & Safety Abbie Jenkins, Medical Directorate Support Manager
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	Dom Hurford, Executive Medical Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Dom Hurford, Executive Medical Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group /Forum Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	

1. Situation /Background

1.1 Since September 2023, a new process for the approval of Clinical Policies has been implemented. The new approach allows Care Groups to review and approve policies first, and then present directly to Operational Management Board for approval without further delay.

1.2 Approved policies that have been taken to the Operational Management Board are collated by the Assistant Medical Director for Quality and Safety and presented to Quality, Safety & Experience Committee. They are also added to SharePoint.

1.3 The Care Groups have more ownership of the development of policies rather than having to attend the Clinical Policies Group as previously.

1.4 The purpose of this report is to provide the committee with an outline of the policies approved at Operational Management Board in the last six months.

2. Specific Matters for Consideration

2.1 In relation to the process put into place for the approval of clinical policies, the following policies have been approved during the period November 2024 to April 2025:

- Clozapine Policy
- Policy for Planning Leave for Patients in Mental Health Inpatient Units
- Policy for the Management of Severely Disturbed Patients or of Violent Behaviour by Adult Inpatients within Cwm Taf Morgannwg
- Patients who walk out of a Healthcare Setting
- Absent Without Leave (AWOL) & Missing Patient Policy
- Olanzapine Long-Acting Injection (OLAI) Policy
- Inpatient Acuity Escalation Process in Adult Mental Health
- Anti-Ligature Safety Policy
- Local Primary Mental Health Support Service (LPMHSS) Operational Policy
- Guidance on the Use of Intravenous Phenytoin for Status Epilepticus in Paediatric Patients
- Cardiopulmonary Resuscitation Policy
- Safe Transfer of Patients Policy
- Physical Health Monitoring of Patients on Antipsychotic Treatment Policy
- Policy for Dealing with Adult Patient Requests for a Change of Consultant (Mental Health)

2.2 The above clinical policies have been uploaded to SharePoint for implementation. The purpose of this report is to provide the committee with an outline of the policies approved at Operational Management Board in the last six months.

3 Key Risks / Matters for Escalation

No specific risks identified. A new process for the approval of Clinical Policies is now operational which allows initial Care Groups scrutiny and approval followed by presentation to the Operational Management Board.

4 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	Not Applicable
	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)*	Not Applicable
	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))*	Not Applicable
	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))*	Effective
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	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	Yes: ☐	No: ☒

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?*	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: Not required
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.	

5 Recommendation

5.2 The Committee are asked to **NOTE** the contents of this report.

6 Next Steps

6.2 Six monthly report to Quality Safety & Experience Committee November 2025.

Agenda Item
8.2.4

Quality, Safety & Experience Committee

Cancer Services Annual Report

Dyddiad y Cyfarfod / Date of Meeting	20/05/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	Tanya Williams – Cancer & Urology Services Senior Manager David Williams – Cancer & Outpatients Improvement Manager Dawn Casey – Macmillan Lead Cancer Nurse Rhian Collins – Macmillan AHP lead for Cancer
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	Dom Hurford, Executive Medical Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Dom Hurford, Executive Medical Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group /Forum Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms

CTMUHB	Cwm Taf Morgannwg University Health Board
SCP	Suspected Cancer Pathway
CWT	Cancer Waiting Times
PTR	Putting Things Right
HB	Health Board
OPA	Outpatient Appointment
MDT	Multi-Disciplinary Team
HEIW	Health Education and Improvement Wales
CNS	Clinical Nurse Specialist
WCISU	Welsh Cancer Intelligence and Surveillance Unit
AHP	Allied Health Professional

1. Situation /Background

1.1 This report provides an annual update on cancer services across CTMUHB.

2. Specific Matters for Consideration

2.1 Impact of non-compliance with the suspect cancer waiting time measure.

3. Key Risks / Matters for Escalation

3.1 Continued failure to meet the suspected cancer waiting time performance measure.

4. 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	Not Applicable
	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))*	Not Applicable
	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))*	Not Applicable
	If more than one applies please list below: Timely, Safe, Person Centred, Equitable, Efficient, Effective
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd	Yes: ☐	No: ☒

Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	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	Yes (Include further detail below)	
	Cancer performance is a key Welsh Government priority	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	Additional funding will be required to meet current cancer waiting time performance target	

5. Recommendation

5.1 The Committee are asked to **NOTE** and **CONSIDER** the contents of this report.

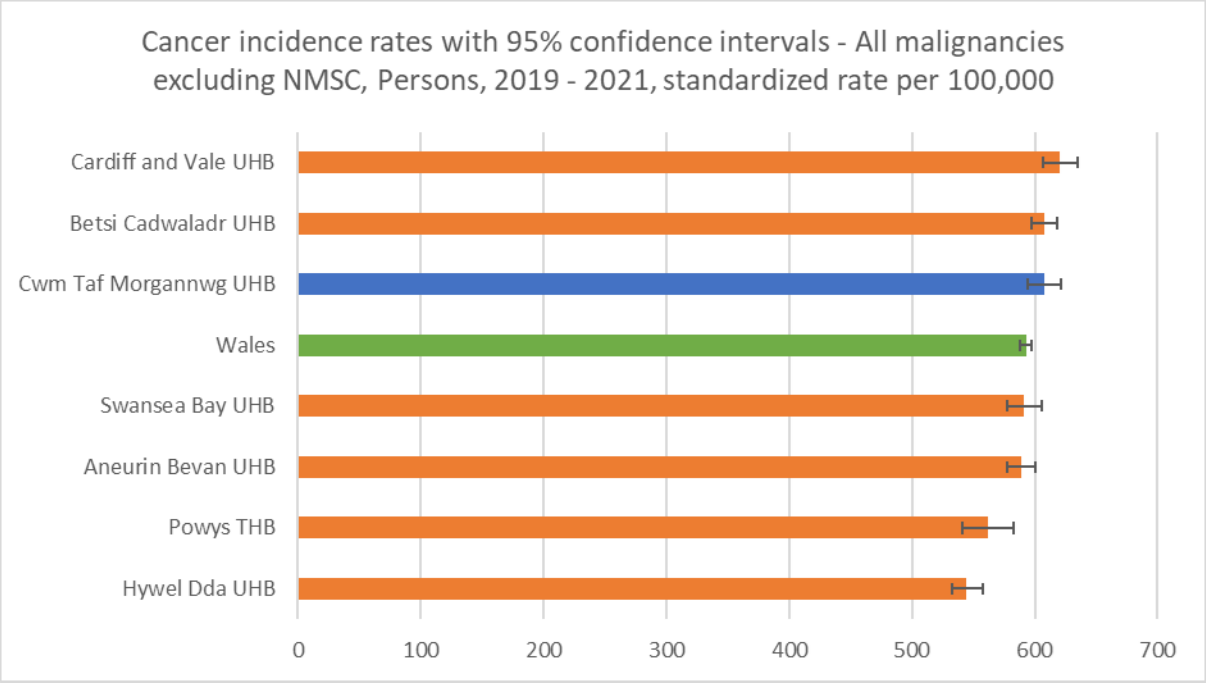
Annual Cancer Report 2024/2025

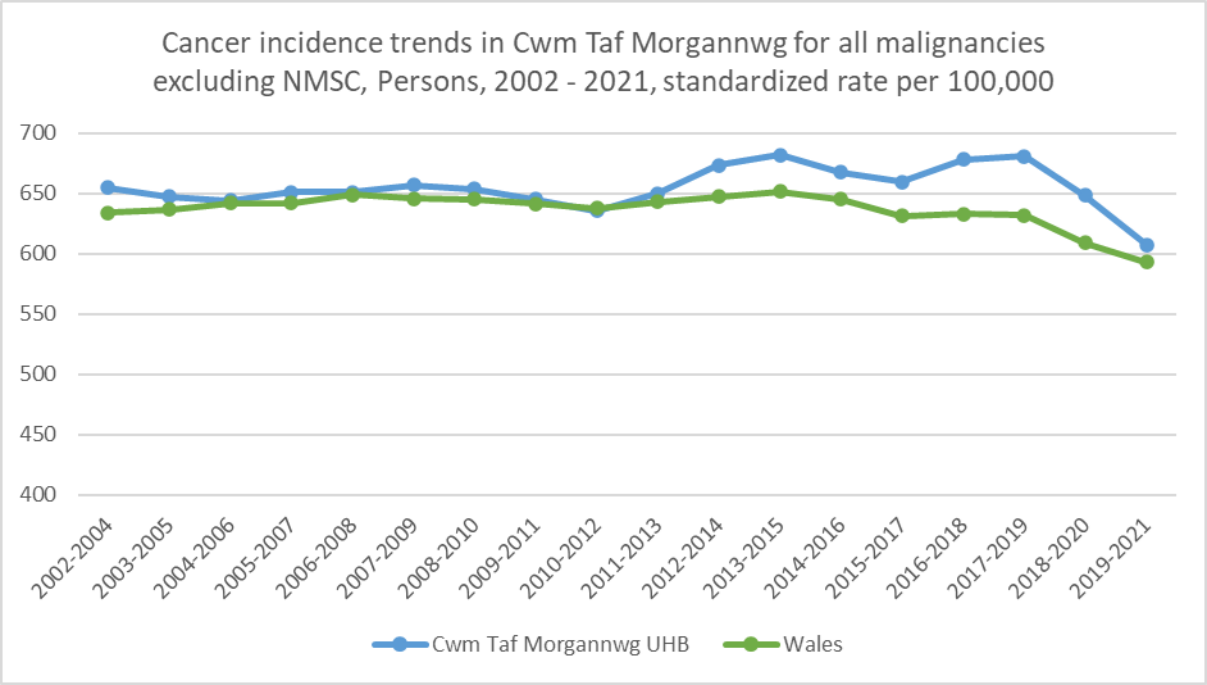
1.0 Introduction

This annual report provides an overview of the challenges faced by our cancer teams, in delivering the National Optimal pathway and our progress made during 2024/2025.

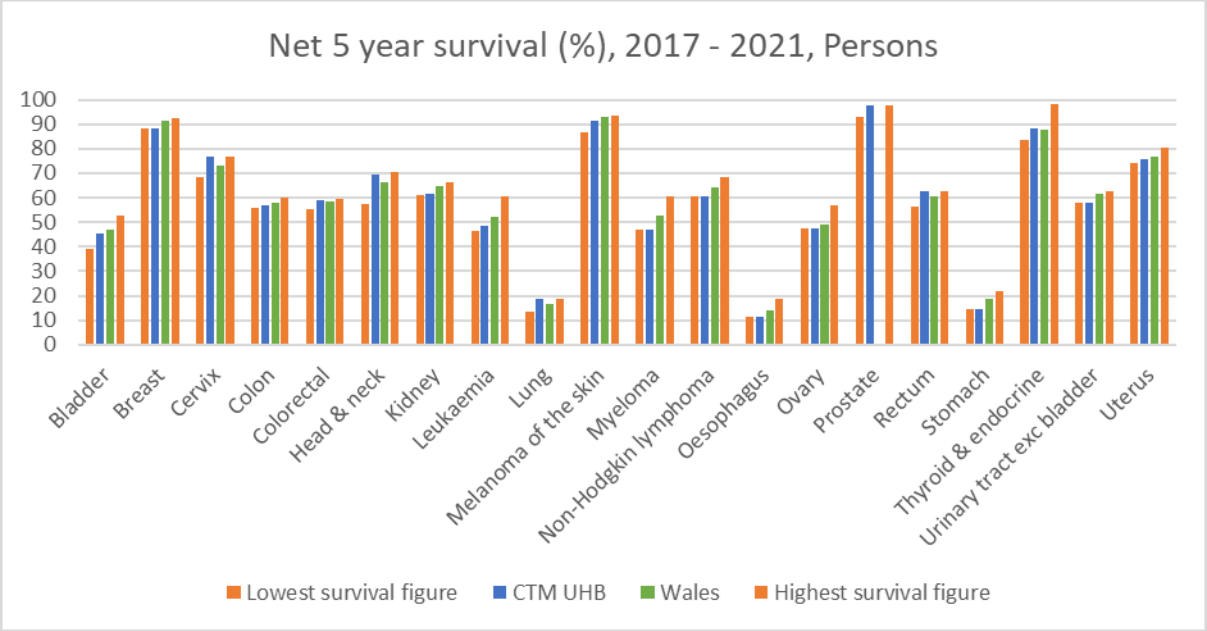
2.0 Cancer landscape across CTMUHB

For noting: Screening data from Bowel Screening Wales has not yet been published by Public Health Wales; as a result, no reports have been included at this time.





Each year around 3,500 people across CTMUHB are diagnosed with cancer. Cancer incidence has remained at a higher rate in CTMUHB than for Wales overall, with the rate for CTMUHB decreasing in the last two periods (2018-2020 and 2019-2021).



The latest published cancer survival figures from WCISU show the long-term historic improvement in five-year net cancer survival for Wales has stagnated

since the 2014-2018 diagnosis period. This stalling in improvement started before the Covid-19 pandemic and has continued beyond it.

All Wales one-year net cancer survival figures stopped improving appreciably each year of diagnosis from 2014 to 2019, then dipped to 71.9% in 2020, the first full year of the pandemic. This improved significantly to 75.2% in 2021 but only returned survival to the pre-pandemic level.

The analysis showed that Cwm Taf Morgannwg survival figures were not statistically different to the all Wales figures for any major tumour site.

3.0 Performance

Whilst now improving, cancer services within CTMUHB were challenged via the ongoing impact and recovery from Covid–19.

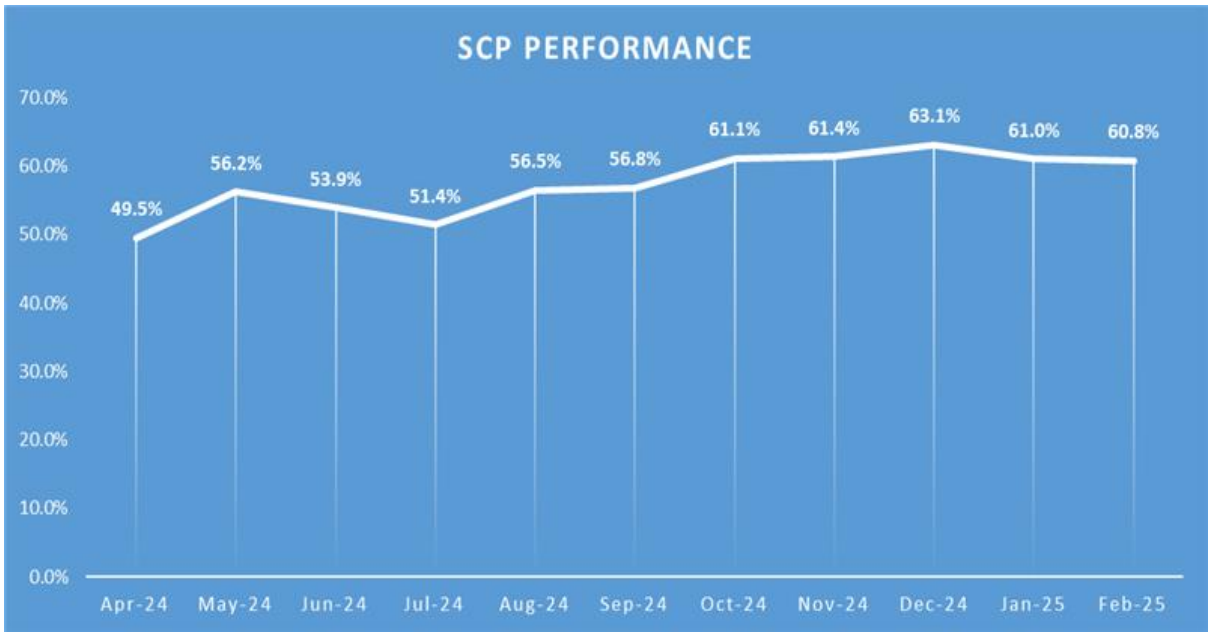
3.1 Referrals

Referral numbers have decreased by 2% over the last 12-month period compared to the previous 12 months. The decrease in referrals seen in Breast services is in part down to border change in the services provided by Swansea Bay UHB and Cwm Taf Morgannwg UHB.

Tumour Site	2023/24	2024/25	Vol Diff	% Diff
Brain/CNS	23	50	27	117%
Breast	5,370	4,079	- 1,291	-24%
Children's	23	40	17	74%
Gynaecological	5,428	5,446	18	0%
Haematological	438	467	29	7%
Head and neck	3,644	4,008	364	10%
Lower GI	5,042	5,372	330	7%
Lung	1,248	1,253	5	0%
Other	3,373	2,079	- 1,294	-38%
Sarcoma	46	78	32	70%
Skin (exc BCC)	5,641	5,463	- 178	-3%
Upper GI	3,187	3,491	304	10%
Urological	4,926	5,717	791	16%
Total	**38,389**	**37,543**	**- 846**	**-2%**

3.2 Cancer Performance

The current CWT target is 75%. The planned care recovery plan established a new target of 80%, to be reached by 2026.

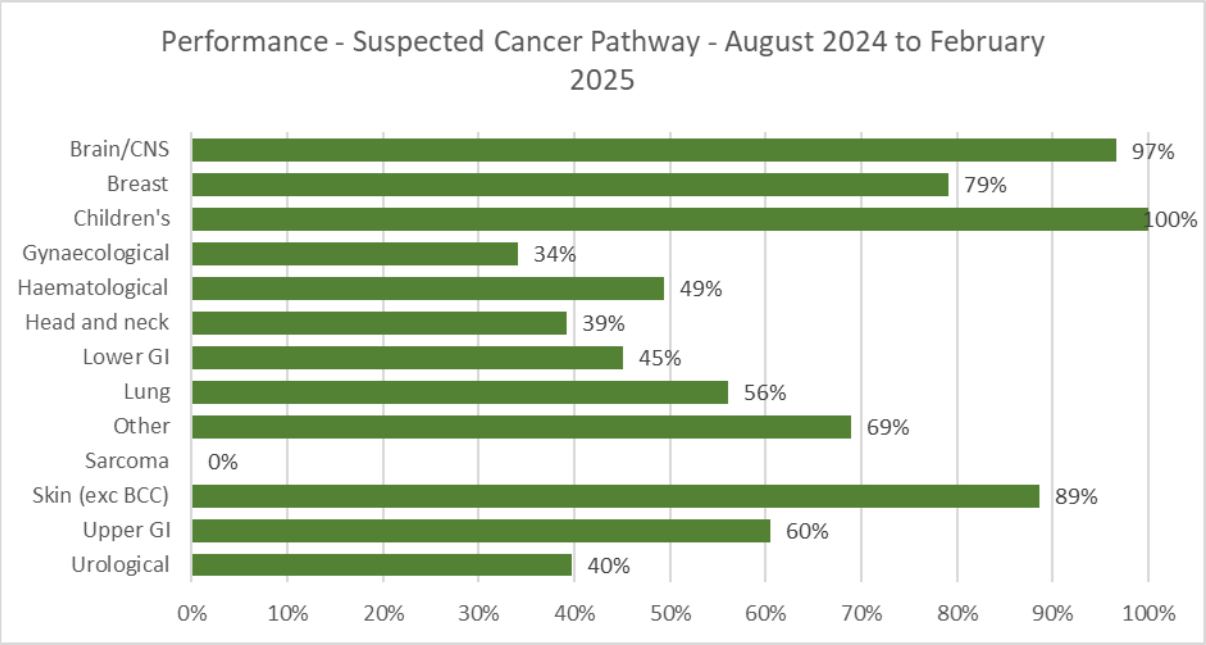


Although there have been great improvements, CTMUHB has not achieved the SCP CWT target in any month over the last 12-month period.

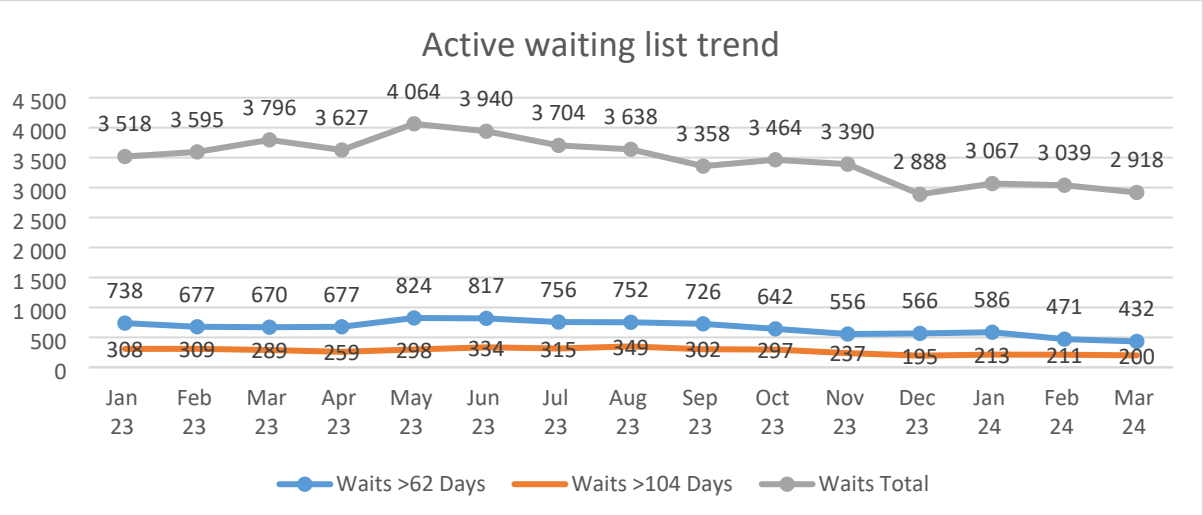
In November 2022 concerns surrounding quality and patient experience were raised by the Minister for Health & Social Services in a number of areas within the HB, cancer being one. Subsequently cancer was placed in targeted intervention. Following improvements seen in cancer performance during 2024/25, CTMUHB has been deescalated from targeted intervention to enhanced monitoring.

CTMUHB's performance has gradually increased over the last 12 months, seeing an increase in performance for the April to February period from 49.5% to 60.8% for 2024/25. In comparison to all other acute HB's throughout Wales, CTMUHB has moved to the third highest average performance for the last 6 months of published data.

Performance - Suspected Cancer Pathway – September 2024 to February 2025	
Betsi Cadwaladr	53.5%
Hywel Dda	52.8%
Aneurin Bevan	61.9%
Cardiff & Vale	68.2%
Cwm Taf Morgannwg	60.9%
Swansea Bay	58.8%
Wales	59.0%



Both the Breast and Skin tumour sites are above the 75% cancer waiting time target. All other tumour sites have failed to achieve it; although performance varies, as illustrated above.



The waiting list and backlog volumes have generally declined over the last 12 months. Bottlenecks specifically at radiology, endoscopy, pathology and specialty specific diagnostics account for the bulk of the diagnostic challenges.

Fundamental to improving cancer performance is investment in diagnostics and the continuation of backlog clearance.

4.0 Quality Assurance of Cancer

4.1 Quality Assurance Framework

The quality assurance framework is available as a dashboard and is reviewed on a quarterly basis, reporting to the cancer programme board. The trends are noted, and an additional deep dive is undertaken when changes are identified. Nothing of concern has been identified.

The annual cancer audits are also reviewed and reported, along with the action plans. These are also discussed at the HB clinical effectiveness meeting.

An annual review of patients who were treated for cancer within 12 months of a cancer downgrade is also undertaken.

There remain challenges around the key worker reporting, following the transition from CANISC. These have been raised with the NHS Executive.

The number of patients who have died on a cancer pathway is also reviewed. Nothing of note.

A Health Board wide cancer patient experience survey has been created on Civica and recently launched; this will give us real time feedback on the services. Complimenting the less frequent National patient experience information.

4.2 Cancer Harm reviews

Since 2023, Welsh Government, no longer require a separate process for cancer harm reviews. Reverting to the standard duty of candour process. In CTMUHB we stopped adding 146-day breaches to Datix in July 2024. The lead cancer nurse is currently working through the historical incidents to ensure there are no cases of harm, prior to closing them. The breaches are routinely reviewed to look for learning and themes, but not added to Datix.

Below is the breakdown of review outcomes since the process started.

Level of harm	No/Low	Moderate	Serious
Total	1028	6	3 (1 no learning)

Following the change of process in July 2024, there have been 115 breaches, 39 pathways went straight to surveillance or hormones.

4.3 Ongoing reviews of CTMUHB organisational cancer risk

Ongoing reviews of the organisational cancer risk continue, and as we make progress with improvements, the risk will be continually reviewed.

4.4 National peer review programme

The skin cancer peer review was positive, actions only required around areas of improvement. An action plan has been produced.

5.0 Workforce

5.1 Macmillan partnership

Macmillan has been undergoing a restructure, they have not been offering any funding since early in 2024.

Posts previously funded by Macmillan and now recruited to.

- Ongoing funding for the welfare benefits advisers
- 1 WTE band 4 urology cancer support worker
- A partnership between Macmillan and Mesothelioma UK for 0.4 TE band 6 mesothelioma CNS

As well as

- Provision of an information pod for Princess of Wales hospital (now fitted).

Several historical Macmillan posts are coming to the end of their funding, with no ongoing funding identified. This includes the cancer Allied health professional lead and the lead cancer clinical psychologist role.

5.2 Maggie's outreach offer

CTMUHB have been working collaboratively with Maggie's (cancer charity) to provide an outreach service on all three sites once a month. The uptake of this offer was limited, but further opportunities will be provided this year. Following a review, it has been decided to offer some fatigue workshops for patients on each acute site. Alongside regular presence (monthly) at the Macmillan information hubs.

5.3 Prehabilitation Team

The prehabilitation team funded via therapies are now in post supporting people diagnosed with cancer to optimise their physical and psychological health prior to surgery. The team consists of a Physiotherapist, Dietitian, Occupational Therapists, two Therapy assistant practitioners and a clinical co-ordinator.

The prehabilitation service continues to expand and is now open to patients with lung, colorectal, UGI, hepatopancreatobiliary (HPB), and gynaecological cancers. To date, the service has received 500 referrals.

The prehab service has completed two research projects, and the fourth phase of the IPREHAB study is due to open shortly.

6.0 Improvement and innovation

Improvement and innovation are crucial in reducing variation across our system and in making strides forward to improve our cancer outcomes. Recently completed and ongoing work streams and projects to support our aims include:

- Two endoscopy theatres within the Vanguard unit at Royal Glamorgan Hospital are now fully operational, helping to offset the capacity lost due to the recent critical incident at Princess of Wales Hospital.
- Task and Finish groups set up for key performance areas within Urology and Endoscopy.
- Tele-dermatology is now live across CTMUHB.
- Expanded USC scanning via Gynae hub by providing sonography training for nurse and consultant within GAU. Subsequently increasing capacity.
- With the support of the CTMUHB Information Team ongoing Business Intelligence improvements are continuing to be made in line with service needs.
- The CANISC replacement Programme is completed from an operational perspective. All CTMUHB cancer MDTs are using the replacement solution.
- The lung health check pilot work has finished, and the reports have been published. The team are currently developing a service specification to guide roll out across Wales, ready for any funding that is agreed.
- In alignment with the Diagnostics Recovery and Transformation Strategy for Wales, we are piloting the 'Capsule Sponge' initiative and continue to receive central funding to support its implementation.
- A local anaesthetic transperineal prostate biopsy machine has been procured for Royal Glamorgan Hospital, enabling sufficient capacity to meet current demand.
- Successful merger of the Colorectal MDTs increasing sustainability and enabling clinical learning across CTMUHB.
- Improved % of patients informed they do not have cancer < 28 days. (67.8% March 2024 to 72.1% in March 2025).
- A sustained focus on the time to first outpatient appointment leading to a significant improvement. (29% being seen within 10 days of date of suspicion of cancer in March 2024 to 46% in March 2025)
- The Breast cancer service has seen a significant increase in performance, primarily by seeing patients quicker in their diagnostic one stop clinics (75% seen by day 29 in March 2024, now 75% are seen by day 14 in March 2025)
- Rollout of digital vetting to more specialties.

7.0 Challenges

There are several long-standing challenges across the HB.

- Achieving the SCP target which is largely attributed to the increased volume of demand and capacity shortfalls in key diagnostic areas.
- Providing a sustainable pathology, radiology, and Endoscopy service (Including Bowel Screening Wales activity). Collectively this relates to workforce, capacity, and demand with both internal and regional solutions required to resolve. The latter forms part of the Welsh cancer improvement plan.
- Achieving performance and backlog clearance in line with target trajectories.

Agenda Item
8.2.5

Quality, Safety & Experience Committee

Bi-Annual Report CTM Radiation Safety Committee

Dyddiad y Cyfarfod / Date of Meeting	20/05/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Sharon Donovan Professional Head of Radiography
Cyflwynydd yr Adroddiad / Report Presenter	Lauren Edwards, Executive Director of AHPs and Health Science
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Lauren Edwards, Executive Director of AHPs and Health Science

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf Morgannwg University Health Board
HIW	Healthcare Inspectorate Wales
IR(ME)R	Ionising Radiation (Medical Exposure) Regulations
LPA	Laser protection advisor
MRI	Magnetic Resonance Imaging

PCH	Prince Charles Hospital
POW	Princess of Wales Hospital
RPSC	Radiation Protection Service, Cardiff
RPS	Radiation Protection Supervisors
RSC	Radiation Safety Committee
US	Ultrasound

1. Purpose

1.1 This report has been prepared to provide the Committee with details of the key matters considered by the Radiation Safety Committee (RSC) at its meeting on 4th April 2025. Minutes are available on request.

1.2 Key highlights from the meeting are reported in section 5.

1.3 The Committee is requested to **NOTE** the report.

2. Specific Matters for Consideration

2.1 CTMUHB RSC is scheduled to meet twice yearly. In 2024/25 the RSC met in February 2024 and then did not reconvene until April 2025, due to changes and subsequent shortages within the radiography management team. During this time assurance was received out of committee.

2.2 As there is now a new management structure in place, with a Professional Head of Radiography and a Radiology Quality Manager, meetings will revert to twice yearly, with the next meeting scheduled for October 2025.

2.3 Aligned to the new management structure, consideration has been given to how the RSC can be improved and the following format change has been suggested, with the RSC being divided into two subgroups.

2.4 Both sub-groups of RSC will follow an Alert, Advise & Assure format. The new format will bring the reports together for each modality in CTMUHB and avoid duplication. It will enable colleagues to attend the group that is most appropriate to them, or both if required. RSC will continue to report into the Quality, Safety & Experience Committee.

2.5 This proposal will be taken through internal governance structures to seek approval of these changes.

3. Highlight Report

Alert / Escalate	There are x2 Statement of Needs (SON) associated to risks in Magnetic Resonance Imaging (MRI) at RGH. These are: SON: 1543 associated Risk 6069 – Lone working in Magnetic RI after 5pm - no waiting area for patient – also hampering patient flow.

	SON: 1555 associated Risk 6137 – x6 access doors into MRI instead of x2 as per Physics guidance. These require urgent attention to mitigate and will be managed at Diagnostics, Therapies, Pharmacy and Sciences Care Group level. There is a requirement to re-establish the Ultrasound Governance Group to oversee and standardise the: • procurement, maintenance and replacement of ultrasound equipment • the establishment and maintenance of ultrasound service standards and the processes of training, supervision and audit • provide assurance on the achievement and maintenance of high levels of competence, performance, patient and staff safety in the use of ultrasound The Terms of reference have been drafted but no Chair identified so the risk will now be escalated through CTM governance structures.
Advise	Mini C Arm, a form of imaging equipment, in surgery in PCH has been out of action for almost 18 months. Imaging alternatives have been used in the interim and plans are now in place to repair by end of May. Training records, entitlement documents and Quality Assurance will be reviewed by the Radiology Quality Manager. The Clinical Engineering service has raised the issue that there is no Laser Protection Advisor in POW. The impact of this along with associated mitigations are being investigated and an update will be provided at the next RSC meeting in October 2025. Ongoing temperature issues in Nuclear Medicine in POW. The impact of which is that if the humidity in the room continues to rise during the warmer weather, the camera is at risk of overheating and subsequently the service will need to cease until resolved. Capital and GE are currently investigating and will advise on the service on the next steps. There is a requirement for the way in which POW orders Iodine 123, for Nuclear Medicine examinations, to change as currently the process used, this makes the service an outlier in South Wales. Presently POW has a SLA with SBUHB, meaning Iodine 123 orders are delivered to SBUHB and then transported onwards to PoW, causing delays in delivery and limiting the numbers of patients seen in a day. Changes to this process, with a proposed merger of Nuclear Medicine at RGH and POW, are

	being considered which will allow POW to directly order from the commercial supplier. Radiation Physics to provide an update on this service at the next RSC meeting. There is currently a lack of Radiation Protection Supervisors (RPS) staff in PCH and RGH, contributing to a poor understanding of IR(ME)R and compliance. The Radiology Quality Manager is currently addressing this issue and working with Cardiff physics to increase RPS staff, ensuring an engaged workforce and a RPS in every area to lead the team. There is a plan in place to send a minimum of two radiographers to the RPS training on May 23rd, which will be hosted at the National Imaging Academy and delivered by Radiation Protection Services, Cardiff. So far, five radiographers from PCH and RGH have expressed interest in attending. The RPS role is essential in ensuring compliance with Ionising Radiations Regulations 2017 by supporting clinical staff in implementing each department's local rules. Consideration for one SLA with a single physics provider to cover all sites in CTMUHB. Work ongoing.
Assure	Radiology Employer's procedures have been merged to form one set for CTMUHB. The Swansea and Cardiff physics teams were both involved in the process. The employers' procedures reflect the Ionising Radiation Medical Exposure Regulations updates which came into effect from 1st April 2025. All were agreed at RSC and subsequently published to the Radiology SharePoint site and sent to applicable staff. Cross site working will be more efficient as staff will work to the same set on all sites. A phased approach to roll these out is underway. PCH are already engaged ahead of an announced Health Inspectorate Wales (HIW) inspection in May.
Inform	Vanguard Theatre in RGH is now operational and Radiology have provided a C Arm from PCH to support the theatre cases. The PCH Radiology C arm that was due for decommissioning has been repaired and has passed all tests so is fully operational in Vanguard. This will assist with patient flow and efficiency in the theatre. HIW inspection due in PCH Radiology general department 20th - 21st May. Self-assessment questionnaire has been submitted, and preparation is underway.

4. Recommendations

4.1 Quality, Safety and Experience Committee are asked to NOTE the report.

Agenda Item
8.2.6

Quality, Safety & Experience Committee

Antimicrobial Stewardship Report – May 2025

Dyddiad y Cyfarfod / Date of Meeting	20/05/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Avril Tucker, Principal Pharmacist for AMS
Cyflwynydd yr Adroddiad / Report Presenter	Hannah Wilton, Director of Pharmacy and Medicines Management
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Dr Dom Hurford, Executive Medical Director

Pwrpas yr Adroddiad / Report Purpose	For noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Antimicrobial Stewardship Group established	20th September 2024	TOR agreed and action log generated (appendix 1 – available on request)
Antimicrobial audit completed across POW, RGH and PCH	11th to 18th November	Action plan created and shared with key stakeholders and discussed at next Antimicrobial Stewardship Group

Antimicrobial Guardian submission	10th January	Both of the entries submitted were shortlisted – Winners announced 9th June
Antimicrobial Stewardship Group Meeting	7th March	Shared audit results and action plan proposal to gain key stakeholder engagement and commitment. Very successful meeting, next meeting 19th June

Acronyms / Glossary of Terms	
POW	Princess of Wales Hospital
RGH	Royal Glamorgan Hospital
PCH	Prince Charles Hospital
RCT	Rhondda Cynon Taf
AMS	Antimicrobial Stewardship
NPI	National Prescribing Indicator
NAP	National Action Plan
AMR	Antimicrobial Resistance
DDD	Defined Daily Dosing

1. Situation /Background

Antimicrobials are critical to maintaining public health in the fight against infection. Through systemic over and inappropriate use of antimicrobials worldwide development of antimicrobial resistance (AMR) poses a significant risk if action is not taken to prevent further development of antimicrobial resistant microbes.

The UK government in response to the threat of AMR has developed a 20-year vision for antimicrobial resistance, setting goals to be delivered via a series of 5-year national action plans (NAP). The current, second NAP focuses on four key themes summarised in figure 1.

Figure 1: *Summary of the 2024 to 2029 NAP*

Operationally theme two 'Optimising the use of antimicrobials' has been targeted as a priority area by the Medicines Management team that specialise in AMR. In order to change the direction of travel this theme will require collaboration with all prescribers across both Primary and Secondary care as well as multiple health care professions.

Within the NAP there are two key aims that directly relate to the activity in theme two:

> Target 4a: by 2029, aim to reduce total antibiotic use in human populations by 5% from the 2019 baseline.
> To make this a measurable metric in Wales the Welsh Health Circular specified Improvement Goal 11a:

Improvement Goal 11a: a reduction in total antimicrobial use in primary care consistent with a trajectory required to achieve a minimum 10% reduction against the 2019/20 baseline by 2029/30. The measure is Defined Daily Doses and will be reported as DDDs/1000 STAR PU.

Figure 2: *Exert from the Welsh Health Circular issued by Welsh Government in response to publication of the second NAP*

Target 4b: by 2029, we aim to achieve 70% of total use of antibiotics from the Access category (new UK category) across the human healthcare system.

Access antibiotics are those with a narrow spectrum of activity, fewer side effects, lower costs, and importantly lower resistance potential[1].

To support delivery of these targets in Wales the All Wales Medicine Strategy Group have developed a series of National Prescribing Indicators (NPIs) which align to the NAP goals:

- Total antimicrobial prescribing
- 4C antimicrobials
- Course duration for respiratory tract antibiotics

2. Specific Matters for Consideration

From a Primary Care perspective CTMUHB continue to be the highest prescribers of antimicrobials in the UK, thus, also the highest prescribers of antimicrobials in Wales, as illustrated in figure 3.

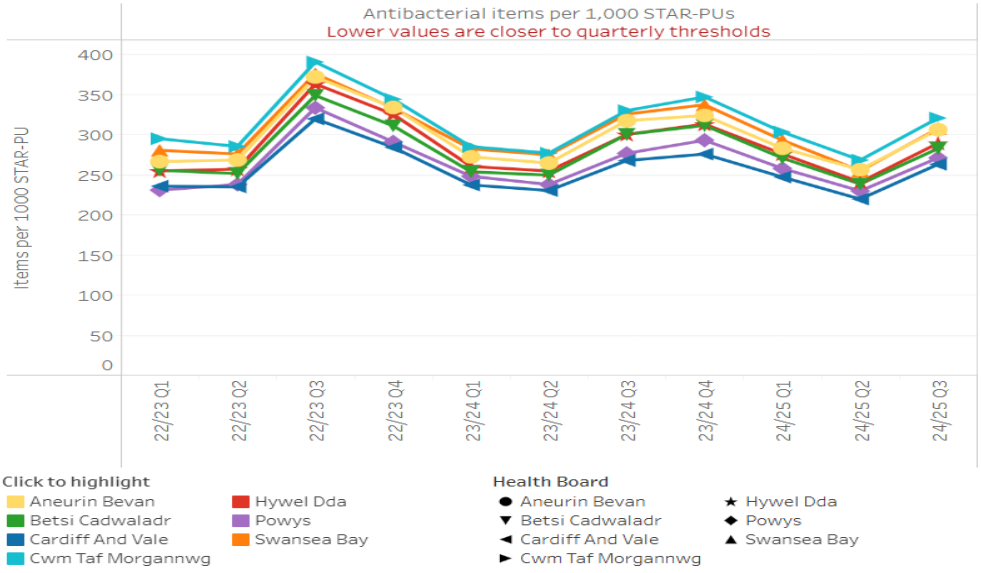


Figure 3: *Comparison of All-Wales anti-microbial prescribing rates in primary care*

[1] UK Access, Watch, Reserve, and Other classification for antibiotics (UK-AWaRe antibiotic classification) - GOV.UK

Whilst figure 3 demonstrates the continuing challenging landscape with high levels of antimicrobial prescribing there has been progress made particularly in primary care over the last 6 months aligned with the new NPIs linked to the NAP targets.

Target 4a progress: Movement to date in Improvement Goal 11a 8.3% vs 10% requirement to be achieved by 2029.

Target 4b progress: The secondary care audit has supported understanding of where current activity levels sit in the Access Category. 4 of the top 5 prescribed antibiotics are from the Access category.

Positively both metrics are showing significant progress over a relatively short time frame. Figure 4 further demonstrates the positive changes being made in secondary care with a visible reduction in total antimicrobial usage.

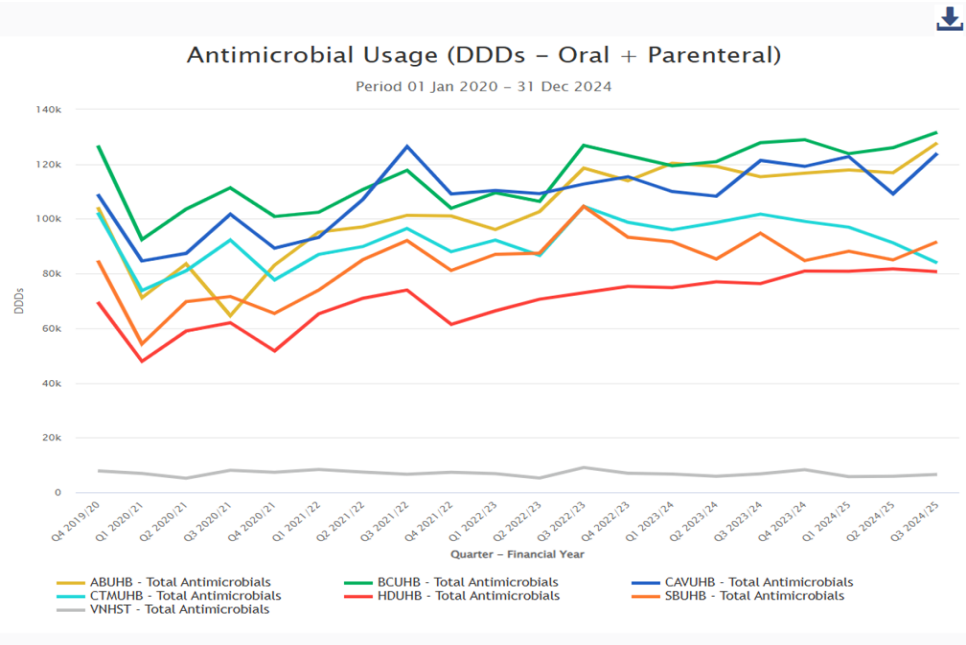


Figure 4: *Comparison of All-Wales anti-microbial prescribing rates in secondary care*

The Primary Care NPIs have shown slower progress and remain the focus for the next 6 months through targeted work in areas of particular challenge. The figures below highlight the NPI data reports:

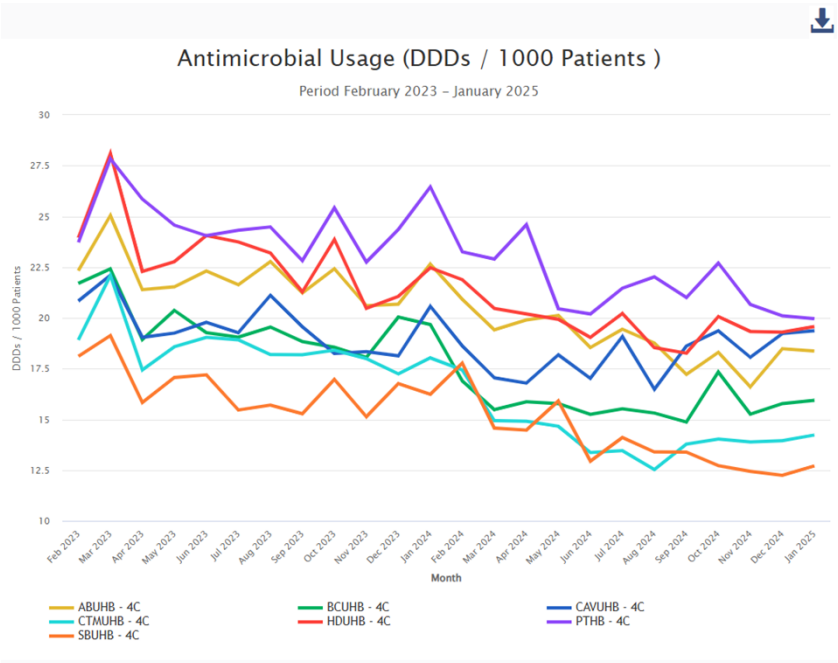


Figure 5: *NPI Report Highlighting 4C antimicrobials usage for CTM Primary Care DDDs/1000patients*

CTM performing favourably on total 4C antimicrobial prescribing compared to other LHBs in Wales in figure 5. Plateau in momentum in recent months demonstrating area of opportunity to be addressed in coming months through the Antimicrobial Stewardship Group and collaboration with the Primary Care Medicines Management Team.

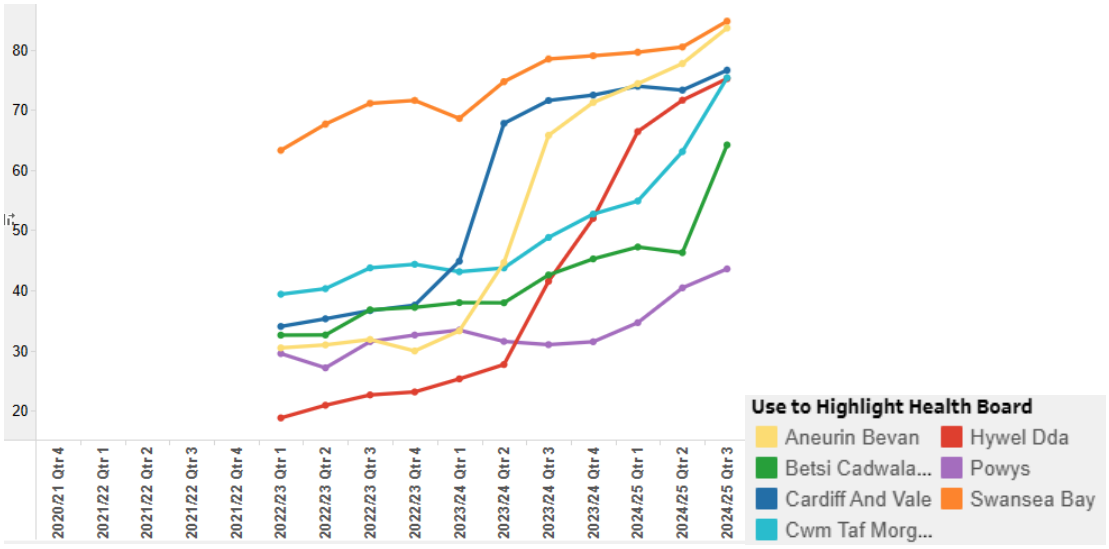


Figure 6: *All Wales NPI Report Highlighting the Percentage of Amoxicillin Prescriptions issued in line with recommended guidelines for treatment duration for respiratory tract infections*

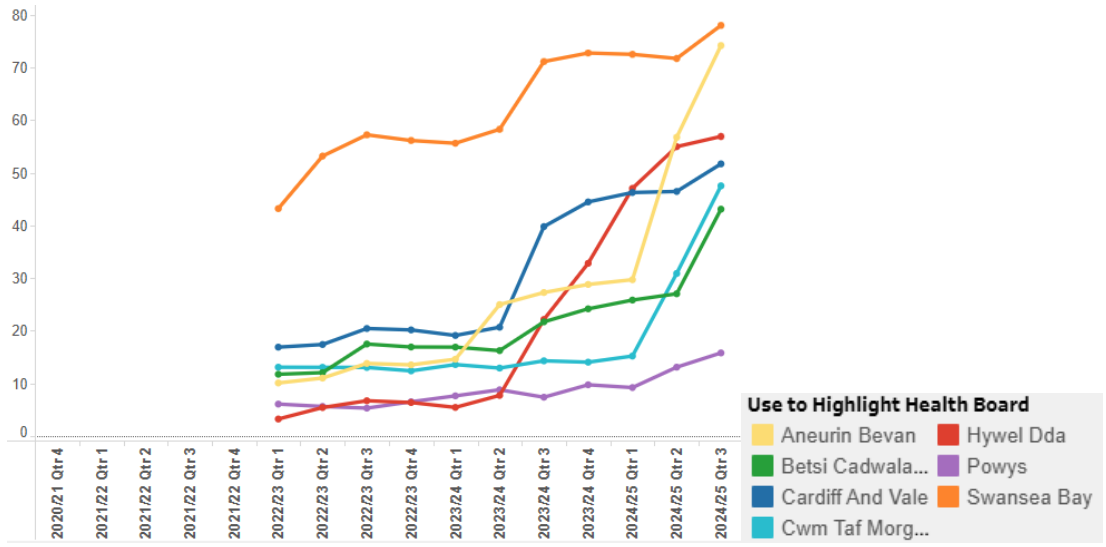


Figure 7: *All Wales NPI Report Highlighting the Percentage of Doxycycline Prescriptions issued in line with recommended guidelines for treatment duration for respiratory tract infections*

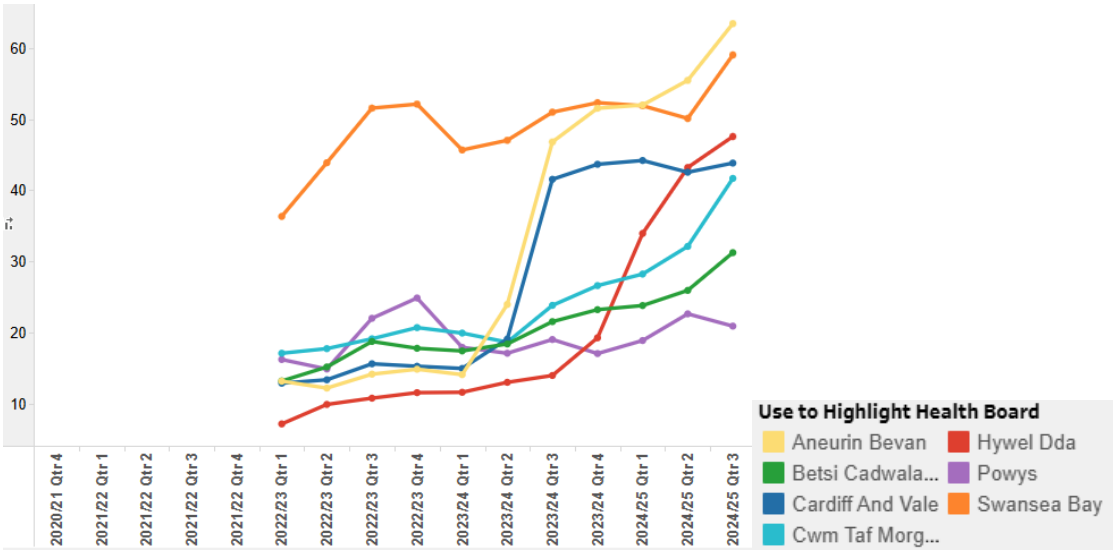


Figure 8: *All Wales NPI Report Highlighting the Percentage of Clarithromycin Prescriptions issued in line with recommended guidelines for treatment duration for respiratory tract infections*

Figures 6-8 are all showing the same positive trend in significantly improved prescribing patterns for key respiratory tract infection antibiotics in Primary Care. It should not be underestimated the number of prescribers driving this data and the volume of stakeholders needed to be engaged to bring about this change. Actions taken have driven results and we will continue with our action plans and monitor performance to ensure the change is maintained.

Movement against these metrics will support the NAP through reduction of the total antimicrobial usage figures as treatment duration in guidelines is shorter compared to what has more traditionally been prescribed (for example a 5 day duration is recommended for amoxicillin in upper respiratory tract infections over the commonly prescribed 7 day duration).

3. Key Risks / Matters for Escalation

The Antimicrobial Stewardship Group was established in September 2024 and terms of reference set out to meet bi-monthly. The subsequent meetings were delayed due to the operational challenges that occurred with the roof situation in POW. The group met again in March this year and have agreed to meet quarterly going forward. This has been altered from the original frequency set out in the terms of reference to align with the release of NPI data in Primary Care.

The second meeting of the Group in March 2025 was well represented by key Medical Stakeholders and appropriate Directors. This was essential for stakeholder agreement on issues raised by the Medicines Management AMR specialist team members to drive key actions across multiple Care Groups.

The outputs of the secondary care AMR audit were shared, and key findings were agreed to be disseminated at the directorate meetings so any missing medical attendees will be captured.

4. 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: Sustaining our Future
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Ageing Well
	If more than one applies please list below: Growing well
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: Data to knowledge Learning, improvement & research

Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Effective
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	Yes - Reduce
	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: All educational slides have had their titles translated to Welsh throughout the presentation.
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.	

5. Recommendation

The committee is asked to **NOTE** the progress made to date

6. Next Steps

The CTM AMR strategy has been established with direct correlation to the National Action Plan (NAP).

A robust action plan has been generated to support the outputs of the Antimicrobial Audit completed in Secondary Care at the end of 2024 and progress will be monitored at each appropriate Antimicrobial Stewardship Meeting.

Review of the National Prescribing Indicator data indicates progress in key Antimicrobial areas and further work is planned to take place across this new financial year with particular focus on Primary Care Prescribing.

Agenda Item
8.2.7

Quality, Safety & Experience Committee

OUTCOME REPORT: QUALITY, SAFETY & EXPERIENCE COMMITTEE EFFECTIVENESS SURVEY

Dyddiad y Cyfarfod / Date of Meeting	20/05/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Emma Walters, Head of Corporate Governance & Board Business
Cyflwynydd yr Adroddiad / Report Presenter	Carolyn Donoghue, Committee Chair/Independent Member
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	

1. PURPOSE

1.1 The Chair of the Quality, Safety & Experience Committee is required to present an annual report outlining Quality & Safety business through the financial year to the Health Board to provide an assurance on the monitoring and scrutiny undertaken of Cwm Taf Morgannwg University Health Board (CTMUHB) performance in relation to Quality & Safety. As part of this process the Committee are required to undertake an annual self-assessment questionnaire.

1.2 Members of the Quality, Safety & Experience Committee are asked to discuss and review the Committee self-assessment questionnaire relating to the activities and performance of the Quality, Safety & Experience Committee during 2024/2025.

1.3 Members should note 10 out of a possible 26 responses were received. Therefore the summary in section 2 is in the context of those who responded.

2. SUMMARY REPORT

Positive Assurance	**1. Committee Effectiveness:** The majority of Members/Attendees were aware that: • There were approved Terms of Reference in place defining the role of the Committee which were reviewed annually. **2. Committee Business** There was a clear consensus that Members/Attendees considered that: • The Committee had been provided with sufficient authority and resources to perform its role effectively; • The Committee has an established Cycle of Business which was dealt with across the year; • The Committee met sufficiently frequently to deal with planned matters and with sufficient time allowed for questions and discussions; • The atmosphere at Committee meetings were conducive to open and productive debate; • The behaviour of all Members/attendees was courteous and professional; • In Committee meetings were convened throughout the year to assist with timeliness of information flows and it was felt that these were used appropriately for items that should not be discussed in the public domain; • It was felt that the Committee meetings had been chaired effectively and with clarity of purpose and outcome;

	• It was felt that through the Committee Highlight Report to Board, the Committee Chair provided clear and concise updates on the activities of the Committee and escalated areas of concern as appropriate; • It was felt that the Committee had been appropriately supported by Executive Director leads in terms of attendance, quality of papers and in their response to challenge and scrutiny.
Areas Requiring Further Assurance	**1. Committee Business** • Whilst the majority of Members were aware that the Committee prepares an annual report on its work and performance in the preceding year for consideration by the Health Board, two responders stated that they were unsure as to whether an annual report had been prepared; • Whilst the majority of members/attendees felt that each agenda item was **closed off** succinctly, one responder advised that they felt that there were occasions where items had not been closed off with requests made for follow up reports to be presented. The responder felt that it would be more appropriate for follow up reports to be presented only when the reported position had changed; • **Welsh Language** at meetings. There was a mixed response, however, overall Members would only welcome greater use of the Welsh Language at meetings, if there was a requirement due to a member/attendee stating this as their preferred language choice; • Whilst the majority of members/attendees felt that **virtual meetings** had overall been a positive experience in that it had allowed meetings to continue to ensure robust scrutiny, some members/attendees considered that virtual meetings had not been a positive experience, with one responder indicating that they would prefer for at least one in person meeting to be held; • Whilst the majority of members/attendees felt satisfied that **boundaries** between this Committee and other Committees were clearly defined with appropriate **cross-referral** if required, one responder indicated that they would welcome further clarity/guidance as to what would instigate a cross committee referral; • Whilst the majority of members/attendees felt that they did not require any **additional training** to fulfil their role, some responders indicated that they would welcome further training, particularly to allow for self-assessment against best practice, with guidance and mentorship being particularly beneficial for new members of the committee with regard to relevance of questioning and information; • Regarding general comments received, it was felt that greater clarity was required in regard to the need for clear reporting of strategic Health &

	Safety and Estates matters through the relevant Board Committee structures.
Areas Requiring Further Action	**Committee Business** • **Committee Annual Report –** Explore the possibility of including the Committee Annual Report on the main agenda for discussion as opposed to the consent agenda to improve visibility; • **Closing off agenda items –** The Chair to identify in their conclusion of each item as to whether a further follow up report is required and the suggested timelines for reporting back to Committee; • **Face to Face meetings –** Explore the possibility of re-introducing at least one face-to-face meeting throughout the year. It has previously been suggested by the Committee Chair that we hold one meeting per year as an in-person meeting with an option to join the meeting virtually for members/attendees who are unable to attend in person; • **Cross Committee Referrals/Additional Training –** Consideration to be given to providing members and attendees with more guidance and training on cross committee referrals and providing guidance and mentorship to newer members of the Committee to help them undertake their role efficiently; • **Reporting of Health & Safety & Estates matters** – Further discussion required with the Executive Team/Corporate Governance Team as to the appropriate governance routes for the reporting of Health & Safety & Estates matters.
Action Plan	• Committee Annual Report to be placed on main agenda for discussion; • Explore the possibility of holding one meeting per year as in person meetings with Teams option available for those unable to attend face-to-face; • Discussion to be held with Committee Chair regarding points made regarding the process of ensuring agenda items were being closed off appropriately; • Consideration to be given by the Corporate Governance Team as to raising awareness of the cross-committee referral process and strengthening the guidance and mentorship being provided to newer members of a Committee; • Discussion to be held with the Executive Team in regard to the governance routes for the reporting of Health & Safety & Estates matters.
Appendices	Nil

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	Living Well 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))*	Learning, Improvement & Research 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))*	Safe If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable 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: Not applicable
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):	If no, please include rationale below: Not applicable

	POSITIVE/NEUTRAL NEGATIVE	
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.	

1. Recommendation

1.1 The Committee are requested to **DISCUSS** and **NOTE** this report.

2. Next Steps

2.1 The actions outlined within the report will be taken forward by the Corporate Governance Team.

Agenda Item
8.2.8

Quality, Safety & Experience Committee

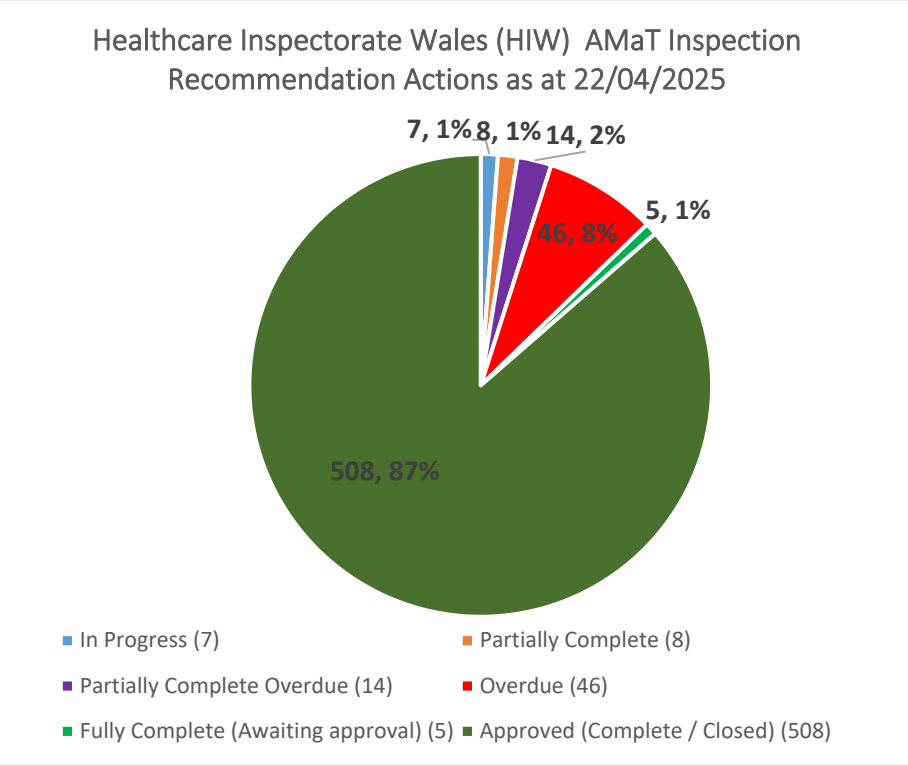
HEALTHCARE INSPECTORATE WALES IMPROVEMENT PLAN TRACKER REPORT

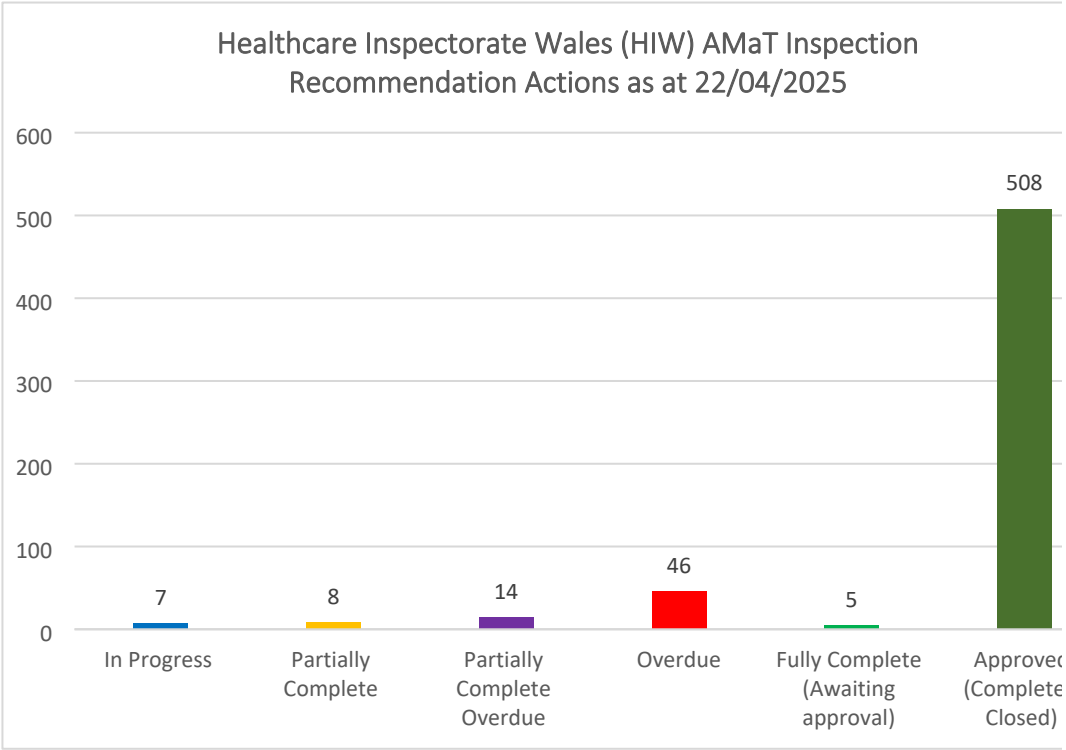
Dyddiad y Cyfarfod / Date of Meeting	20th May 2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Claire Brown- Head of Quality Assurance and Compliance
Cyflwynydd yr Adroddiad / Report Presenter	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

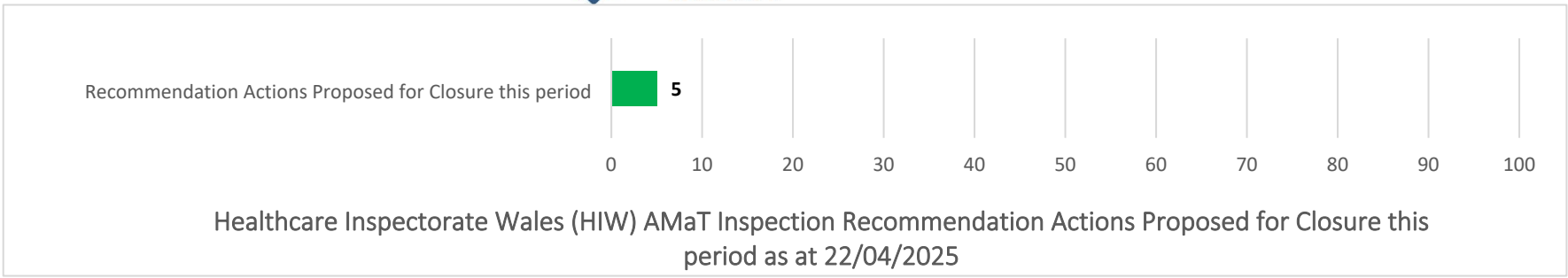
Pwrpas yr Adroddiad / Report Purpose	For Noting

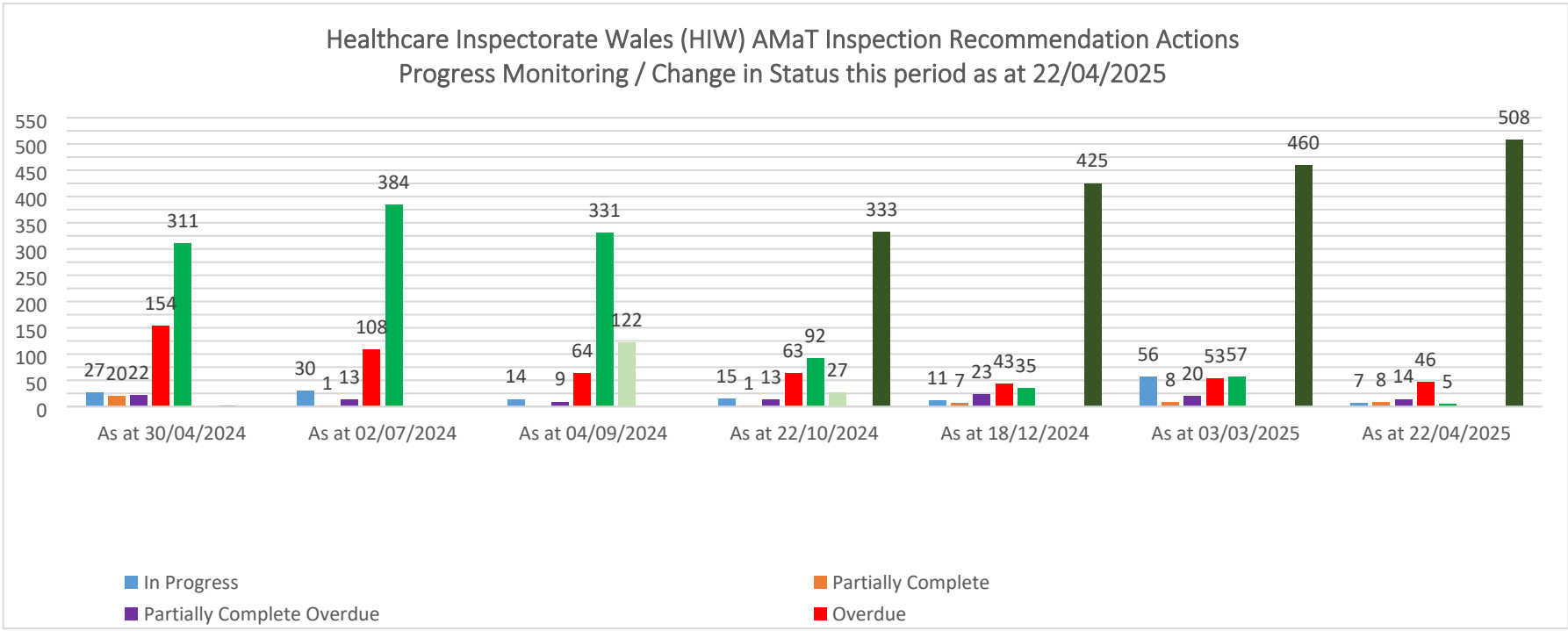
Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
HIW	Healthcare Inspectorate Wales
AMaT	Audit Management and Tracking


Healthcare Inspectorate Wales (HIW) AMaT Inspection Recommendation Actions as at 22/04/2025
7, 1%
8, 1%
14, 2%
5, 1%
46, 8%
508, 87%
In Progress (7)
Partially Complete (8)
Partially Complete Overdue (14)
Overdue (46)
Fully Complete (Awaiting approval) (5)
Approved (Complete / Closed) (508)


Healthcare Inspectorate Wales (HIW) AMaT Inspection Recommendation Actions as at 22/04/2025
600
500
400
300
200
100
0
7
8
14
46
5
508
In Progress
Partially Complete
Partially Complete Overdue
Overdue
Fully Complete (Awaiting approval)
Approved (Complete Closed)


Recommendation Actions Proposed for Closure this period
5
0
10
20
30
40
50
60
70
80
90
100
Healthcare Inspectorate Wales (HIW) AMaT Inspection Recommendation Actions Proposed for Closure this period as at 22/04/2025


Healthcare Inspectorate Wales (HIW) AMaT Inspection Recommendation Actions Progress Monitoring / Change in Status this period as at 22/04/2025
550
500
450
400
350
300
250
200
150
100
50
0
27 2 0 22 154 311
30 1 13 108 384
14 9 64 331 122
15 1 13 63 92 27 333
11 7 23 43 35 425
56 8 20 53 57 460
7 8 14 46 5 508
As at 30/04/2024
As at 02/07/2024
As at 04/09/2024
As at 22/10/2024
As at 18/12/2024
As at 03/03/2025
As at 22/04/2025
In Progress
Partially Complete
Partially Complete Overdue
Overdue

1. Situation /Background

1.1 The purpose of this report is to update the Quality, Safety & Experience Committee on progress against the open actions held on the Healthcare Inspectorate Wales (HIW) tracker of the accepted Improvement Plan(s) submitted to HIW following their Inspection(s) across the organisation for the timeframe from 3rd March 2025 until 22nd April 2025.

2. Specific Matters for Consideration

2.1 The HIW tracker continues to be a live document and each iteration evolves as actions are completed or the date surpasses as well as following the submission and acceptance by HIW of new inspection improvement plans. Therefore, members will note some changes and progress on the actions which remain as open as they transition to closed/completed actions throughout this and future reports.

2.2 All open and live HIW inspection improvement plans continue to be recorded on AMaT. It was decided that Death in Custody Reports should not be included in the QSEC report since the reports are not as a result of inspection nor do Healthcare Inspectorate Wales ever inspect the prison services. The reports from Death in custody reports and the recommendations will continue to be added to AMaT to maintain good governance in terms of tracking and assurance. These will be updated by the team and oversight will sit with the Nurse Director for Primary Care and Communities. Work continues with the Quality Assurance and Senior management team of the Prison service to document, track and manage updates of recommendations and actions via AMaT. These figures no longer contribute to the data collected for this report however continue to be tracked and managed.

2.3 Manual Manipulation of the AMaT report continues to be a requirement whilst system development continues with the developers. The team continuously review the system and look for work arounds that would improve the governance of outstanding actions.

2.4 Care Group Leads have demonstrated engagement in completing progress updates independently prior the deadline for this report as well as in cleansing the historical inspections and actions, however we note that there continues to be outstanding and overdue actions that have not been updated. For actions who have missed more than one update the Quality Assurance and Compliance Team actively engage with the Care groups to encourage them to update any progress or delegate responsibility as appropriate.

2.4 The Head of Quality Assurance and Compliance and Assistant Director of Governance and Risk attended the Executive Nurse Huddle recently to highlight the most common questions and concerns that users of AMaT encounter when attempting to update the actions. Individual training or help was offered as well as the offer to attend senior nurse meetings to provide a short training session on the logistics of AMaT following the produced "How to" guide for users.

2.5 A breakdown of the status position with regards to all actions up to the 24th April 2025 is detailed below.

- A total of **588 actions** are reported with a further breakdown of the stages towards compliance reported in *table 1* located in the dashboard at the beginning of this report.
- **508** Actions were Fully complete, approved and closed with a further **5** actions fully complete and awaiting approval

2.6 **New Inspections / Actions**

- There were **0** new Improvement Plans and **0 new** actions added this period.

3. Key Risks / Matters for Escalation

3.1 It is anticipated that as a result of the awareness raised within the Executive Nurse huddle that further engagement with teams will continue over the following weeks. The Head of Quality Assurance and Compliance is actively encouraging engagement from Care groups and offering one to one sessions for those who may need more support in updating the actions they are assigned to.

3.2 AMaT as a system was developed for all team members to have easy access to update their own actions. This works well in that function however as previously mentioned, there is no ability currently to restrict changes to the original format of the inspection actions. In an attempt to mitigate this risk, the Quality Assurance and Compliance team monitor for any changes and regularly remind users not to change any other areas of the report. A step by step help guide was developed and shared with each team which takes the users through how to input an update on the system.

3.3 System development requests form part of AMaT's forward development plan but we do not yet have an indication on the timescale. The Head of Quality Assurance and Compliance continues to liaise with other Health Boards in Wales to gather support and share experiences on the use of

AMaT for this purpose and gain further support for system development requests.

4. 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	Living Well
	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-acten.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))*	Whole-systems Perspective
	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))*	Effective
	If more than one applies please list below: Efficient, Equitable, Safe, Timely
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd	Yes: ☐	No: ☒
Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Outcome:	If no, please include rationale below: N.A

Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: N.A
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.	

5. Recommendation

5.1 The Quality, Safety & Experience Committee are asked to **NOTE** the contents of this report and the activity underway to progress the actions outstanding and ongoing within the improvement plans across the Health Board following HIW Inspections.

6. Next Steps

6.1 The Head of Quality Assurance and Compliance will continue to work with Care Group Leads in order to provide assurance of the Health Board's engagement and compliance with HIW recommendations and Improvement Plans.

HIW Inspection Recommendations Tracker
Leads as at 22/04/2025

Inspection Code	Title	Date of Inspection	Recommendations	Actions	Care Group & DoN Lead
Healthcare Inspectorate Wales (HIW)/2017/141	National review of Ophthalmology Services	30/01/2017	22	22	**Planned Care** Sharon O'Brien, Nurse Director
Healthcare Inspectorate Wales (HIW)/2020/139	Quality Check Summary Ysbyty Cwm Rhondda [Ysbyty Cwm Rhondda - Ward A1 (Ref: 20030)]	08/09/2020	2	2	**Primary Care & Community** Lucie Owen, Nurse Director
Healthcare Inspectorate Wales (HIW)/2021/137	National Review of Mental Health Crisis Prevention in the Community	30/06/2021	17	18	**Mental Health & Learning Disabilities** Ana Llewelyn, Nurse Director
Healthcare Inspectorate Wales (HIW)/2022/131	Hospital Inspection (Announced) Princess of Wales Hospital – Maternity Services [Appendix C - POW Maternity Unit (Ref: 21233)]	22/03/2022	7	7	**Children & Families** Suzanne Hardacre, Director of Midwifery
Healthcare Inspectorate Wales (HIW)/2023/130	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	07/03/2023	39	180	**Mental Health & Learning Disabilities** Ana Llewelyn, Nurse Director
Healthcare Inspectorate Wales (HIW)/2023/134	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix A - Immediate Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	31/07/2023	2	2	**Unscheduled Care** Emma James, Nurse Director
Healthcare Inspectorate Wales (HIW)/2023/140	HMP Parc Prison	16/05/2023	7	7	**Primary Care & Community** Lucie Owen, Nurse Director
Healthcare Inspectorate Wales (HIW)/2023/155	National Review of Patient Flow - a journey through the stroke pathway	07/09/2023	50	50	**Unscheduled Care** Emma James, Nurse Director
Healthcare Inspectorate Wales (HIW)/2023/157	Appendix C - Improvement Plan: Angelton Clinic, Glanrhyd Hospital (Ref: 03445)	13/11/2023	25	26	**Mental Health & Learning Disabilities** Ana Llewelyn, Nurse Director
Healthcare Inspectorate Wales (HIW)/2023/167	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	31/07/2023	31	36	**Unscheduled Care** Emma James, Nurse Director
Healthcare Inspectorate Wales (HIW)/2024/165	Appendix B Immediate Improvement Plan_PCH Maternity Unit_9-11 January 2024 (Ref: 03600)	09/01/2024	2	27	**Children & Families** Suzanne Hardacre, Director of Midwifery
Healthcare Inspectorate Wales (HIW)/2024/166	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	09/01/2024	14	36	**Children & Families** Suzanne Hardacre, Director of Midwifery
Healthcare Inspectorate Wales (HIW)/2024/235	Hospital Inspection Report (Unannounced) Coity Clinic, Princess of Wales Hospital_Appendix C - Improvement Plan_13, 14 and 15 November 2024 (Ref: 03710)	13.11.2024	27	46	**Mental Health & Learning Disabilities** Ana Llewelyn, Nurse Director

AMaT Recommendation Actions - Status Key

In progress	**Inspection action is in the process of being completed and has not yet reached the deadline.**
Partially complete	**Inspection action is in progress and some of the recommendations have been completed. The deadline has not yet been reached.**
Partially complete (Overdue)	**Inspection action is in progress and some of the recommendations have been met. The deadline has been reached and is now overdue.**
Overdue	**Inspection action deadline has been reached and no recommendations have been completed.**
Fully complete (Awaiting approval)	**Inspection actions have been fully completed and are waiting to be approved to be closed.**
Fully complete (Approved)	Inspection actions and all recommendations have been fully completed, approved and closed. These are not shown on this HIW Inspections Tracker but can be viewed within AMaT.

HIW Inspections Recommendation Actions Tracker as at 22/04/2025
(for Quality, Safety and Experience Committee 20/05/2025)

Inspection Code	Date of Inspection	Inspection Title	Recommendation	AMaT Reference Number	Action	Care Group	Original Due Date	Current / Revised Due Date	Progress Status	Comments/Updates	Barriers	Evidence
Healthcare Inspectorate Wales (HIW)/2017/141	30/01/2017	National review of Ophthalmology Services	Issues relating to patient referral process. All parties (Welsh Government, NWIS, Ophthalmology Planned Care Board and Health Boards) must work together towards the introduction of electronic patient record/referral system from optometrists directly to secondary care.	Healthcare Inspectorate Wales (HIW)/2017/141/MD1/1	Roll out of OpenEyes has been delayed nationally. Primary Care have worked with the programme team to provide contact details for all optometrists requiring access/relevant training. Enhanced support has been offered by the HB ICT programme and projects team to implement OpenEyes, the national electronic patient record/referral system for eye care which will support closer and integrated working across care settings. A task and finish group has been established, with the clear objective of implementing the system in glaucoma clinics in the UHB's hospitals by the end of March 2023. The programme plan is to then implement e-communications (including e-referrals) between primary and secondary care as stage 2 and to roll out to the other sub specialities in Ophthalmology as stage 3. These are in the local and national plans to be undertaken in the financial year 2023/24. Programme management support has been provided by WG for the 15 months from Jan 2023 to March 2024.	Planned Care	01.03.2023	31.12.2025	Partially complete	April 2025 Update - No update against this recommendation action has been received on this occasion. February 2025 Update - No further development to what already implemented within primary care. Dec 2024 Update - Stage 1 is complete, further stages on hold due to delayed national DHCW digital programme rollout - E-referral system (ERS) has returned to tender stage of national procurement. Dept working with IG leads on identifying clinician/consultant Ophthalmology SRO to help drive this, need to identify HB/Digital representation on DHCW national EPR/ERS meetings and ensure feedback to Ophthalmology. 100% of HB primary care optometrists issued NHS email addresses (91% live) with new shared secretarial inbox at RGH to receive urgent referrals (from primary care [GP & optometry] & A and E) launching Jan 2025 (fax line being discontinued) until ERS in situ. Dept continue to attend DHCW workshops to contribute to national ERS design. Due to significant national programme delays, a revised implementation date of 31/12/2025 is required.	Significant delays to national DHCW ERS programme rollout, still in tender stage with no publication of awarded contract as yet.	20241213120058_0168142024.pdf
Healthcare Inspectorate Wales (HIW)/2017/141	30/01/2017	National review of Ophthalmology Services	Lack of feedback provided to optometrists following referral and discharge of patients (Patient Referrals – Communication Following referral) (Discharge patient – Quality of information) C) Health boards/Welsh government must ensure that systems are introduced to improve the amount of information available to optometrists in relation to patients who have been discharged from secondary care.	Healthcare Inspectorate Wales (HIW)/2017/141/MD8/1	The implementation of Open Eyes will provide optometrists with access to patient information that will promote, simplify and improve the quality of referrals and allow optometrists to have sight of all patient data/results/notes to support management of the patient following discharge.	Planned Care	01.04.2024	31.12.2025	Partially complete	April 2025 Update - No update against this recommendation action has been received on this occasion. February 2025 Update - No further update from secondary care. Dec 2024 Update - completion delayed due to national DHCW digital eye care programme rollout delays. EPR implemented in community glaucoma pathway, practices provided with detailed case note/discharge summaries, allowing seamless transfer of care. New primary care optometry contract has defined new national datasets and discharge summary templates mandating minimum data standards on discharge to Optometry - to be implemented in CTM glaucoma, medical retina, and eye casualty pathways (by March 2025). National DHCW work ongoing to provide primary care optometrists with access to WCP (no published timeline). Due to national delays in EPR implementation, a revised due date of 31/12/25 is required.	National/DHCW Eye Care Digitisation programme setbacks delaying local implementation of EPR across both primary and secondary care.	
Healthcare Inspectorate Wales (HIW)/2017/141	30/01/2017	National review of Ophthalmology Services	Concerns around set monitoring for follow-up patients (Treatment Timescale – Targets) A) The Welsh Government should ensure that Patient Administration Systems are capable of providing data on clinician recommended follow-up interval and actual follow-up interval by care pathway.	Healthcare Inspectorate Wales (HIW)/2017/141/MD10/1	Documents and resource related to FUNB patients are shared between the business Informatics and Directorate Management Team by mean of daily downloads. There are a number of status updates reports to include: Total number waiting Patients past target date Patients with a target date Partial booking PIFU Patients with appointments cancelled	Planned Care	01.04.2024	01.04.2024	Partially complete (Overdue)	April 2025 Update - No update against this recommendation action has been received on this occasion. Feb 2025 Update - All clinicians aware of FUNB and discussed collectively at weekly RTT meetings. Health Board strategy being developed to manage patients backlog. KJ 27/2/25 Dec 2024 Update - Service Manager continuing with regular FUNB updates at weekly RTT meetings. Approval for closure to be reviewed at Care Group SMT 23/12/24.		
Healthcare Inspectorate Wales (HIW)/2017/141	30/01/2017	National review of Ophthalmology Services	Concerns around set monitoring for follow-up patients (Treatment Timescale – Targets) B) Health Boards must ensure that care is provided for those (new or follow-up patients) with the greatest health need first, making most effective use of all skills and resources available.	Healthcare Inspectorate Wales (HIW)/2017/141/MD11/1	Patients on the FUNB and New list are all given a HRF and target date. When booking clinics the booking office will filter by target date and HRF ensuring that patients are booked into the most appropriate sub-specialty clinic by priority status. However, we continue to hold significant risk with the FUNB cohort and further resource in terms of validation and capacity is required.	Planned Care	01.04.2024	01.06.2025	Partially complete	April 2025 Update - No update against this recommendation action has been received on this occasion. Feb 2025 Update - All Medical Retina injection FUp's are given dates before leaving clinic to eliminate this high risk cohort of patients (None of this cohort will go on a FUNB). Health Board Strategy being developed to manage backlog KJ 27/2/25 Dec 2024 Update - Glaucoma waiting list validation of longest waiters completed, with appt prioritisation by clinical risk factor. Updated local HRF guidance to primary & secondary care in development, to be issued cross-sector to ensure all across HB are applying HRF consistently/appropriately (including at point of referral and transfer of care between sectors). Utilising HRF will be a new request for the primary care optometry profession - complete by Feb 2025. SOP for regular clinical validation of WLs in development - complete by June 2025. New admin post for Appointment Failsafe Coordinator approved under Glaucoma Diagnostic Hub Business Case, to ensure high risk patients are booked safely and timely across their longterm RTT journey (necessary to complete this action) - review funding award for this April 2025, estimated recruited in post date June 2025. Therefore a revised implementation date of 01/06/2025 is required.	Appointment Failsafe Coordinator role needs to be in post to ensure safe prioritisation and monitoring of follow-up patients - funding for this to be reviewed under later phases of approved Glaucoma Diagnostic Hub business case.	20241213152635_hrfclinicalprioritisationguidance.docx
Healthcare Inspectorate Wales (HIW)/2017/141	30/01/2017	National review of Ophthalmology Services	Concerns around set monitoring for follow-up patients (Treatment Timescale – Targets) C) Clinical teams must clearly document the follow-up regime selected for each case. This should be applied consistently according to agreed protocols. The patient should be kept informed of any changes to the plan.	Healthcare Inspectorate Wales (HIW)/2017/141/MD12/1	Clinic outcome forms are routinely completed for each patient to ensure they are placed on the correct FUNB list immediately following the clinic appointment. The directorate recognises that we continue to have shortfalls in our FUNB monitoring practices. A new management team has been appointed and has identified the current practices fall short of the agreed protocols. A Significant review into waiting list management is required to include: Ratio of FUNB capacity to meet demand Extensive validation work to cleanse the FUNB waiting list Duplication of pathways Cross site skills and resource	Planned Care	01.04.2024	01.06.2025	Partially complete	April 2025 Update - No update against this recommendation action has been received on this occasion. Feb 2025 Update - Outcome forms established and if not completed correctly in clinic are sent directly back to clinician to complete. All patients that require a FU appointment under 6 weeks are booked before the patient leaves clinic. All patients over 6/52 are currently on FUNB with target date determined. Health Board strategy being developed to address and manage backlog KJ 27/2/25		
Healthcare Inspectorate Wales (HIW)/2017/141	30/01/2017	National review of Ophthalmology Services	Lack of incident reporting relating to WG patient harm policy A) Health Boards must ensure that there are mechanisms in place to review incident reports to identify potential patterns providing early warnings to more serious system failures.	Healthcare Inspectorate Wales (HIW)/2017/141/MD13/1	A FUNB Standard Operating Procedure has recently been submitted to the Surgical Safety and Quality Governance group for review and approval, this includes: • Identify adults who have not had an ophthalmology follow up appointment(s) booked in a timely manner • Ensure that National Standards for Ophthalmology screening have been met in order to maintain compliance with good clinical practice • To review patient pathway delays and identify the level of harm resulting from avoidable delays. • To identify how much loss of vision represents a loss of function and whether this is as a result of a delay in treatment • To ensure, when harm is established, the application of Putting Things Policy and/or Serious Incident management process. • To ensure there is an appropriate follow up plan of care in place for each patient reviewed. • To ensure actions are implemented to reduce the risk of a reoccurring delay in the patient's pathway. • To encourage continuous improvement by identifying areas for improvement in FUNB incident reporting.	Planned Care	01.04.2024	01.04.2024	Partially complete (Overdue)	April 2025 Update - No update against this recommendation action has been received on this occasion. Feb 2025 - Historic harm review on going to complete all outstanding NRI's by end of March 25. Health Board strategy being developed to address backlog of FUNB patients KJ 27/2/25 Dec 2024 Update - Q&S historic harm review work continuing, completing outstanding NRI investigations and providing process learning for Ophthalmology team in readiness for end of fixed term project/handover (March 2025). Central team providing coaching for RCA investigations to Ophthalmology senior MDT, and good uptake of HB RCA training in the team. Regular harm review and RCA quality assurance panels continuing, with good subspecialty consultant representation and input. Action to be reviewed for approval for closure at Care Group SLT 30/12/24.		
Healthcare Inspectorate Wales (HIW)/2017/141	30/01/2017	National review of Ophthalmology Services	Lack of capacity/Fragility of services of services due to over-reliance on consultants. Issues relating to lack of capacity, recruitment and lack of investment in services. (Treatment - Capacity) A) Health Boards must proactively develop workforce plans which set out to address any shortfalls in the current service capacity and available facilities to mitigate the risks to patient care. These plans should seek to maximise capacity by making most effective use of the skills of medical and non-medical staff available, as well as available space/facilities.	Healthcare Inspectorate Wales (HIW)/2017/141/MD14/1	a) CTM has a well established optometry department which has a number of experienced, highly skilled and qualified optometrists working across glaucoma, medical retina, DRSS, unscheduled care, paediatric clinics and specialist contact lenses. Recent expansion of the service to include community optometrists on a sessional basis which has increased our capacity across these services whilst additionally improving training to community optometrists to in turn reduce referrals and improve referral quality. Hospital based optometry due to start implementing an optometry laser led pathway to improve SLT and laser capacity in the coming months.	Planned Care	01.04.2024	01.06.2025	Partially complete	April 2025 Update - No update against this recommendation action has been received on this occasion. Feb 2025 Update - Currently shortlisting for Head of Optometry and Head of Orthoptics posts. Anticipating start date by end of April 25 KJ 27/2/25 Dec 2024 Update - Optometry-led laser pathway successfully implemented >12/12 with significant improvement in laser waiting times. MDT recruitment for glaucoma diagnostic hubs in progress (recruitment for phase 1 posts to be completed Jan 2025). Nursing workforce development in progress to expand roles and responsibilities of Band 2 HCSWs (with rebanding evaluation to Band 3, to be completed April 2025). Longstanding vacancies in Heads of Optometry & Orthoptics roles - given this significant obstacle to MDT workforce development, a revised implementation date of 01/06/2025 is required. ser delivery successful (training, signoff & SOP complete) - SLT WL reduced to 12/52. What next? By when? By whom?	Longstanding vacancies in senior MDT Head of Optometry & Head of Orthoptics posts - obstacle to MDT workforce development.	
Healthcare Inspectorate Wales (HIW)/2017/141	30/01/2017	National review of Ophthalmology Services	Lack of capacity/Fragility of services of services due to over-reliance on consultants. Issues relating to lack of capacity, recruitment and lack of investment in services. (Treatment - Capacity) B) Health boards must consider ways to work more closely with colleagues from primary care. For example, providing equipment (and training) to optometry practices to allow them to undertake referral refinement and/or assessments on stable patients. This needs to be done in a planned and strategic way under control of the health board.	Healthcare Inspectorate Wales (HIW)/2017/141/MD15/1	b) CTM has funded a community optometrist to complete his medical retina higher certificate with a placement in the medical retina service starting in March 2023. We continue to provide independent prescribing, glaucoma certificate and pre-registration placements to community optometrists. An AMD new referral refinement pathway (CARRDS) is due to be implemented in the coming weeks with in house training of participating local community optometrists. This will allow all new AMD referrals to be triaged in primary care. A DRSS new patient scheme has been implemented over the last few months with low risk DRSS patients reviewed by primary care with additional training. DRSS waiting list has significantly dropped and allowed the majority of DRSS patients to be kept in primary care	Planned Care	01.04.2024	31.12.2025	Partially complete	April 2025 Update - No update against this recommendation action has been received on this occasion. February 2025 Update - No update against this recommendation action has been received on this occasion. Dec 2024 Update - External funding (£26k) secured from HEIW to facilitate cross-sector optometry placements (under consultant mentorship) to further upskill local primary care optometrist workforce. Recruitment in progress for 0.2wte B4 admin coordinator to support this. Continued opportune use of dual sector/secondary care optometrist in primary care advisory role, for seamless intersector working. Strong consultant engagement in WGOS (primary care optometry contract) rollout of new pathways - glaucoma and AMD filtering (referral refinement) pathways now fully WGOS-compliant (autonomous in primary care). WG Transformation Funds (£57k) secured to support primary care optometry contract implementation (admin & clinician resources). ECCG supporting Hydroxychloroquine Retinopathy Screening pathway implementation in primary care (due March 2025) and development of cross-sector Regional Coordinator role (for safe transfer of care of patients to primary care). Primary care contract implementation is complex and in many cases novel, and with secondary care stakeholder concerns - a revised implementation date of 31/12/2025 is required.	Safe and effective primary care contract implementation relies on cross-sector implementation of electronic patient record & referral systems - national programme delayed. Logistics and job description of regional coordinator role (1 post shared between 3 HBs) is not yet defined, and funding for this is fixed-term (2 years) with no plan from WG to support HBs with this beyond 2026 as yet. Secondary care stakeholder concerns regarding discharging patients from shared-care pathways to autonomous primary care management without EPR and adequate administrative support.	20241213163634_glaucomareferralrefinementpathwaywithgm.pdf
Healthcare Inspectorate Wales (HIW)/2017/141	30/01/2017	National review of Ophthalmology Services	Health Boards should learn from the experiences following progress made in other areas (Treatment - Initiatives to improve Capacity) B) Welsh Government should consider whether there is a need to develop further approaches to encourage shared learning between health boards as well as more integrated methods to address common themes/issues being experienced across Wales. For example, the introduction of non-medical injectors.	Healthcare Inspectorate Wales (HIW)/2017/141/MD17/1	WG to answer	Planned Care	01.04.2024	01.04.2024	Partially complete (Overdue)	April 2025 Update - No update against this recommendation action has been received on this occasion. February 2025 Update - No update against this recommendation action has been received on this occasion. Dec 2024 Update - strong CTM engagement with national Ophthalmology CIN, including ratifying national shared JDs, SOPs, letter templates etc. Learning from RCAs shared with national CIN leads. Non-medical injectors utilised since 2019, with an established SOP and training pathway. Action to be reviewed for approval for closure at Care Group SLT 30/12/24.		
Healthcare Inspectorate Wales (HIW)/2017/141	30/01/2017	National review of Ophthalmology Services	More clarity required in relation to evolving role of optometrist to enable more effective utilisation of optometrists, Welsh Government must provide clarity to health boards relating to Indemnity, resource & finance arrangements, training/qualifications and communication mechanisms.	Healthcare Inspectorate Wales (HIW)/2017/141/MD20/1	This appears to be an action required by WG, though we have answered from a CTM perspective. CTM optometrists are being utilised in multiple areas of ophthalmology such as glaucoma, med retina and corneal specialities and direct WG funding has provided sessional optometrists to work within these areas. Higher level training and qualifications are underway and have been utilised historically and currently. Staff have sourced funding from HEIW in order to gain higher qualifications from The Royal College of Optometrist in order to further develop services (such as the soon to implemented optometry led laser service for glaucoma).	Planned Care	01.04.2024	01.06.2025	Partially complete	April 2025 Update - No update against this recommendation action has been received on this occasion. February 2025 Update - No update against this recommendation action has been received on this occasion. Dec 2024 Update - strong national engagement from CTM on this issue, including key role in national ESR workforce updates for Optometry. Longstanding vacancy in Head of Optometry post obstacle to continued workforce development for secondary care. Implementation of national primary care optometry contract (WGOS) continues to progress. In light of head of service vacancy, a revised implementation date of 01/06/2025.	Longstanding vacancy in Head of Optometry post an obstacle to continued optometry workforce development for secondary care.	
Healthcare Inspectorate Wales (HIW)/2017/141	30/01/2017	National review of Ophthalmology Services	Additional utilisation of optometrists is required to increase capacity (HDHB) example) and reduce the burden on secondary care. (Utilisation of optometrists) Health boards should consider additional utilisation of optometrists to increase available capacity and reduce burden on secondary care. Health Board will need to ensure that issues are clarified around Indemnity, resource & finance arrangements, training and communication, for optometrists.	Healthcare Inspectorate Wales (HIW)/2017/141/MD21/1	See points above. CTM already utilising both hospital and primary care based optometrists in a range of sub-specialities. Primary care pathways and schemes include IPOS or unscheduled care, Glaucoma community monitoring scheme, AMD referrals refinement and DRSS.	Planned Care	01.04.2024	01.06.2025	Partially complete	April 2025 Update - No update against this recommendation action has been received on this occasion. February 2025 Update - No update against this recommendation action has been received on this occasion. Dec 2024 Update - Longstanding vacancy in Head of Optometry post an obstacle to continued workforce development for secondary care. Primary care optometrist filtering (referral refinement) pathways live for glaucoma & AMD, continued monitoring schemes for glaucoma & diabetic retinopathy (under WGOS transition), high volume IPOS (acute eye care) pathway continuing - all of which reduce secondary care appointment demand/improve referral quality. Cross-sector work underway to enable discharge/deflection of suitable patients from Eye Casualty to IPOS (further reducing secondary care pressures). In light of head of service vacancy, a revised implementation date of 01/06/2025 is required. group that will be reviewing the workforce. What next? By when? By whom?	Longstanding vacancy in Head of Optometry post an obstacle to continued workforce development for secondary care optometry.	
Healthcare Inspectorate Wales (HIW)/2020/139	08/09/2020	Quality Check Summary Ysbyty Cwm Rhondda [Ysbyty Cwm Rhondda - Ward A1 (Ref: 20030)]	The Health Board should ensure that the escalation procedure is reviewed.	Healthcare Inspectorate Wales (HIW)/2020/139/MD2/1	A revised Emergency Pressures Escalation Plan has been drafted (9th September 2020) and submitted to the Executive Director of Operations. Once approved, this will be made available on the CTM intranet site.	Primary Care & Community	01.10.2020	01.10.2020	Overdue	April 2025 Update - No update against this recommendation action has been received on this occasion. February 2025 Update - No update against this recommendation action has been received on this occasion. December 2024 Update - An update against this recommendation has not been provided on this occasion. August 2024 Update - The Emergency Preparedness Resilience and Response Manager is following up with Operational colleagues on the development of the Emergency Pressures Escalation Procedure. Draft version is developed and confirmation of approval is being sought. Once confirmed this action will be marked as closed.		
Healthcare Inspectorate Wales (HIW)/2021/137	30/06/2021	National Review of Mental Health Crisis Prevention in the Community	Health boards must ensure that clear processes are in place to ensure that physical health assessments and monitoring is undertaken for relevant patients under the Mental Health (Wales) Measure 2010.	Healthcare Inspectorate Wales (HIW)/2021/137/MD3/1	Working group to be established between Primary Care and mental Health to ensure clear understanding of responsibilities for delivery of Physical Health checks with agreed process	Mental Health & Learning Disabilities	01.11.2024	01.11.2024	Partially complete (Overdue)	April 2025 Update - evidence added to be signed off in May QSRE, delayed due to shortage of representatives at the last QSRE. February 2025 Update (26-02-25) - update being presented at QSRE on 12th March with a view to close December 2024 Update - Plan to complete TOR within the physical health improvement forcus group and to then close by Feb 2025.		20250414111226_physicalhealthworkshopoct2024002.docx, 20250414111435_physicalhealthfocusgroup25february2025.docx
Healthcare Inspectorate Wales (HIW)/2022/131	22/03/2022	Hospital Inspection (Announced) Princess of Wales Hospital – Maternity Services [Appendix C - POW Maternity Unit (Ref: 21233)]	The Health Board should consider consultant job plans that formally allocate a separate consultant to supervise the caesarean section lists and Gynaecology work.	Healthcare Inspectorate Wales (HIW)/2022/131/MD1/1	Business case under development for separate maternity elective theatre case lists to be established. Once finalised will be submitted through Integrated Locality Group structure for consideration.	Children & Families	01.08.2022	01.09.2023	Overdue	April 2025 Update - No update against this recommendation action has been received on this occasion. February 2025 Update - No update against this recommendation action has been received on this occasion. August 2024 Update - Business Case currently on hold as from early September 2024, there will be a temporary closure of the maternity and neonatal units at Princess of Wales Hospital (PoW) to allow for essential maintenance works on both units. This action will be revisited in January 2025.		
Healthcare Inspectorate Wales (HIW)/2022/131	22/03/2022	Hospital Inspection (Announced) Princess of Wales Hospital – Maternity Services [Appendix C - POW Maternity Unit (Ref: 21233)]	Risk assessments are undertaken and recorded in patient records. Medical discussion and decisions are accurately recorded in patient records.	Healthcare Inspectorate Wales (HIW)/2022/131/MD4/1	The specific areas of risk assessment, medical discussions and decisions will be added to the record keeping audit and all service medical staff to participate in this annual audit to drive multi professional improvement in this area.	Children & Families	01.08.2022	01.08.2022	Overdue	April 2025 Update - No update against this recommendation action has been received on this occasion. December 2024, February 2025 Update - No update against this recommendation action has been received on this occasion. August 2024 Update - Update requested from the Medical Director in the Children and Family Care Group.		
Healthcare Inspectorate Wales (HIW)/2022/131	22/03/2022	Hospital Inspection (Announced) Princess of Wales Hospital – Maternity Services [Appendix C - POW Maternity Unit (Ref: 21233)]	The Health Board must ensure that: Additional welfare support is available for KIT staff.	Healthcare Inspectorate Wales (HIW)/2022/131/MD6/1	Workforce team asked for specific resources for KIT staff going forward.	Children & Families	01.06.2022	01.10.2023	Overdue	April 2025 Update - No update against this recommendation action has been received on this occasion. December 2024, February 2025 Update - No update against this recommendation action has been received on this occasion. August 2024 Update - KIT update to be taken to next Care Group Workforce meeting on the 28th August and the Local Partnership Forum.		
Healthcare Inspectorate Wales (HIW)/2022/131	22/03/2022	Hospital Inspection (Announced) Princess of Wales Hospital – Maternity Services [Appendix C - POW Maternity Unit (Ref: 21233)]	The Health Board must ensure that: The backlog of incidents are cleared and consideration of further funding should continue.	Healthcare Inspectorate Wales (HIW)/2022/131/MD7/1	Incident backlog due to be closed by 31.5.22. Service agreed target: All incidents managed and closed within 3 months – using Datix action tracker for ongoing work.	Children & Families	01.06.2022	01.10.2023	Partially complete (Overdue)	April 2025 Update - No update against this recommendation action has been received on this occasion. December 2024, February 2025 Update - No update against this recommendation action has been received on this occasion. August 2024 Update - Children & Family Care Group just completing a review of the governance arrangements in line with the new incident management framework. Outcome of will be presented to the Maternity and Neonatal Safety Board in September 2024 with an implementation plan. The new arrangements will ensure proportionate review and learning.		
Healthcare Inspectorate Wales (HIW)/2023/130	07/03/2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 19 The health board must continue to provide HIW with updates on the plans to implement the unified patient clinical records system. This must also include consideration for its inpatient and community services for Child and Adolescent Mental Health Services across the health board.	Healthcare Inspectorate Wales (HIW)/2023/130/MD18/1	The Executive and Board are committed to the implementation of a unified electronic record system for the Mental Health and Learning Disabilities Care Group, which includes Child and Adolescent Mental Health Services.	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Overdue	April 2025 Update - process has been made in the journey towards achieving the single clinical record that has allowed 3 Health Board's to come together in a collaborative cluster in the discovery of the single care record for Mental Health. It is likely that we will know who the supplier of our digital system will be towards the end of September 2025 into October 2025. An implementation date is yet to be confirmed but anticipated Dec 25 / Jan 26 February 2025 Update (26-02-25) - Letter from WG allowing us now to complete all the job descriptions, and get them on TRACS •Pre engagement session with 2 suppliers are ongoing they are RIO and TPP with engagement extended as we have a new supplier •Full procurement is likely to be around Autumn •Still at risk as we still do not have a definitive date for a single patient record. •Clare Williams appointed as Senior Responsible Officer for this program		
Healthcare Inspectorate Wales (HIW)/2023/130	07/03/2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 36 The health board must provide HIW with an update on the progress of the ongoing work to review and update the mental health service policies and procedures, and when the health board wide documents will be implemented. This must include how this will be shared with all staff across the mental health services as a whole.	Healthcare Inspectorate Wales (HIW)/2023/130/MD35/1	The oversight of this recommendation will be via the Policies Group. The newly established Policy Review group will have an operational scope to: •Review & RAG of all existing MH Policies to establish priorities rating •Develop a policies plan with trajectories for addressing the backlog •To progress for sign off at Care Group level •Maintenance of a register of policies for review Following agreement of ToR at April 2023 Care Group Quality Safety Risk and Experience Group.	Mental Health & Learning Disabilities	01.06.2024	01.06.2024	Overdue	April 2025 Update (01/04/2025) - Total number of MHLD policies / procedures – 65 Actual position: In date – Target – 65, Actual – 55 Out of date – 0 Pending ratification/under review – 10 (7 on target for ratification in May 25, 3 of which are currently out for comment to QSRE Board. Awaiting confirmation of Mental Health Measure Policy, Refeeding Policy being discussed at CTM Nutrition Group, awaiting feedback) February 2025 Update (26-02-25) - MH and LD policies remain at 66 •46 are currently in date •9 policies under review. This will reduce to 8 as 2 communities polices are merging into one •11 Pending ratifications. These should have agreed at OMB but due to Business Continuity issues OMB was cancelled for 2 months. •All MH Policies are in date. •MH Policy page on the intranet has been updated making it simpler and easy to navigate		
Healthcare Inspectorate Wales (HIW)/2023/130	07/03/2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 36 The health board must provide HIW with an update on the progress of the ongoing work to review and update the mental health service policies and procedures, and when the health board wide documents will be implemented. This must include how this will be shared with all staff across the mental health services as a whole.	Healthcare Inspectorate Wales (HIW)/2023/130/MD35/2	Mental health policies will follow the agreed organisational process for ratification. All NH specific policies were reviewed by 1 June 2023 and of the 49 MH specific policies - Review underway 4 In date and approved 13 Expired 32. With an agreement that those that require updating will be completed by 1st June 2024. The 32 expired policies have been prioritised with consideration of patient safety, present best practice and clinical impact and a review schedule has been developed with this in mind. The Mental Health Policy group will monitor this review schedule at each meeting through an agenda item. In the interim the Mental Health Policy group has directed the clinical teams to work with the most current version each Clinical policy. On completion agreed policies will be communicated to all Nursing and Medical staff across all Mental Health services using the care Group "Communication and Learning Framework" (recommendation All current and ratified policies will be live on the Mental Health Policies page on the staff internet site SharePoint.	Mental Health & Learning Disabilities	01.06.2024	01.06.2024	Overdue	April 2025 Update- No update against this recommendation action has been received on this occasion. February 2025 Update - No update against this recommendation action has been received on this occasion. December 2024 Update - 16 policies remain to be updated.		
Healthcare Inspectorate Wales (HIW)/2023/134	31/07/2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix A - Immediate Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken: • to improve mandatory staff training compliance in respect of resuscitation training • to promote patient safety in the interim until compliance has improved	Healthcare Inspectorate Wales (HIW)/2023/134/MD2/1	Cwm Taf University Health Board acknowledges that compliance for mandatory resuscitation training is not where we want it to be in order that Patient Care and Safety can be assured in the event of a patient collapse - Current Training Compliance:- ED •Registered Nurse ILS compliance is currently 38.24% and HCSW BLS is 2.78% as demonstrated in attached training needs analysis.	Unscheduled Care	01.11.2023	30.06.2024	Partially complete (Overdue)	April 2025 Update - An update against this recommendation action has not been provided on this occasion. December 2024, February 2025 Update - An update against this recommendation action has not been provided on this occasion. August 2024 Update - CDU BLS - 94%, ILS 40%. ED BLS - 80% ALS 65% (CDU- Clinical Decisions Unit- (BLS) Basic Life support (ILS) Immediate Life Support (ED) Emergency Department (BLS) Basic Life support (ALS) Advanced Life Support.)		
Healthcare Inspectorate Wales (HIW)/2023/140	16/05/2023	HMP Parc	HMP Parc Prison should ensure that there is a robust mechanism to ensure that drug monitoring bloods are organised in a timely fashion especially for immunosuppressant drugs.	Healthcare Inspectorate Wales (HIW)/2023/140/MD2/1	A review of the current GP management process to be undertaken . To implement a robust process ensuring that bloods required due to drug monitoring are undertaken in a timely manner and results are reviewed appropriately.	Primary Care & Community	31.08.2023	31.08.2023	Partially complete (Overdue)	April 2025 Update - An update against this recommendation action has not been provided on this occasion. December 2024, February 2025 Update - An update against this recommendation action has not been provided on this occasion. October 2024 - Discussion with Head of Healthcare within HMP Parc, chaser email sent to GP contractors to request update on process with implementation of recommendation.		
Healthcare Inspectorate Wales (HIW)/2023/140	16/05/2023	HMP Parc	HMP Parc Healthcare must ensure that all medication recommended is supplied.	Healthcare Inspectorate Wales (HIW)/2023/140/MD7/1	A work stream to understand the correct process and to develop robust process to ensure recommended medication is supplied. This will include- flow chart to be drafted and implemented with a process how staff/ patients access medication in a timely manner. Implementation of critical medication policy. Any process developed will need to consider all stages, pharmacy from the perspective of supply and staff on the wings for administration. Consideration needed regarding prescribing as it may be that in some circumstances an interim prescription for an alternative formulation etc may be required.	Primary Care & Community	31.08.2023	31.08.2023	Partially complete (Overdue)	April 2025 Update - An update against this recommendation action has not been provided on this occasion. December 2024, February 2025 Update - An update against this recommendation action has not been provided on this occasion.		
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should engage with each other, to learn from the good patient education practices taking place across Wales. This could help the shared learning with themselves and with GP practices in their localities, to educate patients of the risks for a stroke, to help reduce the number of strokes across Wales.	Healthcare Inspectorate Wales (HIW)/2023/155/MD1/1	CTM UHB continues to work in partnership with Cardiff and Vale UHB in the Regional Network for stroke services and have collaborated on cross-health board workshops to share and learn from good practice for service development, including patient education. The Health Board will continue to engage in the national network for stroke to ensure that we work together with other Health Boards across Wales to develop and share good practice and learning for the benefit of our patients and teams. Work continues in our GP Practices to target patients at increased risk of stroke and we continue to build on this as part of CTM2030 and our Acute Clinical Services Plan. Governance and reporting have been refreshed and strengthened, with learning fed back through the CTM UHB Stroke Operational Group and Stroke Performance Board into the Stroke Strategy Group for implementation across the Health Board area.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	April 2025 Update - An update against this recommendation action has not been provided on this occasion. December 2024, February 2025 Update - An update against this recommendation action has not been provided on this occasion. August 2024 Update - This work is ongoing and forms part of long term engagement and partnership working via the stroke programme board. Revised Due Date - Ongoing across 2024/25 Ongoing across 2023/24		
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Public Health Wales should consider the development and promotion of a national campaign to raise stroke awareness and its prevention in Wales alongside its Act FAST campaign. This should include raising awareness of stroke prevention within black and minority ethnic communities and the impact of health inequalities and socio-economic deprivation.	Healthcare Inspectorate Wales (HIW)/2023/155/MD2/1	This action is led by PHW however, CTM UHB will continue to engage with PHW, the Stroke Association, and other Health Boards through the national network in order to support the development and implementation of a campaign by PHW. Updates will feed through to the CTM UHB Stroke Strategy Group to ensure continued support.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	April 2025 Update - An update against this recommendation action has not been provided on this occasion. December 2024, February 2025 Update - An update against this recommendation action has not been provided on this occasion. August 2024 Update - "This action is led by PHW however, CTM UHB will continue to engage with PHW, the Stroke Association, and other Health Boards through the national network in order to support the development and implementation of a campaign by PHW. Updates will feed through to the CTM UHB Stroke Strategy Group to ensure continued support.		

Inspection Code	Date of Inspection	Inspection Title	Recommendation	AMaT Reference Number	Action	Care Group	Original Due Date	Current / Revised Due Date	Progress Status	Comments/Updates	Barriers	Evidence
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards and PHW should work closely with Black and minority ethnic communities and people affected by socio-economic deprivation, to understand the specific issues they face with their increased risk of stroke and in accessing preventative care and ensure ongoing engagement with them to support better health outcomes.	Healthcare Inspectorate Wales (HIW)/2023/155/MD3/1	CTM UHB will continue to engage with PHW and Health Boards across Wales through the national network to support a co-ordinated approach to effective engagement with Black and minority ethnic communities and people affected by socio-economic deprivation, to understand the specific issues they face. Listening to all our communities and increased engagement is a key part of the CTM UHB Organisational Strategy Action Plan.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	April 2025 Update - An update against this recommendation action has not been provided on this occasion. December 2024, February 2025 Update - An update against this recommendation action has not been provided on this occasion. August 2024 Update - "CTM UHB will continue to engage with PHW and Health Boards across Wales through the national network to support a co-ordinated approach to effective engagement with Black and minority ethnic communities and people affected by socio-economic deprivation, to understand the specific issues they face. Listening to all our communities and increased engagement is a key part of the CTM UHB Organisational Strategy Action Plan." Revised Due Date - Ongoing across 2024/25 Ongoing across 2023/24		
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must communicate with each other to establish the good practices taking in place in some hospitals for the robust management of patient flow. This includes the implementation of effective action plans to manage daily discharges, which remain active throughout the day, and in planning for subsequent days.	Healthcare Inspectorate Wales (HIW)/2023/155/MD5/1	Significant work is ongoing to ensure the robust management of patient flow. Each site has a well-established daily Safe2Start meeting which provides assurance around site based escalation, staffing, patient safety and clinical priorities. The meeting allows the identification of clinical priorities, including stroke patients, and time frames for movement to appropriate inpatient beds. All patient flow constraints are discussed and risk is shared across the acute inpatient wards and community sites in order to balance risk within the Emergency Department. This remains an action-focused meeting, with clear ownership and delivery prior to the afternoon meeting. As part of this work, under the 6 Goals national programme, the Safe2Start template has been revised to include SAFER, Red2Green and both internal and external delay metrics. There was a delay in launching the new template due to access required into SAFECARE to display nurse staffing levels, this is being worked through by informatics colleagues with the new template expected to be completed and implemented by November 2024. We have introduced Electronic Whiteboards on every ward that track each stage of discharge and highlights any blockages in the process. This information is an integrated tool across health and social care partners. As part of this work, we have also developed Optimise, a programme of work under the national 6goals programme to focus on value added care for patients, including a multi-professional approach to patient flow and Discharge to Recover then Assess (D2RA) pathways. We continue to share our approach with other Health Boards and bring back learning from good practice gleaned from other areas.	Unscheduled Care	01.11.2023	01.11.2023	Overdue	April 2025 Update - An update against this recommendation action has not been provided on this occasion. December 2024, February 2025 Update - An update against this recommendation action has not been provided on this occasion. August 2024 Update - This work is ongoing and forms the central part of the stroke programme board - this is discussed in every other Q&S committee as part of the board update.		
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must review and consider timelier processes of prescribing take home medication and obtaining this promptly from pharmacy to minimise discharge delays. This should include planning well in advance of the scheduled time for discharge (such as the day before).	Healthcare Inspectorate Wales (HIW)/2023/155/MD6/1	CTM UHB is aware that consideration needs to be given to dedicated specialist pharmacist support as part of our review of the Stroke Pathway. The Pharmacy Team are involved in conversations to improve communication regarding estimated dates of discharge and full MDT involvement/use of eWhiteboards, which includes planning the day before for potential discharges. Pharmacy colleagues are also part of the site based Safe2Start meetings, so they are aware of potential discharges across the acute sites early to prevent potential delays.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	April 2025 Update - An update against this recommendation action has not been provided on this occasion. December 2024, February 2025 Update - An update against this recommendation action has not been provided on this occasion. August 2024 Update - CTM UHB is aware that consideration needs to be given to dedicated specialist pharmacist support as part of our review of the Stroke Pathway. The Pharmacy Team are involved in conversations to improve communication regarding estimated dates of discharge and full MDT involvement/use of eWhiteboards, which includes planning the day before for potential discharges. Pharmacy colleagues are also part of the site based Safe2Start meetings, so they are aware of potential discharges across the acute sites early to prevent potential delays.		
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should consider the benefits of dedicated 'discharge phlebotomy slots' for managing the necessary blood tests, to assist with effective and timelier discharge.	Healthcare Inspectorate Wales (HIW)/2023/155/MD7/1	Currently, there is variation in the service provided across the CTM UHB footprint. In Princess of Wales Hospital, phlebotomy is provided through an SLA with Swansea Bay UHB. Prince Charles and Royal Glamorgan Hospitals' phlebotomy services are provided through CTM UHB. Further conversations will take place through the Stroke Programme Board/Operational Group to ascertain the feasibility of starting. Robust data would be required to evidence the implementation of this action which as yet we do not have and so this has not yet been progressed.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	April 2025 Update - An update against this recommendation action has not been provided on this occasion. December 2024, February 2025 Update - An update against this recommendation action has not been provided on this occasion. August 2024 Update - this action is not being progressed as - Currently, there is variation in the service provided across the CTM UHB footprint. In Princess of Wales Hospital, phlebotomy is provided through an SLA with Swansea Bay UHB. Prince Charles and Royal Glamorgan Hospitals' phlebotomy services are provided through CTM UHB. Further conversations will take place through the Stroke Programme Board/Operational Group to ascertain the feasibility of starting. Robust data would be required to evidence the implementation of this action which as yet we do not have and so this has not yet been progressed. Ongoing 2024/25		
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must consider the benefits of Improvement Cymru's Real Time Demand Capacity methodology, and whether this would have a positive impact to implement (or to pilot) within all hospitals to help manage timelier patient flow.	Healthcare Inspectorate Wales (HIW)/2023/155/MD8/1	Within Prince Charles Hospital there was a trial of the RTDC model with some positive effect supported by Improvement Cymru. There is a national move towards the North Bristol Trust model of continuous flow, which has been explored by the USC Group as an option which may have a positive impact on patient flow. We are currently collaborating with NHS Exec colleagues on the roll out of this, with the site planned for proof of concept being Royal Glamorgan. In order to undertake this piece of work, we need to understand the breakdown of our speciality demand and so informatics colleagues are supporting this piece of work which will be developed as an improvement project once relevant base line data is available.	Unscheduled Care	01.02.2024	31.12.2024	Overdue	April 2025 Update - An update against this recommendation action has not been provided on this occasion. December 2024, February 2025 Update - An update against this recommendation action has not been provided on this occasion. August 2024 Update - we remain in collaboration with the NHS exec on this however as an organisation we do not yet have predicted demand modelling available to us which constrains our ability to progress this work.		
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should reflect on their patient flow processes and consider whether improvements can be made with predictive methodology for demand in each of their hospital sites, such as with medical and surgical admissions.	Healthcare Inspectorate Wales (HIW)/2023/155/MD9/1	CTM UHB has significant experience of using predictive methods to enhance patient and system outcomes. In building on this as part of the development of an USC Dashboard, which is now embedded for operational use, and the future development of an ED Electronic Whiteboard/Viewer, there is the ability to start to inform the USC leadership team around their predicted demand. Later developments will allow the breakdown of this into speciality and also to further explore surgical demand data. The Health Board continues to build on its use of data to enhance the provision of business intelligence on offer at all levels of the organisation, in order to scrutinise the demand and flow of patients through the system. These additional developments have been built into the Informatics IMTP proposals for 2024/2025.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	April 2025 Update - An update against this recommendation action has not been provided on this occasion. December 2024, February 2025 Update - An update against this recommendation action has not been provided on this occasion. August 2024 Update - CTM UHB has significant experience of using predictive methods to enhance patient and system outcomes. In building on this as part of the development of an USC Dashboard, which is now embedded for operational use, and the future development of an ED Electronic Whiteboard/Viewer, there is the ability to start to inform the USC leadership team around their predicted demand. Later developments will allow the breakdown of this into speciality and also to further explore surgical demand data. The Health Board continues to build on its use of data to enhance the provision of business intelligence on offer at all levels of the organisation, in order to scrutinise the demand and flow of patients through the system. These additional developments have been built into the Informatics IMTP proposals for 2024/2025.		
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should consider whether a daily senior nursing/ clinical oversight for each directorate could be implemented to facilitate clinical issues with flow. This may help ensure staff are making timely progress to discharge patients, challenge medical staff to undertake key tasks where necessary, and help expedite any outstanding clinical patient needs. In addition, to commence planning for patient discharge on subsequent days.	Healthcare Inspectorate Wales (HIW)/2023/155/MD10/1	See also response to Rec 5. Within the USC Group and under the umbrella of the national 6 Goals programme, there is a significant focus on patient flow, aligned to SAFER, Red2Green and right patient, right time, within work stream 3. Part of this work includes the implementation of a standardised process around board and ward rounds, with senior nursing and clinical teams having direct involvement with information relating to internal and external delays as part of this being captured on an electronic whiteboard which feeds into the afternoon Safe2Start site based meeting. This piece of work is Optimise and focuses of value added care. This work is ongoing and is large scale transformation with a detailed project plan and times lines for implementation that are monitored via 6goals Board.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	April 2025 Update - An update against this recommendation action has not been provided on this occasion. December 2024, February 2025 Update - An update against this recommendation action has not been provided on this occasion. August 2024 Update - a proposal has been shared with the board for extension of the CNS workforce with Senior nurse oversight. this requires resource allocation. November launch. Full implementation 24-25.		
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards and WAST should engage with people to better understand the barriers to them accessing, or choosing, from the range of healthcare services available in Wales. Once the barriers are understood, this in turn, could be used to influence service design.	Healthcare Inspectorate Wales (HIW)/2023/155/MD11/1	Listening to our communities and understanding their experiences is a key part of the CTM UHB Organisational Strategy Action Plan. As part of CTM2030 and our Acute Clinical Services Plan there will be multiple opportunities to engage with our communities in order to influence service design.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	April 2025 Update - An update against this recommendation action has not been provided on this occasion. December 2024, February 2025 Update - An update against this recommendation action has not been provided on this occasion. August 2024 Update - Listening to our communities and understanding their experiences is a key part of the CTM UHB Organisational Strategy Action Plan. As part of CTM2030 and our Acute Clinical Services Plan there will be multiple opportunities to engage with our communities in order to influence service design.		
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should seek assurance that their MIUs and ED departments ensure all reception staff have received up to date Act FAST training, and they are competent with this. In addition, that appropriate escalation process is in place if a receptionist is or is not sure a patient may be suffering with a stroke.	Healthcare Inspectorate Wales (HIW)/2023/155/MD12/1	Due to significant changes within CTM in relation to a large scale OCP process with multiple changes to staff groups and lines of reporting the review of current training in relation to Act FAST training has not yet taken place. This is scheduled to start in the next month with an aim for completion by September. There is also a national e-triage system being implemented which may prevent the need for this in future, as stroke symptoms are built in as part of 'red flagging' leading to an appropriate clinical triage category for patients who are symptomatic of a stroke.	Unscheduled Care	01.10.2024	01.10.2024	Overdue	April 2025 Update - An update against this recommendation action has not been provided on this occasion. December 2024, February 2025 Update - An update against this recommendation action has not been provided on this occasion. August 2024 Update - this work remains a focus and is part of ongoing discussions as programme board - Due to significant changes within CTM in relation to a large scale OCP process with multiple changes to staff groups and lines of reporting the review of current training in relation to Act FAST training has not yet taken place. This is scheduled to start in the next month with an aim for completion by September. There is also a national e-triage system being implemented which may prevent the need for this in future, as stroke symptoms are built in as part of 'red flagging' leading to an appropriate clinical triage category for patients who are symptomatic of a stroke. Revised Review - August 2024. Ongoing implementation. Review March 2024 Implementation October 2024		
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	WAST and all health boards must work collaboratively to identify a consistent approach to ensure handover of stroke patients is made within the Welsh Government 15-minute target. This is to ensure that time critical investigations and treatment are undertaken promptly.	Healthcare Inspectorate Wales (HIW)/2023/155/MD13/1	Collaborative working with WAST continues as part of the CTM UHB Stroke Programme Board/Stroke Operational Group to collaboratively identify and implement a consistent pathway for stroke patients, both confirmed and query arriving at our emergency departments. In addition, we are currently reviewing our nurse specialist provision in order to create capacity to better support the early handover of stroke patients and transfer directly to time critical investigations.	Unscheduled Care	01.10.2024	31.01.2025	Overdue	April 2025 Update - An update against this recommendation action has not been provided on this occasion. December 2024, February 2025 Update - An update against this recommendation action has not been provided on this occasion. August 2024 Update - collaborative work with WAST in relation to patient pathways is ongoing.		
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Welsh Government should work collaboratively with WAST, health boards and social care providers to evaluate and strengthen the current processes in place to improve flow through health and care systems, with a concerted focus on the analysis of flow, the bottlenecks impeding flow and the issues with achieving timely discharge.	Healthcare Inspectorate Wales (HIW)/2023/155/MD14/1	This action remains ongoing as stroke and flow performance indicators continue to form part of regular performance meetings with Welsh Government, resulting in scrutiny and discussion. In addition, CTM UHB is working with the NHS Wales Executive Performance and Assurance Directorate regarding stroke performance and the nation review of self-presenters. Recently reviewed data (as per below *table removed for AMaT purposes*), shows a decrease in patients self-presenting to CTM for Stroke, which in theory should enable a more efficient stroke pathway across PoW and PCH where we have stroke provision.	Unscheduled Care	01.10.2024	01.10.2024	Overdue	April 2025 Update - An update against this recommendation action has not been provided on this occasion. December 2024, February 2025 Update - An update against this recommendation action has not been provided on this occasion. August 2024 Update - This action remains ongoing as stroke and flow performance indicators continue to form part of regular performance meetings with Welsh Government, resulting in scrutiny and discussion. In addition, CTM UHB is working with the NHS Wales Executive Performance and Assurance Directorate regarding stroke performance and the nation review of self-presenters. Recently reviewed data (as per below *table removed for AMaT purposes*), shows a decrease in patients self-presenting to CTM for Stroke, which in theory should enable a more efficient stroke pathway across PoW and PCH where we have stroke provision.		
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that ED staff undertake the triage of patients within the 15-minute target time. Where this has not been possible, it should be clearly documented 'why not' within the patient's clinical record.	Healthcare Inspectorate Wales (HIW)/2023/155/MD15/1	Triage within 15 minutes is a national tier one target and quality metric that we always strive to achieve. If not possible, additional resource is allocated to mitigate where possible. Any delays in triage is captured via ED huddles and site management patient safety reports, which are escalated to the Flow Manager of the day and the Exec on call to explore mitigations and actions to reduce any delays. Implementation of e-triage will minimise delays as patients will self-triage and be clinically prioritised following this. If triage times are starting to escalate then additional nursing resource is allocated to support.	Unscheduled Care	01.10.2024	01.10.2024	Overdue	April 2025 Update - An update against this recommendation action has not been provided on this occasion. December 2024, February 2025 Update - An update against this recommendation action has not been provided on this occasion. August 2024 Update - Triage within 15 minutes is a national tier one target and quality metric that we always strive to achieve. If not possible, additional resource is allocated to mitigate where possible. Any delays in triage is captured via ED huddles and site management patient safety reports, which are escalated to the Flow Manager of the day and the Exec on call to explore mitigations and actions to reduce any delays. Implementation of e-triage will minimise delays as patients will self-triage and be clinically prioritised following this. If triage times are starting to escalate then additional nursing resource is allocated to support. Ongoing targeted improvement		
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that medical staff who carry the bleep for stroke alerts recognise the urgency of both thrombolysis and non-thrombolysis stroke calls. A patient may still be symptomatic whilst out of the thrombolysis window but may still be within the thrombectomy time frame. This is particularly important if a referral tertiary centre is relatively close to the ED.	Healthcare Inspectorate Wales (HIW)/2023/155/MD16/1	Significant work is ongoing within CTM UHB to review the clinical workforce required to review stroke patients within the ED. Work continues to ensure we have the right workforce with the right skills and attributes to support early recognition and treatment of stroke. Patients eligible for thrombectomy are described in the thrombectomy pathway, which forms part of teaching given to junior doctors and the stroke CNS team who carry the bleep for stroke alerts. The Unscheduled Care Group have developed a case for change to create additional ACP capacity to support urgent stroke alerts and more timely progress through the stroke pathway.	Unscheduled Care	01.01.2025	01.01.2025	Overdue	April 2025 Update - An update against this recommendation action has not been provided on this occasion. December 2024, February 2025 Update - An update against this recommendation action has not been provided on this occasion. August 2024 Update - Case submitted to Board in January 2024 and rejected - Significant work is ongoing within CTM UHB to review the clinical workforce required to review stroke patients within the ED. Work continues to ensure we have the right workforce with the right skills and attributes to support early recognition and treatment of stroke. Patients eligible for thrombectomy are described in the thrombectomy pathway, which forms part of teaching given to junior doctors and the stroke CNS team who carry the bleep for stroke alerts. The Unscheduled Care Group have developed a case for change to create additional ACP capacity to support urgent stroke alerts and more timely progress through the stroke pathway. Ongoing 2024/25		
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should review the provision of the CNS or ANP stroke specialist service at each acute site and consider how they can maximise their availability throughout the stroke service.	Healthcare Inspectorate Wales (HIW)/2023/155/MD17/1	Within CTM, a review of the CNS Stroke workforce has been undertaken with recommendations made to significantly increase the workforce but it is recognised that this requires significant additional resource. This paper has been refreshed to develop an ACP workforce over extended hours to support early recognition and treatment of stroke patients. Ongoing workforce modernisation is underway to ensure we have the right workforce with the right skills and attributes looking after our patients.	Unscheduled Care	01.01.2025	01.01.2025	Overdue	April 2025 Update - An update against this recommendation action has not been provided on this occasion. December 2024, February 2025 Update - An update against this recommendation action has not been provided on this occasion. August 2024 Update - case submitted to board in January 2024 - Within CTM, a review of the CNS Stroke workforce has been undertaken with recommendations made to significantly increase the workforce but it is recognised that this requires significant additional resource. This paper has been refreshed to develop an ACP workforce over extended hours to support early recognition and treatment of stroke patients. Ongoing workforce modernisation is underway to ensure we have the right workforce with the right skills and attributes looking after our patients. Ongoing 2024/25		
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should ensure that EDs track and monitor all patients arriving at hospital with a suspected stroke (by ambulance and self-presenting), to drive improvement on assessment times, so people can commence on the stroke pathway in a timely manner.	Healthcare Inspectorate Wales (HIW)/2023/155/MD18/1	Work is underway to develop a patient alert system embedded in the Electronic White Board that will allow stroke wards to track and monitor suspected stroke patients from the Emergency Department. This is in an early development phase and development and progress is monitored via the 6 Goals Programme Board.	Unscheduled Care	01.01.2025	01.01.2025	Overdue	April 2025 Update - An update against this recommendation action has not been provided on this occasion. December 2024, February 2025 Update - An update against this recommendation action has not been provided on this occasion. August 2024 Update - remains ongoing with digital team - Work is underway to develop a patient alert system embedded in the Electronic White Board that will allow stroke wards to track and monitor suspected stroke patients from the Emergency Department. This is in an early development phase and development and progress is monitored via the 6 Goals Programme Board.		
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that all relevant staff within EDs are trained and are competent to use the ROSIER assessment tool. In addition, that staff are consistently using a validated tool, such as ROSIER, to enable prompt differentiation with strokes or stroke mimics, such as TIA.	Healthcare Inspectorate Wales (HIW)/2023/155/MD19/1	Work is ongoing within the USC Group to streamline processes and ensure the domains of quality are met across the organisation, with a focus on equity of treatment and patient outcomes. There is a comprehensive stroke pathway that are working to replicate on other sites working in collaboration with stroke teams and other relevant stakeholders to support standardisation where possible to ensure compliance with the ROSIER assessment tool.	Unscheduled Care	01.10.2024	31.01.2025	Overdue	April 2025 Update - An update against this recommendation action has not been provided on this occasion. December 2024, February 2025 Update - An update against this recommendation action has not been provided on this occasion. August 2024 Update - this remain a priority - Work is ongoing within the USC Group to streamline processes and ensure the domains of quality are met across the organisation, with a focus on equity of treatment and patient outcomes. There is a comprehensive stroke pathway that are working to replicate on other sites working in collaboration with stroke teams and other relevant stakeholders to support standardisation where possible to ensure compliance with the ROSIER assessment tool.		
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that ED staff fully and clearly complete the clinical diagnostic assessment tool for stroke	Healthcare Inspectorate Wales (HIW)/2023/155/MD20/1	As part of ongoing work within the USC Group, actions are being developed to streamline processes and ensure the domains of quality are consistently met, with a focus on equity of treatment and patient outcomes. There is a comprehensive stroke pathway in place that we are working to replicate across all sites. This work is being done in collaboration with stroke teams and other relevant stakeholders to support the standardisation wherever possible and appropriate. This will ensure compliance with completing the clinical diagnostic tool for stroke.	Unscheduled Care	01.10.2024	31.01.2025	Overdue	April 2025 Update - An update against this recommendation action has not been provided on this occasion. December 2024, February 2025 Update - An update against this recommendation action has not been provided on this occasion. August 2024 Update - USC Care Group continue to work towards equity across our sites and this forms part of stroke programme board discussions.		
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that the reason for delayed brain imaging is monitored and analysed for possible stroke patients to ensure scans are completed in a timely manner in line with NICE guidance.	Healthcare Inspectorate Wales (HIW)/2023/155/MD22/1	The work of the CTM UHB Stroke Operational Group is ongoing in its analysis of the stroke pathway through from arrival at hospital front door to discharge. All breaches are reviewed to identify learning and any associated actions. The work of the group will include implementation of processes to monitor delays in the pathway for scans and actions to address.	Unscheduled Care	01.01.2024	01.01.2024	Overdue	April 2025 Update - An update against this recommendation action has not been provided on this occasion. December 2024, February 2025 Update - An update against this recommendation action has not been provided on this occasion. August 2024 Update - this work is continuous - The work of the CTM UHB Stroke Operational Group is ongoing in its analysis of the stroke pathway through from arrival at hospital front door to discharge. All breaches are reviewed to identify learning and any associated actions. The work of the group will include implementation of processes to monitor delays in the pathway for scans and actions to address. Revised Due Date - Ongoing, 2024/25		
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that all possible stroke patients who are clinically appropriate for thrombolysis, receive treatment in a timely manner.	Healthcare Inspectorate Wales (HIW)/2023/155/MD25/1	Within CTM UHB stroke pathway, all patients presenting inside of the thrombolysis window (Code 1 stroke) are to be reviewed by the medical registrar, Stroke CNS and Stroke Consultant on arrival. In hours, the target is to administer thrombolysis within the 45 minute guideline. There are delays out of hours due to waiting for Everlight to report CT scans. Work is ongoing to develop a more robust stroke Consultant rota with other Health Board colleagues and discussions are ongoing around resuming the regional Stroke Consultant rota. This would enable us to avoid Everlight delays by stat reporting by the stroke Consultants.	Unscheduled Care	01.10.2024	01.10.2024	Overdue	April 2025 Update - An update against this recommendation action has not been provided on this occasion. December 2024, February 2025 Update - An update against this recommendation action has not been provided on this occasion. August 2024 Update - USC Care Group continue to explore regional solutions however this remains multifaceted and complex - Within CTM UHB stroke pathway, all patients presenting inside of the thrombolysis window (Code 1 stroke) are to be reviewed by the medical registrar, Stroke CNS and Stroke Consultant on arrival. In hours, the target is to administer thrombolysis within the 45 minute guideline. There are delays out of hours due to waiting for Everlight to report CT scans. Work is ongoing to develop a more robust stroke Consultant rota with other Health Board colleagues and discussions are ongoing around resuming the regional Stroke Consultant rota. This would enable us to avoid Everlight delays by stat reporting by the stroke Consultants. Ongoing 2024/25		
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must explore the options available to improve the process for prioritising stroke patient admissions to acute stroke wards within the four-hour target, to help maximise their clinical outcome.	Healthcare Inspectorate Wales (HIW)/2023/155/MD28/1	As part of the Stroke Programme Board/Stroke Operational Group, there is ongoing transformation work around patient flow and prioritisation of stroke patients to meet the 4 hour target. This is a key improvement metric within CTM UHB and work will continue around exploring more extensive ring fencing of beds, early identification, and pull of patients from the Emergency Department. This work needs to be supported by workforce modernisation, digital enablers and resource allocation. A task and finish group has delivered a single pathway for patients self-presenting at RGH to transfer to the Stroke unit at PCH this in continuously monitored and re/evaluated as required.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	April 2025 Update - An update against this recommendation action has not been provided on this occasion. December 2024, February 2025 Update - An update against this recommendation action has not been provided on this occasion. August 2024 Update - this work is ongoing as was a focus as part of the recent 'reset fortnight' - As part of the Stroke Programme Board/Stroke Operational Group, there is ongoing transformation work around patient flow and prioritisation of stroke patients to meet the 4 hour target. This is a key improvement metric within CTM UHB and work will continue around exploring more extensive ring fencing of beds, early identification, and pull of patients from the Emergency Department. This work needs to be supported by workforce modernisation, digital enablers and resource allocation. A task and finish group has delivered a single pathway for patients self-presenting at RGH to transfer to the Stroke unit at PCH this in continuously monitored and re/evaluated as required.		
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Ring fenced stroke beds are frequently used for non-stroke patients, which may impact on a new stroke admission to ED. Therefore, health boards must explore how a ring fenced stroke bed can be maintained, to help ensure the best outcome for a stroke patient following their arrival at ED.	Healthcare Inspectorate Wales (HIW)/2023/155/MD29/1	As above, this continues to be a priority for CTM UHB, with non-stroke patients identified via a ward/board round, inputted into the electronic white board, and moved to the appropriate inpatient area. Ring-fenced capacity is identified at the twice daily cross site bed meetings and forms part of the out of hours and weekend planning cycle of the HB. Work is underway to better understand the risks/benefits of more extensive ring-fencing of stroke beds.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	April 2025 Update - An update against this recommendation action has not been provided on this occasion. December 2024, February 2025 Update - An update against this recommendation action has not been provided on this occasion. August 2024 Update - this continues to be a priority - As above, this continues to be a priority for CTM UHB, with non-stroke patients identified via a ward/board round, inputted into the electronic white board, and moved to the appropriate inpatient area. Ring-fenced capacity is identified at the twice daily cross site bed meetings and forms part of the out of hours and weekend planning cycle of the HB. Work is underway to better understand the risks/benefits of more extensive ring-fencing of stroke beds.		
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must review their therapies staffing models to ensure there are sufficient resources and staff in place to adequately manage the rehabilitation and recovery of stroke patients in line with NICE guidance.	Healthcare Inspectorate Wales (HIW)/2023/155/MD31/1	Current therapies workforce data is being captured, with a review of therapy workforce provision to explore the best models for therapy provision. This is linked to recommendation 38 regarding need for funded 7 day service. In order to achieved this, a case for resource to expand ESD is being developed.	Unscheduled Care	01.01.2024	01.01.2024	Overdue	April 2025 Update - An update against this recommendation action has not been provided on this occasion. December 2024, February 2025 Update - An update against this recommendation action has not been provided on this occasion. August 2024 Update - Current therapies workforce data is being captured, with a review of therapy workforce provision to explore the best models for therapy provision. This is linked to recommendation 38 regarding need for funded 7 day service. In order to achieved this, a case for resource to expand ESD is being developed. Revised Due Date - 2024/25		
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must consider the need for psychological support for people with stroke, and that adequately trained staff can provide this support to help effectively manage patient recovery.	Healthcare Inspectorate Wales (HIW)/2023/155/MD32/1	This service is fragile in CTM UHB and historical funding was for the north of the CTM footprint only, excluding Bridgend. The national withdrawal of the funding for the Community Neurorehabilitation service combined with maternity leave for a senior psychologist has led to the temporary cessation of the neuropsychology service to ESD patients within CTM. The Health Board remains committed to the ongoing development of the stroke pathway and consideration will be given to this aspect of the service as part of any redesign/investment opportunities.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	April 2025 Update - An update against this recommendation action has not been provided on this occasion. December 2024, February 2025 Update - An update against this recommendation action has not been provided on this occasion. August 2024 Update - this remains ongoing - This service is fragile in CTM UHB and historical funding was for the north of the CTM footprint only, excluding Bridgend. The national withdrawal of the funding for the Community Neurorehabilitation service combined with maternity leave for a senior psychologist has led to the temporary cessation of the neuropsychology service to ESD patients within CTM. The Health Board remains committed to the ongoing development of the stroke pathway and consideration will be given to this aspect of the service as part of any redesign/investment opportunities.		
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must consider introducing the provision of sufficient seven-day therapies services to comply with NICE guidance, to help improve patient flow by supporting a seven-day discharge for patients, and to help meet targets as highlighted within SSNAP.	Healthcare Inspectorate Wales (HIW)/2023/155/MD33/1	CTM UHB currently offers a 5 day clinical model. A 7 day clinical model remains the ambition for the health board but requires identification of significant financial resource. This is linked to the response to recommendation 36. The Health Board remains committed to the ongoing development of the stroke pathway and consideration will be given to this aspect of the service as part of any redesign/investment opportunities.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	April 2025 Update - An update against this recommendation action has not been provided on this occasion. December 2024, February 2025 Update - An update against this recommendation action has not been provided on this occasion. August 2024 Update - this remains ongoing - CTM UHB currently offers a 5 day clinical model. A 7 day clinical model remains the ambition for the health board but requires identification of significant financial resource. This is linked to the response to recommendation 36. The Health Board remains committed to the ongoing development of the stroke pathway and consideration will be given to this aspect of the service as part of any redesign/investment opportunities.		
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that stroke rehabilitation environments are appropriate and are adequate to meet the needs of patients.	Healthcare Inspectorate Wales (HIW)/2023/155/MD34/1	Risk assessments have been submitted as part of the Health Board stroke action plan. Current rehabilitation space is sub-optimal and review of the stroke pathway includes detailed consideration of the environment and we are actively exploring options to address this. This action has been recognised as a risk and is regularly reviewed.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	April 2025 Update - An update against this recommendation action has not been provided on this occasion. December 2024, February 2025 Update - An update against this recommendation action has not been provided on this occasion. August 2024 Update - we continue to review this as a risk -Risk assessments have been submitted as part of the Health Board stroke action plan. Current rehabilitation space is sub-optimal and review of the stroke pathway includes detailed consideration of the environment and we are actively exploring options to address this. This action has been recognised as a risk and is regularly reviewed.		
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must work collaboratively with social workers and social care providers to ensure that delays in arranging or holding Best Interest Meetings are minimised, to ensure timely and effective hospital discharge for patients to improve flow.	Healthcare Inspectorate Wales (HIW)/2023/155/MD39/1	As part of the D2RA improvement programme, a task and finish group was set up to improve delays in the overall Mental Capacity Act process, including Best Interest meetings and associated Court of Protection proceedings. A training programme has been rolled out across social care and the Health Board. Delays are monitored though EWB and escalated as previously outlined. Timescales have been collaboratively agreed across health and social care of a 21 day maximum assessment period for Pathway 3 patients, which include MCA processes.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	April 2025 Update - An update against this recommendation action has not been provided on this occasion. December 2024, February 2025 Update - An update against this recommendation action has not been provided on this occasion. August 2024 Update - significant work ongoing under the optimise project to address MCA challenges with supported intervention from Head of nursing to maintain training and standards on their sites.		
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must develop and strengthen Home First services across Wales to benefit the people who need this across Wales, and to help manage the issues with patient flow through health and social care systems.	Healthcare Inspectorate Wales (HIW)/2023/155/MD40/1	Implementation of D2RA in CTM UHB has widely promoted the increase of Home First pathways. Awareness and engagement sessions have been held with nearly 500 staff. Key questions to increase update for Pathway 1 are included on board round guidance as well as guidance on selection of pathway. We continue to monitor the volume of home first pathways, with a balance to bed based pathways with the trend shown below (*table removed for AMaT purposes).	Unscheduled Care	01.04.2024	01.04.2024	Overdue	April 2025 Update - An update against this recommendation action has not been provided on this occasion. December 2024, February 2025 Update - An update against this recommendation action has not been provided on this occasion. August 2024 Update - this is ongoing - Implementation of D2RA in CTM UHB has widely promoted the increase of Home First pathways. Awareness and engagement sessions have been held with nearly 500 staff. Key questions to increase update for Pathway 1 are included on board round guidance as well as guidance on selection of pathway. We continue to monitor the volume of home first pathways, with a balance to bed based pathways with the trend shown below (*table removed for AMaT purposes).		
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Welsh Government, health boards and local authorities must work collaboratively to consider the options of improving the accessibility to care in the community, such as domiciliary care.	Healthcare Inspectorate Wales (HIW)/2023/155/MD41/1	A targeted improvement plan has been created through the Integrated Discharge Delivery Board that also reports directly in the 6GUEC board, the Integrated Adults and then into the Regional Partnership Board. Specific improvement has been identified for accessibility for intermediate care, domiciliary care and care homes. This action plan escalates activity highlighted through the market stability statement published by the region. A PoCD action plan addressing community delays has been collaboratively agreed with all partners. A work programme in line with WG guidance for Enhanced Community Care has been set up under an Integrated Director.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	April 2025 Update - An update against this recommendation action has not been provided on this occasion. December 2024, February 2025 Update - An update against this recommendation action has not been provided on this occasion. August 2024 Update - this is ongoing but being prioritised - "A targeted improvement plan has been created through the Integrated Discharge Delivery Board that also reports directly in the 6GUEC board, the Integrated Adults and then into the Regional Partnership Board. Specific improvement has been identified for accessibility for intermediate care, domiciliary care and care homes. This action plan escalates activity highlighted through the market stability statement published by the region.		

HIW Inspections Recommendation Actions Tracker as at 22/04/2025
(for Quality, Safety and Experience Committee 20/05/2025)

Inspection Code	Date of Inspection	Inspection Title	Recommendation	AMaT Reference Number	Action	Care Group	Original Due Date	Current / Revised Due Date	Progress Status	Comments/Updates	Barriers	Evidence
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must consider their discharge lounge services and whether they are utilised efficiently and effectively to support timely discharge to improve patient flow.	Healthcare Inspectorate Wales (HIW)/2023/155/MD42/1	The USC group continue to review inpatient bed base and patient flow to better understand the requirement for discharge lounges. Planned/predicted discharges are identified through the cross site bed meetings, in addition they form part of the out of hours and weekend planning cycle. There is a discharge lounge in place in POW and we are exploring the feasibility of further discharge lounges on the other two sites, recognising that capital and revenue investment would be required.	Unscheduled Care	01.01.2024	01.01.2024	Overdue	April 2025 Update - An update against this recommendation action has not been provided on this occasion. December 2024, February 2025 Update - An update against this recommendation action has not been provided on this occasion. August 2024 Update - this remains ongoing and requires capital funds - The USC group continue to review inpatient bed base and patient flow to better understand the requirement for discharge lounges. Planned/predicted discharges are identified through the cross site bed meetings, in addition they form part of the out of hours and weekend planning cycle. There is a discharge lounge in place in POW and we are exploring the feasibility of further discharge lounges on the other two sites, recognising that capital and revenue investment would be required.		
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health board must identify the hospital sites that do not have a discharge lounge service and should consider the benefits of implementing this service on improving patient flow.	Healthcare Inspectorate Wales (HIW)/2023/155/MD43/1	As above, the USC group continue to review inpatient bed base and patient flow to better understand the requirement for discharge lounges across our sites. Planned/predicted discharges are identified through the cross site bed meetings and form part of the out of hours and weekend planning cycle. There is a discharge lounge in place in POW and we are exploring the feasibility of further discharge lounges on the other two sites, recognising that capital and revenue investment would be required.	Unscheduled Care	01.01.2024	01.01.2024	Overdue	April 2025 Update - An update against this recommendation action has not been provided on this occasion. December 2024, February 2025 Update - An update against this recommendation action has not been provided on this occasion. August 2024 Update -As above, the USC group continue to review inpatient bed base and patient flow to better understand the requirement for discharge lounges across our sites. Planned/predicted discharges are identified through the cross site bed meetings and form part of the out of hours and weekend planning cycle. There is a discharge lounge in place in POW and we are exploring the feasibility of further discharge lounges on the other two sites, recognising that capital and revenue investment would be required. Ongoing 2024/25		
Healthcare Inspectorate Wales (HIW)/2023/155	07/09/2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must assure themselves that ward staff are promptly declaring a fully completed patient discharge within the electronic patient systems once they have left the ward. This is to enable patient flow managers to see that a bed as become available, to help manage timely patient flow.	Healthcare Inspectorate Wales (HIW)/2023/155/MD44/1	The electronic Whiteboard developed under the 6 Goals programme allows the site management team to see when a discharge has completed. As part of ongoing improvement to the system, there is an ambition for future versions to include a 'push report' that would notify the site team that a patient has been discharged.	Unscheduled Care	01.10.2024	01.10.2024	Overdue	April 2025 Update - An update against this recommendation action has not been provided on this occasion. December 2024, February 2025 Update - An update against this recommendation action has not been provided on this occasion. August 2024 Update - this work is ongoing with digital colleagues - The electronic Whiteboard developed under the 6 Goals programme allows the site management team to see when a discharge has completed. As part of ongoing improvement to the system, there is an ambition for future versions to include a 'push report' that would notify the site team that a patient has been discharged. Ongoing 2024/25		
Healthcare Inspectorate Wales (HIW)/2023/157	13/11/2023	Appendix C - Improvement Plan: Angelton Clinic, Glanrhyd Hospital (Ref: 03445)	The health board must ensure that hospital systems and processes can be suitably filtered to extract ward specific data to support effective supervision, governance oversight and shared learning.	Healthcare Inspectorate Wales (HIW)/2023/157/MD24/1	The incident management system Datix Cloud IQ can be filtered down to show specific data relating to areas, incident type and severity. The Head of Nursing is working with the Patient Care and Safety Business Intelligence officer to ensure all Lead Nurse, Senior Nurse and ward Managers have access to and training on Datix dashboards.	Mental Health & Learning Disabilities	31.01.2024	10.07.2024	Overdue	April 2025 Update - Awaiting dashboards to be diseminated, once this is completed we can take to QSRE for sign off and provide evidence. February 2025 Update (26-02-25) - LG has been working with the Business Intelligence Manager in the Patient Care and Safety team to move the structure of Datix to reflect the Care Groups functional model which went live 27th February 2025. This will now enable the development of a Quality Dashboard and allow the Care Group, directorates and all group of wards and teams to easily identify themes and trends.		
Healthcare Inspectorate Wales (HIW)/2023/167	31/07/2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with an update on the plans to reconfigure the EU footprint to address the environmental and operational challenges identified within the Ambulatory Care area.	Healthcare Inspectorate Wales (HIW)/2023/167/MD5/4	PCH is currently in the process of major construction works to remove and as part of this further applications for Welsh Government funding are being explored to support significant changes to the EU footprint. This will facilitate improved patient clinical areas allowing for improved patient and staff experience.	Unscheduled Care	01.06.2024	31.12.2024	Overdue	April 2025 Update - An update against this recommendation action has not been provided on this occasion. February 2025 update - capital work is still ongoing and PCH major construction works are continuing. Welsh Government funding continues to be explored, which will facilitate improved patient clinical areas allowing for improved patient and staff experience.		
Healthcare Inspectorate Wales (HIW)/2023/167	31/07/2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with an update on the plans to reconfigure the EU footprint to address the environmental and operational challenges identified within the Ambulatory Care area.	Healthcare Inspectorate Wales (HIW)/2023/167/MD5/6	CTM has implemented a pre-emptive transfer and boarding process to support patient flow, sharing the risk across inpatient areas allowing the de-escalation of risk held in ambulatory care. This reinforces that patient flow is a team approach across the site.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	April 2025 Update - An update against this recommendation action has not been provided on this occasion. February 2025 - this remains in progress, work ongoing August 2024 Update - work ongoing Awaiting date from Welsh Government following a successful bid for Funding. This will supply an extra toilet and showering facilities.		
Healthcare Inspectorate Wales (HIW)/2023/167	31/07/2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with an update on the plans to reconfigure the EU footprint to address the environmental and operational challenges identified within the Ambulatory Care area.	Healthcare Inspectorate Wales (HIW)/2023/167/MD5/7	We are awaiting capital works to progress to take down a wall partially of the large non-clinical area with the Ambulatory Care Area-this will facilitate improved observation of patients within the area to ensure patient care and safety.	Unscheduled Care	01.09.2023	01.09.2023	Overdue	April 2025 Update - An update against this recommendation action has not been provided on this occasion. February 2025 - capital plans and work remain ongoing at the PCH site, when completed the Ambulatory Care Area will be able to implements to plan to facilitate improved observations of patients within that area. Whist awaiting this work make safes are in place including regular timed routine checks of all areas including the waiting room to identify any changes in patients condition whilst awaiting clinical assessment. There is also increased monitoring of the patients vital signs for early recognition of any clinical changes. August 2024 Update - part of ongoing capital plans - We are awaiting capital works to progress to take down a wall partially of the large non-clinical area with the Ambulatory Care Area-this will facilitate improved observation of patients within the area to ensure patient care and safety.		
Healthcare Inspectorate Wales (HIW)/2023/167	31/07/2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to improve staff compliance with Departmental Fire Safety (EU) and Mental Capacity and DoLS (CDU) training.	Healthcare Inspectorate Wales (HIW)/2023/167/MD29/1	The Senior Nurse for Professional Education is key to progressing this agenda in EU and maintaining a database of training compliance and has developed a training needs analysis template. A plethora of study days, and protected study time for the inclusion of mandatory training and recovery of face to face study time has been provided. Ongoing training dates are in place with an improving picture which is monitored by the Nurse Director at bi-monthly workforce meeting. The Fire Officer has been undertaking bespoke training sessions for the PCH site weekly to improve compliance as part of the resetting post Covid-19 pandemic where training was unavailable as of Aug'23 fire training for staff is as follows:- ED-RN 72.85% HCSW 84% CDU-RN 97.50% HCSW 58.33%	Unscheduled Care	01.04.2024	01.04.2024	Overdue	April 2025 Update - An update against this recommendation action has not been provided on this occasion. February 2025 Update - The monthly workforce meetings chaired by the Director of Nursing to review workforce metrics and as part of this training compliance is reviewed with all areas required to achieve 85%. Ongoing Fire Training continues. CDU (now named AMU) Fire Training compliance is 92% to date. ED Fire Training compliance is 64% this is lower due the recruitment drive which has resulted in new Registered Nurses and Health Care Support Workers, this is being managed by the Senior Nurse for Professional Development and is being closed monitored by the Senior Nurse for ED.		
Healthcare Inspectorate Wales (HIW)/2023/167	31/07/2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with assurance Violence and Aggression, Mental Capacity and DoLS training compliance is effectively tracked for the EU.	Healthcare Inspectorate Wales (HIW)/2023/167/MD30/1	Monthly mandatory training study days and reports now include V & A, DoLs, medications management, safeguarding and MCA training and compliance. Mandatory training compliance is monitored during the 6 weekly Workforce and Business meetings; trends are monitored for improvements, where there is deterioration-action plans are required. V&A compliance is recorded on the Mandatory Training database held by the Senior Nurse for professional Education.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	April 2025 Update - An update against this recommendation action has not been provided on this occasion. February 2025 Update - The monthly workforce meetings chaired by the director of nursing to review workforce metrics and as part of this training compliance is reviewed with all areas required to achieve 85% continue. ED compliance has been reduced due to a recruitment drive which has resulted in a number of new Registered Nurses and Health Care Support Workers who are booked for, or awaiting training dates. Violence and aggression training compliance CDU (now named AMU) is 94% Violence and aggression training compliance is 77% MCA training compliance AMU is 79% MCA training compliance ED is 64% Safeguarding training compliance AMU is 90% Safeguarding training compliance ED is 78%		
Healthcare Inspectorate Wales (HIW)/2024/165	09/01/2024	Appendix B Immediate Improvement Plan_PCH Maternity Unit_9-11 January 2024 (Ref: 03600)	Midwifery staffing levels on night shift The health board are required to provide HIW with details of how it will ensure there are sufficient numbers of suitably qualified and trained staff on every night shift within the maternity service.	Healthcare Inspectorate Wales (HIW)/2024/165/MD1/7	g)Working with finance colleagues to develop a new model for obstetric theatre nursing (releasing midwifery time).	Children & Families	01.02.2024	01.02.2024	Partially complete (Overdue)	April 2025 Update - An update against this recommendation action has not been provided on this occasion. February 2025 Update - An update against this recommendation action has not been provided on this occasion. December 2024 Update - due to the current pressure at Princess of Wales site in relation to the roof repairs - theatre workforce has been on hold. Plans to re-instate the finance meeting is due February 2025. August 2024 - activity underway with finance colleagues but pace of progress has been impacted by the temporary closure of the maternity and neonatal units at Princess of Wales Hospital (PoW). A meeting took place with the lead nurse for Perioperative services and Finance to explore the feasibility for perioperative services to cover emergency and elective theatres 24/7. costings did not align with funding. The financing is now being revised to cover 3 elective theatres in the first instance, with meetings being arranged for May 2024. Commenced September 2023. Due for completion February 2024.		
Healthcare Inspectorate Wales (HIW)/2024/165	09/01/2024	Appendix B Immediate Improvement Plan_PCH Maternity Unit_9-11 January 2024 (Ref: 03600)	Midwifery staffing levels on night shift The health board are required to provide HIW with details of how it will ensure there are sufficient numbers of suitably qualified and trained staff on every night shift within the maternity service.	Healthcare Inspectorate Wales (HIW)/2024/165/MD1/10	j)Work with the Corporate Communications department to develop a Comms Recruitment strategy to demonstrate the benefits to attract staff to work in CTM UHB.	Children & Families	29.02.2024	29.02.2024	Partially complete (Overdue)	April 2025 Update - An update against this recommendation action has not been provided on this occasion. February 2025 Update - An update against this recommendation action has not been provided on this occasion. December 2024 Update: New qualified midwives are now in post with an additional 3 NQM due to date early 2025. Additional posts have been advertised and a further 5 WTE were appointed and due to be in post early March 2025. August 2024 Update - Work underway in conjunction with the recruitment and retention lead including developing a short video as part of an attraction campaign. There will be a focus on the PCH site.		
Healthcare Inspectorate Wales (HIW)/2024/166	09/01/2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	UNICEF Baby Friendly Initiative The health board must work to achieve the UNICEF Baby Friendly Initiative reaccreditation.	Healthcare Inspectorate Wales (HIW)/2024/166/MD3/1	There are dedicated infant feeding co-ordinators in place across the perinatal services who are working together toward BFI reaccreditation. The service is currently undertaking a number of audits in readiness for re-assessment which is planned for April 2024. Recent PREM data shows that infant feeding experience is positive. The service has implemented a feeding voice partnership.	Children & Families	01.05.2024	01.05.2024	Fully complete (Awaiting approval)	February 2025 Update - CTM Infant feeding strategy launched in CTM and Confirmation that PCH maternity is now BFI accredited. August 2024 Update - In response to a recent positive inspection audit there are a few actions underway. Accreditation being sought in the next couple of months.		20250305144524_accreditationmarkrequestformforreaccreditations.docx, 20250305144545_reassessmentlettercwmtafmaternity202502.pdf, 20250306195059_reassessmentlettercwmtafmaternity202502.pdf
Healthcare Inspectorate Wales (HIW)/2024/166	09/01/2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Healthcare Inspectorate Wales (HIW)/2024/166/MD11/6	Working with finance colleagues to develop a new model for obstetric theatre nursing (releasing midwifery time).	Children & Families	01.03.2024	01.03.2024	Partially complete (Overdue)	March 2025 Update - Meetings planned to revisit this work for PCH and PoW in March 2025. August 2024 Update - activity underway with finance colleagues but pace of progress has been impacted by the temporary closure of the maternity and neonatal units at Princess of Wales Hospital (PoW)		
Healthcare Inspectorate Wales (HIW)/2024/166	09/01/2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Healthcare Inspectorate Wales (HIW)/2024/166/MD11/8	Review safe care tool to ensure that red flags according to NICE Safe Staffing 2015 are included in the tool. Birth rate + assessment in progress, challenges with Safe care tool to meet the needs of maternity services and therefore returning to BR+	Children & Families	31.01.2024	31.01.2024	Fully complete (Awaiting approval)	March 2025 Update - Safe care has not been an effective tool for use in Maternity services the decision was made to return to using Birth Rate + Conversation had with Birth rate + , improvements have been made to the app to overcome previous issues. Birth rate + assessment in currently in progress. August 2024 Update - need to be reviewed at Care Group Workforce Meeting on the 28th August to monitor implementation.		20240923150337_safecaredataentryjuly2024.pptx
Healthcare Inspectorate Wales (HIW)/2024/166	09/01/2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Healthcare Inspectorate Wales (HIW)/2024/166/MD11/9	Work with the Corporate Communications department to develop a Comms Recruitment strategy to demonstrate the benefits of attracting staff to CTM UHB.	Children & Families	29.02.2024	29.02.2024	Partially complete (Overdue)	March 2025 Update - Mat-Neo services in PoW has now re-opened - Will revisit this work, contact made with recruitment to meet in April 2025. December 2024, February 2025 Update - An update against this recommendation action has not been provided on this occasion. UPDATE 11/9/24 Filming of staff has commenced, currently on hold due to pressures due to PoW temporary closure. August 2024 Update - Work underway in conjunction with the recruitment and retention lead including developing a short video as part of an attraction campaign. There will be a focus on the PCH site.		
Healthcare Inspectorate Wales (HIW)/2024/166	09/01/2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Healthcare Inspectorate Wales (HIW)/2024/166/MD11/16	The team are working with the wider Health Board initiative to ensure maternity services are included as part of 'Safe to Start'.	Children & Families	12.01.2024	12.01.2024	Partially complete (Overdue)	March 2025 Update- There have been challenges with attendance in Safe to Start meetings during the PoW temp closure due to the acuity and timing of the sessions which clash with handover and essential safety briefings in maternity. this will be revisited in a meeting arranged for 25th 2025, Senior on-call midwifery managers attend daily and weekend site escalation meetings. August 2024 Update - included in 'safe to start' meetings and working with the corporate team to ensure the mat neo template is fit for purpose.		
Healthcare Inspectorate Wales (HIW)/2024/166	09/01/2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Datix reporting The health board should undertake a review of the processes for reviewing incidents. The reviewing team should include clinicians and practitioners with the appropriate experience and expertise.	Healthcare Inspectorate Wales (HIW)/2024/166/MD13/1	All moderate and above are reviewed by the MDT and SMDT. A review of all no and low level incidents is underway to explore any emerging themes, trends and ensure that the service is addressing any concern / incident in a robust manner. A wider review of governance process is underway to ensure that there is sustainability and assurance in accordance with the Duty of Quality and Maternity and Neonatal Assurance Escalation Framework. The review was discussed in the Maternity and Neonatal Safety Board in February 2024, the outcome of this work and any recommendations will be presented at the Maternity and Neonatal Safety Board in April 2024.	Children & Families	01.04.2024	01.04.2024	Partially complete (Overdue)	April 2025 Update - An update against this recommendation action has not been provided on this occasion. December 2024, February 2025 Update - An update against this recommendation action has not been provided on this occasion. August 2024 Update - Children & Family Care Group just completing a review of the governance arrangements in line with the new incident management framework. Outcome of will be presented to the Maternity and Neonatal Safety Board in September 2024 with an implementation plan. The new arrangements will ensure proportionate review and learning.		
Healthcare Inspectorate Wales (HIW)/2024/235	13.11.2024	Hospital Inspection Report (Unannounced) Coity Clinic, Princess of Wales Hospital_Appendix C - Improvement Plan_13, 14 and 15 November 2024 (Ref: 03710)	5. The health board must develop a policy in line with best practice guidelines that ensures the safety, privacy, dignity and rights of patients can be maintained throughout the mixed gender wards as well as keeping patients of the same gender safe in dormitories.	Healthcare Inspectorate Wales (HIW)/2024/235/MD5/2	The Health Board has developed a Single Sex accommodation policy. The draft version Is currently going through the Health Board's ratification process.	Mental Health & Learning Disabilities	30.04.2025	30.04.2025	In Progress	April 2025 Update - In progress, Estimated date for completion 30/04/2025. Added to tracker February 2025.		
Healthcare Inspectorate Wales (HIW)/2024/235	13.11.2024	Hospital Inspection Report (Unannounced) Coity Clinic, Princess of Wales Hospital_Appendix C - Improvement Plan_13, 14 and 15 November 2024 (Ref: 03710)	7. The health board must develop a policy to provide guidance to staff regarding patients' use of electronic equipment, mobile phone devices and access to the internet.	Healthcare Inspectorate Wales (HIW)/2024/235/MD7/1	There is an all Wales Social Media Policy and a Health Board policy that supports use of mobile phones within hospital settings. Both policies are out of date. A request has been made to update the Health Boards policy.	Mental Health & Learning Disabilities	30.06.2025	30.06.2025	In Progress	April 2025 Update - In progress, Estimated date for completion 30/06/2025. Added to the tracker February 2025.		
Healthcare Inspectorate Wales (HIW)/2024/235	13.11.2024	Hospital Inspection Report (Unannounced) Coity Clinic, Princess of Wales Hospital_Appendix C - Improvement Plan_13, 14 and 15 November 2024 (Ref: 03710)	12. The health board must: • Provide an update in relation to the Section 136 process in terms of staffing and outcome of the review into a centralised Section 136 suite. • Provide assurance on what actions will be taken in the meantime to meet the guidance for standards of the Section 136 assessment facility and outline how individuals will be kept safe while under their care.	Healthcare Inspectorate Wales (HIW)/2024/235/MD12/1	Prior to the inspection, a capital bid had been approved for a centralised Section 136 suite within the RGH, and a specific ward had been allocated for this purpose. However, due to unforeseen circumstances at the Princess of Wales Hospital (POWH), many wards needed to be relocated, including the designated ward for the Section 136 suite. This work is part of a Health Board improvement plan and requires a substantial programme of repair. Until further notice, Section 136 assessments will be conducted within the mental health suites across the Health Board. At Coity Clinic, the Crisis Resolution Home Treatment Team (CRHT) now coordinate all Section 136 assessments. They are a dedicated team who specialise in crisis assessments to ensure continuity of care for patients during this time. This approach aligns with the process across the Health Board. The CRHT Operational Policy is being reviewed as part of the improvement work to align all 3 CRHTs.	Mental Health & Learning Disabilities	30.04.2025	30.04.2025	In Progress	April 2025 Update -In progress, Estimated date for completion 30/04/2025. Added to tracker February 2025.		
Healthcare Inspectorate Wales (HIW)/2024/235	13.11.2024	Hospital Inspection Report (Unannounced) Coity Clinic, Princess of Wales Hospital_Appendix C - Improvement Plan_13, 14 and 15 November 2024 (Ref: 03710)	13. The health board must: • Ensure all hospital areas are effectively cleaned. • Ensure patients on both wards have access to a working washing machine and tumble dryer. • Ensure staff have access to a working sink in the clinic room on Ward 14. • Strengthen the audit and oversight process to identify and action IPC issues. • Review the cleaning roles and responsibilities of nursing and domestic staff to ensure all areas of the wards are covered. • Update and review the Cleanliness Standard Roles, Responsibilities and Audit Tool Procedure policy and Housekeeping Standard Operating Procedure.	Healthcare Inspectorate Wales (HIW)/2024/235/MD13/3	The washing machine and tumble dryer will be replaced as part of the Capital scheme.	Mental Health & Learning Disabilities	31.08.2025	31.08.2025	In Progress	April 2025 Update -In progress, Estimated date for completion 31/08/2025. Added to tracker February 2025.		
Healthcare Inspectorate Wales (HIW)/2024/235	13.11.2024	Hospital Inspection Report (Unannounced) Coity Clinic, Princess of Wales Hospital_Appendix C - Improvement Plan_13, 14 and 15 November 2024 (Ref: 03710)	15. The health board must update the Medical Gas Cylinder policy, ensure that warning signs are displayed and review its current arrangements in terms of emergency equipment stock and oversight to ensure it is in line with guidance from the Resuscitation Council UK.	Healthcare Inspectorate Wales (HIW)/2024/235/MD15/3	The Medical Gas Cylinder policy has recently undergone a thorough review and refresh through the Medical Gases Advisory Group and is currently awaiting final sign-off stages this is expected to be completed by April 2025.	Mental Health & Learning Disabilities	30.04.2025	30.04.2025	In Progress	April 2025 - In progress, Estimated date for completion 31/04/2025. Added to tracker February 2025.		
Healthcare Inspectorate Wales (HIW)/2024/235	13.11.2024	Hospital Inspection Report (Unannounced) Coity Clinic, Princess of Wales Hospital_Appendix C - Improvement Plan_13, 14 and 15 November 2024 (Ref: 03710)	16. The health board must ensure the daily stock checks undertaken against the controlled drug logbook are recorded appropriately on Ward 14.	Healthcare Inspectorate Wales (HIW)/2024/235/MD16/1	The Health Board Control Drug (CD) policy is due for ratification which will align monitoring across all directorates.	Mental Health & Learning Disabilities	30.04.2025	30.04.2025	In Progress	April 2025 -In progress, Estimated date for completion 30/04/2025. Added to tracker February 2025.		
Healthcare Inspectorate Wales (HIW)/2024/235	13.11.2024	Hospital Inspection Report (Unannounced) Coity Clinic, Princess of Wales Hospital_Appendix C - Improvement Plan_13, 14 and 15 November 2024 (Ref: 03710)	16. The health board must ensure the daily stock checks undertaken against the controlled drug logbook are recorded appropriately on Ward 14.	Healthcare Inspectorate Wales (HIW)/2024/235/MD16/2	The Lead Pharmacist will deliver training in CD monitoring and medication schedule standards to all wards.	Mental Health & Learning Disabilities	31.03.2025	31.03.2025	Fully complete (Awaiting approval)	April 2025 Update, signed off QSRE March 2025; evidence attached. Added to tracker February 2025.		20250414112929_evidencecdlegalrequirementsmh.docx
Healthcare Inspectorate Wales (HIW)/2024/235	13.11.2024	Hospital Inspection Report (Unannounced) Coity Clinic, Princess of Wales Hospital_Appendix C - Improvement Plan_13, 14 and 15 November 2024 (Ref: 03710)	18. The health board must review the seclusion arrangements in place on the PICU and make improvements to ensure they adhere to the health board policy and best practice standards.	Healthcare Inspectorate Wales (HIW)/2024/235/MD19/1	The National Association of PICUs (NAPICU) standards outline best practice standards and minimum requirements. The Directorate will review the seclusion arrangements against the NAPICU standards and bench mark against the current provision the directorate have, outline areas of improvement and share within the Care Group QSRE meeting	Mental Health & Learning Disabilities	30.04.2025	30.04.2025	In Progress	April 2025 Update - In progress, Estimated date for completion 30/04/2025. Added to tracker February 2025.		
Healthcare Inspectorate Wales (HIW)/2024/235	13.11.2024	Hospital Inspection Report (Unannounced) Coity Clinic, Princess of Wales Hospital_Appendix C - Improvement Plan_13, 14 and 15 November 2024 (Ref: 03710)	20. The health board must ensure that patients receive appropriate nutrition and hydration monitoring and can access dietetic specialist services when required to help fully meet their medical needs.	Healthcare Inspectorate Wales (HIW)/2024/235/MD21/1	Within the Adult inpatient service there is Specialist Dietetic Service available to provide support and advice when required to ensure patients medical needs are met. Senior Nurse will carry out a spot check audit of the use of patients that require nutrition and hydration monitoring. This audit will be continued by the ward manager as part of the Managers Monthly Audit and reported to the Senior Nurse. Any themes, concerns will be escalated through the Senior Nurse's highlight report to the directorate QSRE meeting. There is a Health promotion board available within ward 14 and PICU.	Mental Health & Learning Disabilities	17.02.2025	17.02.2025	Fully complete (Awaiting approval)	April 2025 Update - completed, see evidence attached Added to tracker February 2025; this action is marked as Complete 17/02/2025 as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 25th March 2025 as Fully Complete.		20250414104526_evidencepicu.msg, 20250414104555_evidencewardmanageraudit.docx, 20250414104618_evidenceauditofntritionandhydrationmonitoring.docx
Healthcare Inspectorate Wales (HIW)/2024/235	13.11.2024	Hospital Inspection Report (Unannounced) Coity Clinic, Princess of Wales Hospital_Appendix C - Improvement Plan_13, 14 and 15 November 2024 (Ref: 03710)	24. The health board must reflect on the issues raised in the report by staff and engage further with all members of staff to fully understand their views and provide assurance to HIW on what actions it will take to address the concerns raised.	Healthcare Inspectorate Wales (HIW)/2024/235/MD25/1	A meeting has been held with the Senior Nurse to engage with staff and discuss issues raised during the inspection. Ward Managers will conduct regular supervision and hold Ward Meetings to provide staff with opportunities to share any issues or concerns. Concerns and recurring themes will be escalated and discussed within the Senior Management Team (SMT). 'Have your Say' informal drop-in sessions are in place with the Senior Nurse on a monthly basis.	Mental Health & Learning Disabilities	17.02.2025	17.02.2025	Fully complete (Awaiting approval)	Added to tracker February 2025; this action is marked as Complete 17/02/2025 as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 25th March 2025 as Fully Complete.		

Agenda Item
8.2.9

Quality, Safety & Experience Committee

Continuing Health Care

Dyddiad y Cyfarfod / Date of Meeting	20/05/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Lead Nurse Continuing Health Care & Head of MHLD Commissioning
Cyflwynydd yr Adroddiad / Report Presenter	Ana Llewellyn Nurse Director MHLD, Lucie Owen Nurse Director Primary Care and Communities
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Review

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group /Forum Individuals	**Date**	**Outcome**
MHLD QSRE	Monthly meetings	
PCC QSRE	Monthly meetings	

Acronyms / Glossary of Terms	
CIW	Care Inspectorate Wales
FNC	Funded Nursing care
HIW	Health Inspectorate Wales

ICPCB	Individually Commissioned Patient Care Board
JCC	Joint Commissioning Committee
MAOG	Multiagency operational group
NCCU	National Collaborative Commissioning Unit
PoCD	Package of Care Delays
PREMS	Patient reported experience measures
PROMS	Patient reported outcome measures
RPB	Regional Partnership Board
MHLD	Mental Health and Learning Disabilities
SLA	Service Level Agreement
PC&C	Primary Care & Communities
CHC	Continuing Health Care

1. Situation /Background

1.1 The purpose of this report is to provide members with an update on Quality, Safety, Risk and Experience (QSRE) issues in Continuing Health Care (CHC) services provided across Cwm Taf Morgannwg University Health Board.

1.2 This is annual report reflects the QSRE issues for the period of April 2024 to and including March 2025. The previous report to the QSRE Committee was on 14TH March 2024.

1.3 For the purpose of this report, the scope of Continuing Health Care (CHC) is inclusive of packages of care commissioned by the Health Board for individuals who are eligible for Continuing Health Care, Funded Nursing Care (FNC), S117 Aftercare and other joint health and social care packages.

1.4 CHC is provided across a range of settings including in hospitals, care homes and domiciliary care at home.

1.5 Continuing Health Care services are delivered and monitored through the following areas, Adult, Children, Mental Health (MH) and Learning Disabilities (LD).

1.6 Adult and Children are responsible within the Primary Care and Communities Care Group and MH and LD through the MHLD Care Group. Each service group has its respective QSRE meetings to report, discuss and seek assurance on matters relating to CHC in these areas.

1.7 The Health Board has recently established an Individual Commissioned Patient Care Board (ICPCB) which will strengthen the governance arrangements for CHC ongoing.

1.8 Each Care Group has a monthly cycle of Clinical Placement Panels whereby individual packages are scrutinised, approved and financed.

1.9 Additionally Clinical Placement Panels monitor the Quality and Safety of care package reviews, which are completed 3 months after inception and annually thereafter. More focused reviews are completed in response to changes in individual needs or risk.

1.10 There is a regional approach to responding to concerns within the Care Homes and Domiciliary care providers in CTM UHB in line with the national guidance on managing 'Escalating Concerns', known locally as the Multi Agency Operational Group (MAOG). This is a collaboration between Local Authorities (LA), the Health Board, Safeguarding and Care Inspectorate Wales (CIW) established to review the governance of the providers operating in the region.

1.11 The National Policy on Patient Safety Incident Reporting & Management 2023 set out specific guidance for the Incident reporting, Investigation and Management of incidents in

commissioned care. du.nhs.wales/files/incidents/national-policy-on-patient-safety-incident-reporting-2-0-pdf/

2. Specific Matters for Consideration

2.1 Internal Quality Assurance

2.1.1 CHC Finance Report

Mar-24				
Care Group	2023/24 full year cost of current packages £	**Number of Current Packages**	**D & D**	**New Packages**
CYP	271,403.05	3	1	1
Primary Care & Community	14,269,336.01	194	253	199
Mental Health & LD	42,424,590.70	614	335	346
Grand Total	**56,965,329.76**	**811**	**589**	**546**

Mar-25				
Care Group	2024/25 full year cost of current packages £	**Number of Current Packages**	**D & D**	**New Packages**
CYP	238,492.30	6	1	5
Primary Care & Community	15,540,550.00	217	253	241
Mental Health & LD	47,931,744.00	682	315	382
Grand Total	**63,710,786.30**	**905**	**569**	**628**

These figures demonstrate growth in both the numbers and the financial element of CHC in year. The clinical teams work hard to ensure that the care provision meets the assessed need and care plan of individuals by negotiating with the care sector and containing the cost.

The transformation of LD inpatient services under the Improving care Improving Lives report 2020 supports reducing the number of patients in specialist LD hospitals. The alternative community provision is challenging in terms of both capacity and cost. The cost of a complex care home bed is routinely more expensive than that of a hospital bed. Through the Regional Partnership Board Capital

program LD accommodation and support services has been prioritised.

MHLD has seen in year increase in the commissioning of independent rehabilitation and secure inpatient services for Adult Mental Health. Whereas within Older Adult Mental Health there have been noticeable increases in the commissioning of enhanced dementia care for those with more complex needs.

There are an additional 268 individuals who received their care through core services and our SLA with Marie Curie, these are predominately our palliative care patients receiving end of life care in their own home. Please note, the cost of Marie Curie is funded separately to CHC.

2024/25 saw providers request a substantial inflammatory uplift to meet the challenges of the independent sectors rising costs of care to include the minimum wage increases and staff retention.

There is an expectation that 2025/26 will have a similar trend with the added pressures of social services care allocations and further increases to the national wage.

2.1.2 Review Compliance

Under the CHC Framework 2021 there is a requirement to review all commissioned health care packages at 3 months after the package commences and annually thereafter. There is currently a 73% compliance in undertaking reviews for MHLD and 84% PC&C.

Compliance performance is influenced by a number of factors;

- Team capacity has not grown in line with the volume of packages being commissioned.
- Capacity to develop smarter ways of working is hampered by duplication and electronic systems which are not fit for purpose, resulting in duplication across systems.
- Focused, more frequent reviews are required with more complex packages which are considered high risk from a quality or cost perspective.
- Responding to new workstreams through Mental Capacity Act, Court of Protection referrals and redress through retrospective claims.

- Responding to patients' needs which change. Particularly prevalent in complex domiciliary care packages and specialist hospital placements.
- Responding to CHC Assessment requests made by family, solicitors and social workers.
- Participating in urgent escalating concerns such as home closures.
- CHC awards being made on 'Last Days of Life Pathways', where patients are deceased before the review period triggered.

To prioritise reviews individual case managers, receive monthly supervision. Those packages out of compliance with commissioning reviews continue to receive clinical oversight through Primary and Secondary care clinical services.

2.1.3 Compliments and Concerns

There has been 7 informal and 2 formal complaints across the CHC agenda. These have been regarding CHC process and eligibility and Legal Authority in relation to applying for a Retrospective Claim.

During the report period there were 42 compliments received. These range from across professional relationship to direct feedback from service users and carers. Some examples illustrated below.

Compliment from Patient

I've found the Commissioning Team very helpful. Whenever there was a small issue, though there was many, they were very responsive. My care Co-ordinator is always available to me and very pleasant to chat to. I feel we've build a positive relationship.

Compliment from Patient

I've found the Commissioning Team very helpful. Whenever there was a small issue, though there was many, they were very responsive. My care Co-ordinator is always available to me and very pleasant to chat to. I feel we've build a positive relationship.

From the family of a patient

Thanks for the update, good to hear you've been there regularly.

I am very satisfied with the way she's slipped back into Oakhill-life, she is now out most days. We're all very aware of the pressure the NHS staff face and they can only do so much in a short space of time, but being back with the people who know and love her so well has done wonders. I was there yesterday and could see more positive small changes they have made to try and get her mobility back.

I believe the new OT assessment will be another leap forward as she's not a fan of using the hoist, which I believe will also lead to being able to have more exercises as well.

All in all we as a family are very pleased with everything since returning and hope she is able to stay there for a long time yet.

The CHC process can be very emotional experience and process for patients and carers involved. Initial aspirations to identify and adopt an appropriate set of PREMS and PROMS to inform the service has been delayed but remains an area of priority for the Care Groups. Item 2.5.1 below looks at a local pilot for PREMS.

2.1.4 Incident Management in CHC

The CTM Incident Management Framework requires all incidents in commissioned care which are reported moderate and above are recorded through Datix. Due to the nature of the contract and regulatory standards, incidents in hospitals and care homes are also reported through statutory and regulatory bodies HIW, CIW and regional Safeguarding arrangements. The Care Groups participation in these processes and subsequent investigations, we are able to discharge the Health Boards responsibilities with Duty of Quality and Candour.

During the report period there were 12 locally MHLD reportable incidents recorded through Datix.

The highest prevalence on nature of these incidents relates to deliberate self-harm in MHLD independent hospitals.

All 12 incidents have been subject to a proportionate investigation and closed with no harm outcomes attributable to the Health Board.

3 incidents however remain open to external investigation, two are subject to Coroners Hearing and one subject to ongoing Police investigation. The findings of these external reviews will be reviewed for additional action and learning by the Health Board.

There is a well-established safeguarding policy embedded with the Care homes commissioned across CTM. This is a multi-agency approach to manage all incidents as these are encouraged to be reported as safeguarding referrals. All incidents are considered on a multiagency basis involving representations from the LA's, HB's, safeguarding officers, Care Standards inspectorate Wales, South Wales Police and family.

A workstream has been developed to ensure CTM are compliant with the Duty of Quality and Candour responsibilities for commissioned services for both FNC and CHC. Whilst recognising

the independent providers are responsible for the Duty of Candour, CTM have a responsibility to ensure that they are complaint with the guidance.

It has been necessary for the Care Groups to give consideration to the interface between the NHS Incident Management Framework and established Safeguarding processes to ensure that patient safety incidents are reported, subject to a proportionate investigation whilst avoiding unnecessary duplication. By mapping the current patient safety activity in our Care Homes through the Safeguarding pathways we are seeking assurance that this process will support the Health Boards in discharging its Duty of Quality and Candour.

2.1.5 Appeals & Disputes

Following a robust multi-agency assessment and completion of a decision support tool (DST), it is possible that the Local authority and the health board representatives do not agree an outcome and these cases are referred to as an inter-agency dispute. The national CHC Framework guidance offers a robust process to resolve these.

Families can also disagree and can appeal the decision, if they feel the process has not been followed or the criteria has not been applied appropriately, which is considered by an independent chairperson.

DISPUTES 24/25				
Total	**Closed Change of Circumstance**	**Completed Via Informal Process**	**Progressed to Formal Process**	**In progress**
36	**6**	**18**	**3**	**9**

Outcomes	
CHC Outcome	**No CHC Outcome**
7	**14**

APPEALS 24/25			
Total	**Resolved by an Independent Chair**	**Resolved via Escalation to Independent Review Panel**	**Activated and in progress, within the 6-month time frame**
26	**12**	**3**	**11**

Outcomes	
CHC Outcome	**No CHC Outcome**
0	**15**

Retrospective Claims

A retrospective claim enables individuals and or their legal representative to receive an independent review into their eligibility for CHC and free NHS care, we currently have 37 cases with 13 pending, waiting legal and financial authority to pursue. 17 cases were reviewed/completed during 2024/25, of which only 5 cases identified partial eligibility/full eligibility receiving a level of reimbursement.

The Health Board has seen a steady increase of requests through 2024/25, resulting in an increased workload. There is a strict timeframe of 6 months to consider all cases. There are currently 9 breaches in this area, mainly due to the delay in accessing care home notes. In an aim to address these breaches some additional resources have been diverted from the Nurse Assessor Team to focus on completing case chronologies, to address current breaches and limit others reaching these deadlines.

2.2 External Quality Assurance

2.2.1 Escalating Concerns & Closures

Two MHLD secure hospitals within CTM were subject to enhanced monitoring by regulatory bodies during the report period and remain open at the time of the report. In response to these concerns the CTM patients at these sites receive enhanced monthly monitoring which is reviewed through the Care Groups existing governance arrangements. Both HIW and JCC provide external oversight to both hospitals required improvements and are making progress towards de-escalation.

There are 26 Care Homes in the CTM footprint delivering nursing care for both NHS Funded Nursing Care and CHC residents. During

the report period only 2 of these 26 Care Homes have been monitored through a formal multi-agency escalating concerns process, none resulting in an embargo of admissions or a corrective action plan.

However, there have been an additional 3 Care Homes where the CHC team have provided enhanced monitoring visits on a monthly basis to support the home management teams with areas such as improving care planning, elements of training, mentoring new Clinical Leads.

Out of Area

One MHLD Residential Care Home out of area subject to escalating concerns. Initially an embargo to any new admissions was implemented however this has since been lifted however ongoing improvement plan continues to be monitored by the JCC. Any patient(s) at the site are being jointly reviewed by MHLD commissioning team in conjunction with RCT Local Authority.

One Nursing Care Home out of area, with CTM patients, resumed routine monitoring from the 30th April 2024 following a 12-month period in escalating concerns.

Two MHLD Care Homes closed during the report period resulting in a reduction of 10 units of residential and supported living accommodation. CTM patients were successfully relocated to alternative provision within CTM.

Outside of CTM region one MH secure hospital and one care home closed with CTM patients being successfully repatriated back to equitable provision in CTM.

2.2.2 National CHC developments

Following a national review of CHC undertaken by the JCC in 2024 the following recommendations and areas for development were made to the Value and Suitability Board, NHS Executive;

- An all-Wales digital system for CHC.
- All Wales support for NHS CHC assessors and reviewers training and competency.
- A process to identify opportunities to ensure value through consistent pricing.

- A continuation of the High-Cost Mental Health & Learning Disabilities Placements Reviews.
- CHC Health and Social Care Co-operation group.
- Strategic Commissioned Care Planning.
- Improving governance and oversight national and local CHC work

CTM will review its contribution to and progress against these areas through the newly established ICPCB.

2.2.3 Hospital & Care Home Capacity

There are approximately 1120 care home beds delivering nursing care across CTM, this is broken down to 800 general nursing and 320 EMI. The regulatory body, CIW, now have a more flexible approach to allow providers wishing to vary the existing registration of services, by increasing capacity in different aspect of care. This has resulted in a number of care homes flexing their services to increase the number of Emi provision across the patch, enabling a small number of residents with changing need to remain in the home, without the upheaval of a move. There has also been an increase in general nursing provision, some of these are new beds, with the opening of a new unit in a home in the Bridgend area, with others resulting from a variation from residential to nursing care.

EMI Nursing beds continue to be challenging to access periodically which can impact on patient flow from our inpatient areas. Compounded with a reliance on enhanced care provision (1-1 nursing) caring for patients with Dementia in our Acute and Community Hospitals, accessibility and cost of care home beds is challenging. Discharging patients with enhanced packages of care places additional demands on CHC Teams and those involved in the community reviews.

Operational models of Care Homes and Hospital based care for people with Dementia is necessary to avoid commissioning care, which is not proportionate to, and challenging to reduce in community settings.

Residential Care is the single, nationally reported reason for inpatients with LD to be a PoCD from a specialist MHLD bed. The most recent CTM inpatient audit identifies six patients recoded as PoCD with five waiting for suitable residential and one requiring

nursing care home. The RPB LD group is currently reviewing the regional accommodation strategy for people with LD. Since the inpatient audits commenced in 2022, CTM has lowest number of patients with an LD receiving care in MHLD hospitals.

The majority of female secure hospital placements are located outside of Wales and the one site available within Wales remains a site of concern to HIW. Thus, the options for females requiring this provision are limited and no current NHS Health Board in Wales offers this provision as part of its core service provision. There are currently 5 females requiring conditions of low security, 4 of whom require their care in England. Specialist inpatient provision for females is being reviewed by the Rehabilitation strategic board in MHLD Care Group.

2.3 Quality Improvement

2.3.1 CHC Training

Following the delivery of the revised national framework for CHC 2021 both MHLD and PC&C Care Groups delivered intensive programme of training for staff in CTM. Focussed training on request by services or departments can be facilitated. However, the sustainability of future training will benefit from a national approach and opportunities to develop digital delivery such as eLearning models. This will be delivered through a subgroup of the NHS Wales Continuing Healthcare Cooperation Programme Board.

In the interim the development of 'bitesize' eLearning opportunities is currently being explored with Senior Nurse for Quality Improvement in MHLD with similar opportunities within PC&C Care Group. This will ensure the quality of individual assessment and embed the CHC policy across all areas of the Health Board.

2.3.2 Process Mapping

A Health Board wide CHC process mapping event took place to bring interested parties together to review the current arrangements and explore opportunities for development. The event highlighted the complexities across Care Groups and the limited understanding that exists outside of those with direct responsibilities for CHC.

The priority area identified for development was a unified model for individually commissioned patient care and an agreed set of operational definitions that could be used as a foundation to future developments. Progress on this work is now monitored through the newly formed ICPCB.

2.3.3 Domiciliary Care Contract

Under the direction of the Commercial Contracting, Commissioning and Effectiveness work stream, we have worked closely with procurement to establish contract and service specification for Domiciliary care to be implemented from April 2025. Currently Domiciliary care commissioned on a spot purchase basis and the development of the contract and service specification will provide sustainability and financial governance of such packages.

2.4 Quality Planning

2.4.1 Individually Commissioned Patient Care Board (ICPCB)

The introduction of the ICPCB provides a new approach to the Health Boards governance arrangements for CHC, recognising that individually commissioned care is more than just continuing health care, is increasing in volume and cost and requires a structure of governance equitable to the risks involved. The ICPCB is Chaired by the Executive Director of Nursing.

2.4.2 Direct Payments and CHC

In February 2025 the Welsh Government passed legislation which will allow for the provision of Direct Payments to individuals assessed as eligible for CHC. Whilst this landmark ruling empowers patients to have greater control over who provides their care, considerable national and local developments will be required to ensure there is the appropriate governance and delivery functions to support this practice. National oversight is under the Welsh Government Policy division and reviewed through the National Complex Care Group.

2.4.3 Deputyship responsibilities and CHC

There is currently a Policy impasse in Wales between Health Boards and some Local Authorities regarding the responsibility for

arranging Deputyship for individuals who are eligible for CHC, and have been assessed as lacking mental capacity to manage their finances. The impasse is a matter of interpretation of the current CHC framework 2021 and the National Complex Care Group has written to Welsh Government for advice which remains outstanding at the time of the report. Without clarification the impasse presents such individuals without the necessary safeguards over their finances, unless they engage with a private arrangement. Such private arrangements can be made to the Court of Protection via a Best Interest Decision, however have a financial impact on the individual.

2.5 Peoples Experience

2.5.1 Patient & Carer Feedback

A pilot project was initiated in MHLD to gain feedback from patients in commissioned care using Microsoft Forms and QR code link to provide feedback. The report reflects the experience taken from 27 responses during the report period. Feedback was unanimously positive and where improvements could be made these have been acted upon.

In discussion with Commissioning Case Managers and Nurse Assessors, we recognise there are limitations in individuals' capacity to provide feedback so further development is required to seek the views of carers through a similar process.

3. Key Risks / Matters for Escalation

3.1 Care Groups capacity to fulfil its commitments to individually commissioned patients care.
3.2 Funding of the national priorities likely to be directed back to individual Health Boards.
3.3 Direct Payments for CHC and the readiness of Health Boards to support this additional/new responsibility.
3.4 Deputyship responsibilities under CHC – reputational risk to Health Boards favouring instruction of independent legal representatives.
3.5 Increase in Retrospective claims and capacity to manage within prescribed time frames.

4. 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	Living Well 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))*	Whole-systems Perspective 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))*	Effective If more than one applies, please list below: Efficient, equitable, person centred, timely and safe.
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable 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	If no, please include rationale below:

	Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	
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.	
	Any additional funding to support National CHC recommendations will be presented to the Values and Sustainability Board.	

5. Recommendation

5.1 The Committee is asked to **NOTE** the findings of this report.

6. Next Steps

6.1 Continue to strengthen the Governance arrangements for CHC through the ICPCB

Agenda Item
8.2.10

Quality, Safety & Experience Committee

Infection Prevention Control

Dyddiad y Cyfarfod / Date of Meeting	20/05/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	Becky Gammon – Assistant Director of Nursing
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	Filipe Leitao- Head of Infection Prevention and Control
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group /Forum Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	

1. Situation /Background

1.1 This report provides a summary of the Infection Prevention and Control (IPC) work plan associated with the implementation of the IPC strategy launched in 2025. It highlights achievements, challenges, and key strategic enhancements in line with the Welsh Government's Code of Practice for the Prevention and Control of Healthcare-Associated Infections.

2. Specific Matters for Consideration

- There have been significant achievements to date:

  - A reduction in healthcare-onset Methicillin Susceptible Staphylococcus aureua. (MSSA), Pseudomonas aeruginosa, Klebsiella spp., and E. coli bacteraemia, meeting most national targets.
  - A successful roll-out of the centralised IPC Hub model to streamline communication and provide extended hours support.
  - The implementation of new outbreak toolkit for use across the Health Board
  - A review of all outstanding investigations and policies
  - Secured over £400,000 in funding to establish a new community IPC team focused on improving infection surveillance and training in care homes and primary care.
  - The continued investment in infrastructure, including upgrades to sterile services and development of negative pressure isolation rooms (funds secured).
  - Forging strong collaboration with Public Health Wales to ensure the wider national agenda has oversight

3. Key Risks / Matters for Escalation

- CTMUHB did not meet national targets for Clostridium difficile, despite maintaining a rate below the all-Wales average.
- Low compliance with Level 2 IPC training, notably among medical and dental staff, poses risks to patient safety. IPC is raising awareness through Safe to Start and the IPC committee to ensure adequate visibility for all professional groups. IPC level 2 training will be made exclusively online for ease of access.
- The inconsistent delivery of microbiology services and testing methodologies, particularly concerning C. difficile, is significantly impacting benchmarking and data interpretation. Currently, the Clinical Testing Management (CTM) team is engaged in discussions regarding Service Level Agreements, wherein Infection Prevention and Control (IPC) will play a role in shaping future service strategies for microbiological services and testing.
- The designated Epidemiologist is no longer affiliated with the CTM. This matter is currently under discussion with our Director for Public Health to determine the appropriate next steps and engagement strategy.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Choose an item. If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable 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))*	Whole-systems Perspective 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))*	Safe If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable 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**	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below:

Have you undertaken an Equality and Welsh Language Impact Assessment Screening?	Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	Choose an item.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	Choose an item.	

5. Recommendation

The Committee are asked to **NOTE** the report.

6. Next Steps

- Priorities for 2025–2026.
- Address community-onset infection trends through cross-sector collaboration.
- Launch the IPC link worker program to embed best practices locally.
- Implement an improved system for incident review and lessons learned dissemination, including a Health Board-wide matrix.
- Finalise and embed the Development Framework to build IPC resilience and succession.

Infection Prevention and Control Annual Programme of work 2025/26

RED Immediate attention required Amber Goal ongoing/delayed Green Goal completed or scheduled as planned

No	Objective	Lead	Q1	Q2	Q3	Q4	Progress Review
MANAGEMENT SYSTEMS, Surveillance, audit, training, policy review, risk assessment							
1	**Policies and Procedures**						
	Water Safety Plan review approval	WSG members					Review presented at Water Safety Group, waiting for approval
	TB policy	TB nurse with IPC support					
							Policies to have included compliance criteria to inform further monitoring
							Policies to have included compliance criteria to inform further monitoring
							Policies to have included compliance criteria to inform further monitoring
							Policies to have included compliance criteria to inform further monitoring
2	**Reports**						
	Annual IPC	IPC Lead					2024/25 presented at Q1 committee 2025/26
	Monthly IPC update to Deputy Nurse Director	IPC Lead					
	Monthly IPC locality report	Senior IPC					
	Quarterly IPCC report	IPC Lead					
	Quarterly Decontamination Committee report	Decontamination Expert					
3	**Training**						
	Link worker program launch – 1st Link worker session deliver	IPC Nurse					
	IPC team monthly sharing and training meetings	IPC Team and microbiology (external presenter by invitation)					Alternate Months
	ANTT training to clinical staff – Face to face	IPC Team					
	Bespoke training session	IPC Team					Update on content to be included in updates

4	**Harm Reduction**						
	Point prevalence study - PPE	IPC Team					Findings to inform action
	Poin Prevalence study – Insertion and maintenance of catheter bundles	IPC Team					Findings will inform action
	Point prevalence study – PVC and CVAD	IPC Team					To be agreed
	Decontamination compliance audits	Decontamination expert, IPC Team					
	Task and finish groups for IPC standardization across the HB	IPC Team					Ongoing
	CDIFF testing and management review – Testing criterias across CTM, IPC data collection and RCA meetings review	Microbiology, IPC team and clinical leads					
	IPC part of all Wales collaborative work for reduction of CAUTI	PHW, IPC and blader and bowel team					
	IPC Part of CDiff steering Group	PHW and IPC					
5	**Audit**						
	Infection control standards by “areas of concern”	IPC Lead					Report presented at IPCC
	New Cleaning standards	Head of Facilities and IPC					Waiting for new standards to be approved
	IPC audit to HMP	IPC Nurse					
	IPC audit to Nursing homes – Community tool	IPC Nurse					Pending deployment of IPC community team – aimed at Q2
	Antibiotic use and outcomes (Quarterly)	Chief Pharmacist					Presented at IPCC
5	**New Builds and Refurbishments**						
	Negative pressure rooms at RGH and POW						Waiting for capital projects
6	**Risk Register Review**						
	Quarterly Review	IPC Lead					Presented at IPCC

The following tables sets measurable goals to achieve key objectives during the year 2025/26

No	Objective	Lead	Q1	Q2	Q3	Q4	Progress Review
1	**Targets to achieve reduction of HCAI**						
Goals 1 to 6, 9 &10	ANTT Training mandate re-instated	ESR Team					Essential to ensure baseline is determined and pursue next goal
	ANTT baseline determined and mark improvement goal	ESR team and IPC					
	Deploy Awareness initiatives for ANTT	Comms, IPC, Clinical leads					
	Increase IPC Level 1 and 2 compliance level – Target 85%	Comms, IPC, Clinical leadership				T85%	
	Catheter passport rollout at IPC sites and community (Nursing Homes)	Bladder and Bowel team lead and IPC			Full at inpt	Full inc. com.	
	All post infection reviews no longer than 3 weeks from positive result	IPC Team, microbiology and clinical leads					
Goals 7&8	All CDI reviews within no longer than 2 weeks of positive result (except when pending cluster investigation)	IPC team, microbiology and clinical leads					
	Testing under agreed criteria – Measured through RCA – Target 80% by Q4	IPC team, microbiology and clinical leads with comms support				T80%	
	PPI review for all known previous Cdiff patients within 48h of admission – Target 80% of cases reviewed through RCA by Q4	IPC, Clinical Leads, microbiology and pharmacy with comms support				T80%	Abx stewardship related goals to be measured through pharmacy report
2	**Link workers program**						
Resilence strategic goals	Achieve at least 1 link worker per ward at each acute site	IPc Team and clinical leads					
	Achieve at least 1 link worker per nursing home	IPC Team					
	Link workers training days – Minimum 1 per quarter	IPC Team					
3	**Community**						

Community Strategic goals	Visit and audit 100% of nursing homes on CTM geographical area	IPC Nurse, Local authorities, HPT					
	Visit and identify link worker for IPC at least 25% of GP Surgeries on CTM geographical area	IPC Nurse, Local authorities, HPT					
	Identify link worker at HMP	IPC Team					

Agenda Item
8.2.11

Quality, Safety & Experience Committee

Highlight Report from the Health, Safety & Fire Sub Committee

Dyddiad y Cyfarfod / Date of Meeting	20/05/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	Emma Walters, Head of Corporate Governance & Board Business
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	Dilys Jouvenat, Independent Member/Sub Committee Chair
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Hywel Daniel, Executive Director for People

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	

1. Introduction

1.1 This report had been prepared to provide the Quality, Safety & Experience Committee with details of the key issues considered by the Health, Safety & Fire Sub Committee at its meeting on 1 April 2025.

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

2. Purpose of this Meeting

2.1 The purpose of this Sub-Committee is to:

- Advise and assure the Board and the accountable officer on whether effective arrangements are in place to ensure organisational wide compliance of the health Board's health and safety policy, approve and monitor delivery against the health and safety priority action plan and ensure compliance with the relevant standards for Health Services in Wales.

- This will be achieved by encouraging strong leadership in health and safety, championing the importance of a common sense approach to motivate focus on core aims distinguishing between real and trivial issues.

  Where appropriate, the committee will advise the Board (through the Quality, Safety & Experience Committee) and the accountable officer on where and how, its health and safety management may be strengthened and developed further.

Highlight Report

Alert / Escalate	• There were no matters identified for escalation in this section.
Advise	• The Sub Committee received a Spotlight Presentation on Health, Safety & Fire issues at Royal Glamorgan Hospital. Members noted the steps being taken to address issues highlighted in relation to equipment blocking fire routes and exits and noted that a standardised approach across the three sites would be developed, with collaboration between Hospital Managers and the Facilities Service Director, noting the focus on ensuring safety and preparing a unified plan to be periodically shared with the sub-committee. Members also noted that Health, Safety & Fire matters would be included on the agenda for all future meetings of the Operational Management Board; • The Assistant Director of Health, Safety & Fire report was received. Members raised concerns about the Did Not Attend (DNA) rates for manual handling training sessions and noted that a discussion would be held at the Operational

	Management Board as to how the position could be addressed; • The Fire Safety report was received. Members noted that fire awareness training had been revised to fall under departmental responsibility which would involve assigning specific personnel to deliver the training tailored to the needs of their respective departments; • The Overarching Care Group Health, Safety & Fire report was received. Members noted the ongoing issues with car parking across several sites, particularly at Royal Glamorgan Hospital, which was affecting both patients and staff. The importance of maintaining close monitoring to address these concerns effectively was noted; • The Unscheduled Care Group Health, Safety & Fire Highlight Report was received and discussed. A discussion was held in relation to double and triple boarding on wards and how frequent this was occurring. Members noted that risk assessments in relation to boarding of patients were not always being undertaken by Nurse Managers and noted that this was in the process of being addressed with the Assistant Director of Quality Safety and Hospital Managers
Assure	• The Planned Care Group Health, Safety & Fire report was received and discussed; • The Health, Safety & Fire Performance Report was received and discussed; • The Organisational Risk Register report was received and discussed.
Inform	• The Unconfirmed Minutes of the meeting held on 24 January 2025 were received and approved; • The Annual Cycle of business for 2025 was received and noted.
Appendices	None identified.

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	Living Well
	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))*	Learning, Improvement & Research
	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))*	Safe
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	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: Not applicable for this report
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: Not applicable for this report

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.

4. Recommendation

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

Agenda Item
5.2.2

Joint Commissioning Committee

Quality Safety and Outcomes Sub-Committee Highlight Report

Dyddiad y Cyfarfod / Date of Meeting	18/03/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Helen Tyler, Head of Corporate Governance
Cyflwynydd yr Adroddiad / Report Presenter	Susan Elsmore, Lay Member
Noddwr yr Adroddiad / Report Sponsor	Carole Bell, Director of Nursing and Quality

Pwrpas yr Adroddiad / Report Purpose	For Noting Choose an item.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
N/A		Choose an item.

1. SITUATION/BACKGROUND

This report had been prepared to provide a summary of the key issues considered by the Joint Commissioning Committee Quality, Safety and Outcomes sub-committee at its meeting on 3 February 2025.

Key highlights from the meeting are reported in Section 3.

2. PURPOSE

The Purpose and Role of the Joint Committee and the sub-committees are set out in Paragraphs 2.18 and 2.20 of the JCC Standing Orders.

The Quality and Safety Outcomes Committee Terms of Reference can be found here.

3. HIGHLIGHT REPORT

(Links to reports highlighted February 2025 – NHS Wales JCC QSO)

RAG Rating	Highlight
Alert / Escalate	• The Chair and Members expressed concern in relation to the risks and pace of resolution for Neonatal and Paediatric Services. Before escalating this formally to the JCC a specific update on the strategic approach and progress from the escalation process will be brought to the March 2025 QSO meeting for further discussion. Members discussed potential inequity of access and how this would be reported. It was agreed that where such inequities were identified these could be highlighted and addressed within the Director reports. This will form part of the Commissioning Approach for the JCC which will be developed over the coming months as part of the next phase of the formation work and organisational development.
Advise	• The Chair welcomed members and attendees to the first JCC QSO meeting. The Terms of Reference and Forward Work Plan were presented. Members noted the inclusion of a HB CEO as a member rather than an attendee. Further work on the forward work plan will be undertaken to ensure a comprehensive approach to reporting. The reporting of patient experience was queried and members were assured that outcomes reporting would be included within the directors' commissioning reports and the overarching incident and concerns reports. A suggestion was made to broaden the scope of the concerns report to include patient experience to meet the reporting requirements for the duty of Candor and duty of Quality. • Members discussed the reporting mechanisms into Health Boards (HBs), with the Director of Nursing suggesting the reinstatement of the Quality Newsletter to share information with HBs, as this highlighted good practice and service improvements. This would be in addition to a highlight report for inclusion on HBs' Quality and Safety Agendas and the Joint Commissioning Committee (JCC) public meeting Agenda.

RAG Rating	Highlight
	• The Director of Commissioning for Specialised Services provided updates on various specialist services, including improvements in workforce for paediatric and neonatal services, progress in plastic surgery wait times, and the status of the major trauma network data system. Members raised concerns in relation to neonatal and paediatric services as highlighted above. • The Director of Nursing presented the Director of Commissioning for Ambulance Services and 111 report and provided updates in relation to ongoing emergency ambulance pressures, including a critical incident declared by the Welsh Ambulance Service. The commissioning team has been working closely with health board colleagues to address these pressures and develop improvement plans. The quality and safety dashboard, which includes high-level reports on quality domains was highlighted. An update on ambulance measures review was provided which aims to align quality patient outcomes with ambulance performance targets. Members raised concerns over bundle compliance and it was noted that compliance for ST-elevation myocardial infarction (STEMI) was under 70%. A request was made for adding immediate release red and amber data to this report for future meetings. • The Director for Mental Health and Vulnerable Groups report was presented and members noted in relation to framework services quality ratings, that some units, including St. Andrews in Northampton, faced staffing and medication challenges, which may lead to safety concerns. Action plans have been implemented to address these issues. Staffing issues at Rampton High Secure Hospital and one patient waiting for many months for admission was highlighted as an issue within High Secure Services. The JCC Director for Mental Health will write to the Director of Specialised Commissioning in England highlighting concerns with Broadmoor Hospital not being accessible to Welsh patients. Capacity issues at Caswell were also noted. Members received an update on the review of gender assessment clinics in England and plans to open satellite clinics in Wales. An update on children and young people's gender services and the commissioning of beds in a new perinatal unit in North Wales was also provided.

RAG Rating	Highlight
Assure	• Members were informed about the Risk approach and noted that by March 2025, risks related to quality and safety will be reported to this sub-committee for review and assurance. Members requested additional information for the March 2025 meeting on the following items: • Specific update on the qualitative information regarding the review of long waiters for plastic surgery (south Wales). • An update on the resolution of the radioactive isotope production issue at Cardiff University and its impact on South Wales patients. • There were gaps in the Ambulance and 111 reporting data around percentages of patients kept at home rather than transferred to hospitals and further information was requested; and • Mental Health –a detailed update on the commissioning framework for secure services including staff training and experience to be provided. A discussion around concerns and incident reporting led to the Director of Nursing and Lay Member agreeing to meet and progress some work on this outside of the meeting.
Inform	• A presentation was shared which focused on the Microprocessor Knee (MPK) Service at Cardiff Artificial Limb and Appliance Service (ALAS). The presentation highlighted the benefits of MPKs, such as improved mobility, less pain, and increased confidence among users. The presentation included quotes from patient impact statements, emphasising the positive changes in their lives due to the MPK. • A patient story was also received, and the patient highlighted the benefits in improved mobility, reduced falls and overall quality of life along with the improved emotional and mental wellbeing. • Members received an update on incidents and concerns across the range of JCC commissioned services. A summary of the open incidents and complaints was provided and members noted that work was underway to improve reporting on complaints and concerns. • Members received an update on regulatory activity, including recent changes in representation and ongoing work with the NHS executive and Welsh Government.
Appendices	None

4. ASSESSMENT

Objectives / Strategy	
Dolen i Amcan (au) Strategol CBC Link to JCC Strategic Objectives(s)	Improve Equity and Population Health Ensure Quality
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 More Equal Wales
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Whole-systems Perspective 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: Equitable
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable 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: N/A
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☒	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please include rationale below: N/A
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Joint Committee as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. RECOMMENDATIONS

The Joint Committee is asked to:

- **Note** the highlights outlined in Section 3 of this report.