

Quality, Safety & Experience Committee

Tue 25 March 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 25 March 2025.pdf (5 pages)

3.2. Matters Arising not contained within the Action Log

Discussion

Carolyn Donoghue, Independent Member/Committee Chair

09:15 - 09:35
20 min

4. STAFF AND SERVICE USER EXPERIENCE

4.1. Shared Listening & Learning Story - Care Received at the Snowdrop Breast Centre

Discussion

09:35 - 10:35
60 min

5. SETTING THE SCENE - SERVICE DELIVERY

5.1. Spotlight Presentation - Stroke Unit Temporary Centralisation

Discussion

Emma James, Care Group Nurse Director

 5.1 USC Care Group-Spotlight Report Stroke QSEC 25 March 2025 v2.pdf (10 pages)

5.2. Report from the Clinical Executives

Discussion *Clinical Executives*

 5.2 Clinical Executive Directors Update QSEC 25 March 2025.pdf (13 pages)

5.3. Care Group Highlight Reports

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

- Children & Families
- Unscheduled Care
- Planned Care
- Mental Health & Learning Disabilities
- Primary Care & Communities
- Diagnostics, Therapies, Pharmacy & Specialities

 5.3a Highlight Report Children & Families Care Group QSEC 25 March 2025.pdf (7 pages)

 5.3a Appendix MatNeo Metrics March 25 QSEC 25 March 2025.pdf (27 pages)

 5.3b Highlight Report USC QSEC 25 March 2025.pdf (11 pages)

 5.3c Highlight Report Planned Care QSEC 25 March 2025.pdf (7 pages)

 5.3d Highlight Report MHL D QSEC 25 March 2025.pdf (9 pages)

 5.3e Highlight Report PCC QSEC 25 March 2025.pdf (9 pages)

 5.3f Highlight Report DTPS QSEC 25 March 2025.pdf (13 pages)

10:35 - 11:05
30 min

6. DELIVERING OUR PLAN

6.1. Patient Safety, Quality & Experience Dashboard

Discussion *Assistant Director of Quality & Safety*

 6.1 Patient Safety and Quality Dashboard Report QSEC 25 March 2025.pdf (23 pages)

6.2. Safe Care Partnership 2 and developing a Quality Management System

Discussion *Paul Gimson, Assistant Director of improvement Culture Capability and Delivery*

 6.2 Quality Management Systems QSEC 25 March 2025.pdf (6 pages)

11:05 - 11:35
30 min

7. GOVERNANCE, RISK AND ASSURANCE

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

Discussion *Gareth Watts, Director of Corporate Governance/Board Secretary*

 7.1a Organisational Risk Register - March 2025 - QSEC.pdf (8 pages)

 7.1b App 1 - Org RR March 2025 - QSEC 25 March 2025.pdf (9 pages)

7.2. Coroner's Inquest – Case Activity & Lessons Learned

Discussion *Assistant Director of Quality & Safety*

 7.2 Coroners Inquest report QSEC 25 March 2025.pdf (6 pages)

7.3. Health, Safety & Fire Sub Committee Highlight Report 24 January 2024

Discussion *Hywel Daniel, Executive Director for People*

 7.3 Health Safety Fire Sub Committee Highlight Report QSEC 25 March 2025.pdf (6 pages)

8. CONSENT AGENDA

5 min

8.1. FOR APPROVAL

8.1.1. Unconfirmed Minutes of the Meeting held on 21 January 2025

Discussion Carolyn Donoghue, Independent Member/Committee Chair

 8.1.1 Unconfirmed Minutes QSE Committee 21 January 2025 QSEC 25 March 2025.pdf (16 pages)

8.1.2. Unconfirmed In Committee Minutes of the Meeting held on 21 January 2025

Discussion Carolyn Donoghue, Independent Member/Committee Chair

 8.1.2 Unconfirmed Minutes In Committee QSEC 21 January 2025 QSEC 25 March 2025.pdf (2 pages)

8.1.3. Policy for the Asbestos Management Plan

Decision Sally May, Executive Director of Finance

 8.1.3a Asbestos Plan QSEC 25 March 2025.pdf (4 pages)

 8.1.3b AMP Final R 18-Mar 2025 QSEC 25 March 2025.pdf (39 pages)

8.1.4. Medical Gases Management Policy

Decision Sally May, Executive Director of Finance

 8.1.4a Med Gas Policy QSEC 25 March 2025.pdf (5 pages)

 8.1.4b Med Gas Policy FINAL 25-Feb 2025 QSEC 25 March 2025.pdf (29 pages)

8.1.5. Water Safety Plan

Decision Sally May, Executive Director of Finance

 8.1.5a Water Safety Plan QSEC 25 March 2025.pdf (4 pages)

 8.1.5b Water Safety Plan FINAL 25-Feb 2025 QSEC 25 March 2025.pdf (62 pages)

8.2. FOR NOTING

8.2.1. Non-Routine Committee Business (Forward Plan)

Information Gareth Watts, Director of Corporate Governance/Board Secretary

 8.2.1 CTMUHB QSEC Non Routine Bus QSEC 25 March 2025.pdf (3 pages)

8.2.2. Annual Cycle of Business

Information Gareth Watts, Director of Corporate Governance/Board Secretary

 8.2.2 CTMUHB QSEC Cycle of Business QSEC 25 March 2025.pdf (5 pages)

8.2.3. Health Inspectorate Wales (HIW) Audit Tracker Report

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

 8.2.3a HIW Tracker Inspection Improvement Plans- QSC Mar 25 v2.pdf (7 pages)

 8.2.3b App 1- HIW Inspections Tracker_QSEC March 2025 - V2.pdf (14 pages)

8.2.4. Cwm Taf Morgannwg University Health Board (CTMUHB) National Clinical Audit Programme Quarter 3 Update 2024-25

Information Dom Hurford, Executive Medical Director

 8.2.4 Clinical Audit Quarterly Report QSEC 25 March 2025.pdf (7 pages)

8.2.5. Cwm Taf Morgannwg University Health Board (CTMUHB) Clinical Audit Forward Plan for 2025-26

Information Dom Hurford, Executive Medical Director

 8.2.5a Clinical Audit Forward Plan 2025 2026 QSEC 25 March 2025 (003).pdf (5 pages)

 8.2.5b Appendix 1 National Clinical Audit Annual Plan CTMUHB 2025_26 QSEC 25 March 2025.pdf (11 pages)

8.2.6. Organ Donation Sub Committee Highlight Report

Information Dom Hurford, Executive Medical Director

 8.2.6 Organ Donation Sub Committee Highlight Report QSEC 25 March 2025.pdf (5 pages)

11:40 - 11:50 9. CLOSE OUT BUSINESS 10 min

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

11:50 - 11:55 10. Private / Closed Session Business 5 min

Discussion Carolyn Donoghue, Independent Member/Committee Chair

The following item is being discussed at the In Committee session:

- Organisational Risk Register - Closed Risks

11:55 - 12:00 11. Date & Time of the Next Meeting 5 min

Information Carolyn Donoghue, Independent Member/Committee Chair

Tuesday 20 May 2025 at 9:00am

Committee Action Log

the action originated from	reference	Reference Page Number	Item 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	In progress The Quality, Safety & Experience Dashboard includes a section on Ombudsman cases. Ongoing efforts are focused on identifying specific lessons learned for sharing across the organisation and wider, with an emphasis on any identified themes. It is proposed that information detailing the learnings from Complaints, Ombudsman Reviews, and Coroners' cases will be included in the Patient Safety, Quality & Experience Dashboard for presentation at the May 2025 QSEC meeting .
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	Open	Proposed for Closure Presentation shared at the meeting held on 21 January 2025.
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	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	Open	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	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
21.01.2025	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	Open	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	Open	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	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	Open	In progress Confirmation received from WAST that they no longer produce this report. Deputy Director of Nursing has proposed that USC Care Group could be requested 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, for presentation to the May 2025 meeting. Agreement received from the Committee Chair that she was content with this proposed approach
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	Open	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	5,1	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	Open	In progress Discussion held at agenda planning session held on 11 February 2025 where Deputy Director of Nursing advised that the USC Care Group had indicated this would be difficult to provide on a regular basis. Agreed that the Deputy Director of Nursing would ask the USC Care Group to undertake a problem solving exercise to consider the areas that Members feel concerned about and how it would be best to report back to Committee in order to provide Members with assurance
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	In progress Care Group Nurse Director has confirmed that this report will be presented to the May meeting of the Committee. Added to forward work programme
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	Open	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	Open	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	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

Committee Action Log

Committee
Member

the action originated from	reference	Reference Page Number	Item Title / Summary	Nature of Action	Lead Officer	Lead Executive	Timescale for action to be completed	Status of Action	Narrative Progress Update
23.07.2024	2,1	4	Listening & Learning Story	Review to be undertaken to determine why a decision had been made by the Bed Manager to not move the patient into one of the vacant beds, as opposed to this decision being made by the staff working on the ward.	Unscheduled Care/Planned Care Group Nurse Directors	Executive Director of Nursing/Deputy CEO	18-sep-24	Open	Proposed for Closure – Response provided from E James and S'O Brien and shared with G Jones and Committee Members by email on 23 August 2024. Further assurance sought by Committee Members who felt response did not address the concerns raised Further response shared with the Committee Chair and Independent Member by email. Confirmation received that assurance has now been provided
18.09.2024	5.2e	9	Unscheduled Care Group Highlight Report	Discussion to be held outside the meeting in relation to the most appropriate level of detail that could be provided to Committee Members in relation to the risk highlighted within the alert/escalate section and in what forum this should be presented in order to provide the Committee with assurance, for example, in Committee session.	Director of Corporate Governance/ Board Secretary	Director of Corporate Governance/ Board Secretary	19-nov-24	Open	Proposed for Closure Further discussion held at the In Committee session held on 18 September where it was agreed that further detail would be shared with Members outside the meeting in regards to this matter. Following agreement with the Committee Chair, it was agreed that a further update on the steps taken to address the issues would be included in the January 2025 iteration of the Unscheduled Care Group Highlight report. On agenda
18-sep-24	2.1 (CLOSED ITEM)	2	Current position - Health Visiting Services Bridgend	Action plan to be presented to a future meeting of the Committee.	Director of Midwifery	Executive Director of Nursing/Deputy CEO	21-jan-25	Open	Proposed for Closure The action plan has been made available for Members to view on request
19.11.2024	6,2	12	HMP Parc and Young Persons Unit A Year On	Focussed session to be provided to Board Members on Parc Prison at a future Board Development Session given the number of complexities within the service.	Deputy Chief Operating Officer	Chief Operating Officer	21.01.2025	Open	Proposed For Closure Has been added to the forward work plan for Board Development topics
19.11.2024	6,6	14	CTMUHB Welsh Risk Pool and Legal & Risk Services Annual Review 2023-24	Discussion to be held with the Corporate Governance Team outside the meeting to confirm future reporting requirements moving forwards.	Assistant Director of Quality & Safety	Executive Director of Nursing/Deputy CEO	21.01.2025	Open	Proposed for Closure The actions referred to within the meeting were actions captured within the review undertaken by Internal Audit on the Welsh Risk Pool. These actions have been captured within the Audit Recommendations Tracker which is regularly being reported to the Audit, Risk & Assurance Committee

19.11.2024	2.1 (CLOSED ITEM)	2	CTMUHB Welsh Risk Pool and Legal & Risk Services Annual Review 2023-24	Update on progress against actions to be presented at a future meeting of the Committee.	Assistant Director of Quality & Safety	Executive Director of Nursing/Deputy CEO	21.01.2025	Open	Proposed for Closure The actions referred to within the meeting were actions captured within the review undertaken by Internal Audit on the Welsh Risk Pool. These actions have been captured within the Audit Recommendations Tracker which is regularly being reported to the Audit, Risk & Assurance Committee.



Agenda Item 5.1		25 th March 2025	Quality, Safety & Experience Committee	Spotlight report – Stroke Unit Temporary Centralisation	
Report Details:			Impact Assessment:		
FOI Status:	Open (Public)		Indicate the Quality / Safety / Patient Experience Implications:	The presentation will highlight the issues experienced on quality, safety and experience and the measures teams have implemented in seeking to mitigate concerns.	
If closed please indicate reason:					
Prepared By: <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Emma James – Director of Nursing for USC Gary Howell – Interim Clinical Director of Therapies Victoria Healey – Head of Quality and Patient Safety		Related Health and Care Standard	Governance, Leadership & Accountability	
Presented By:	Emma James – Director of Nursing for USC		Equality and Welsh Language <i>Have you undertaken an Equality and Welsh Language Impact Assessment Screening?</i>	No, this is a presentation to update on issues and progress on issues within the CTM stroke service at RGH.	
			Are there any Legal Implications /Impact.	No	
			Are there any resource (capital/Revenue/Workforce Implications / Impact?	No	
			Link to Strategic Goals	Please Select: Inspiring People Improving Care	
Report Purpose	Please Select: For Discussion For Noting				
Engagement undertaken to date:	Care group led 1:1 discussions with staff and executive reporting.				

Spotlight report – Stroke Unit Temporary Centralisation (currently occupying ward's 19& 20 at RGH)

Overview – This report will capture the journey the teams and the broader care group have embarked on since the temporary centralisation of services following both estate and medical workforce challenges.

POW Move – October 31st 2024 – Transition of POW staff following critical incident.

PCH Move – January 8th 2025 – Following multiple team meetings and 1:1's from the 17th-23rd December and engagement with trade union colleagues, staff transitioned to RGH as a whole team. Multiple wellbeing sessions offered plus further 1:1's at the 6 week mark and proposed at 12 week mark also.

IM & Exec Walkthrough – 6th February 2025 – Time spent with the Ward 19 side of Stroke Unit. Feedback provided to the USC group and subsequent improvement actions taken.

Independent Member and Executive Feedback

Areas of good practice/ achievements

The staff have worked hard to establish the unit following being relocated

Dedicated rehab bay has been created

Centrally located nursing station good area for staff to work around

Area's of concern

Low staff morale

Staff seeking posts elsewhere and being prevented from moving

A greater leadership presence was required

Lack of office space

Transport continuation concerns

Concerns over patient outcomes due to loss of specialist skills and lack of space to mobilise and rehab effectively

Concerns around handling of the move in relation to individual circumstances

Practical issues over ward layout, toilet sizes and numbers of cubicles compared to PCH

Concerns over models differing between ward's 20 & 19 and staff now caring for more rehab patients

Issues around patient care in relation to patients not sitting out enough, oral care and falls increases (reported via Datix) were also raised

Fire doors were blocked with equipment and there was generally lots of equipment blocking evacuation areas

Key Issues/ Notable Practice

Recently appointed lead nurse having a positive impact

The Stroke Unit Temporary Centralisation Workforce

Complexity

Environment

Monitoring on Ward 20

Shift Harmonisation

Different process' & approach

Therapies team amalgamation

Medical workforce harmonisation

TIA clinics

Review of the CNS workforce

The Environment

Datix

AMaT audits

Environmental walk through with estates colleagues

Quick Wins/ v's Capital requirements

Dedicated rehab space

Office/Admin spaces

Storage

Improvement Cycles

Key Achievements & Progress:

Establishing a Structured Huddle Format: Implemented a 10-minute rapid improvement huddle at a fixed time (12:30 PM) with a rotating facilitator.

Used a whiteboard setup for visibility and accountability, tracking wins, concerns, actions, and follow-ups.

Early Wins & Improvements:

Cross-covering by daily review of nursing skill mix trailed successfully.

Therapy prioritisation working well with increased patient sitting-out rates across the unit & rehab sessions continuing despite PT workforce challenges.

Standardised handover and visiting times

Patient flow and bed allocation ideas in progress and challenges identified and solutions implemented

Action log in progress to track and ensure ongoing progress

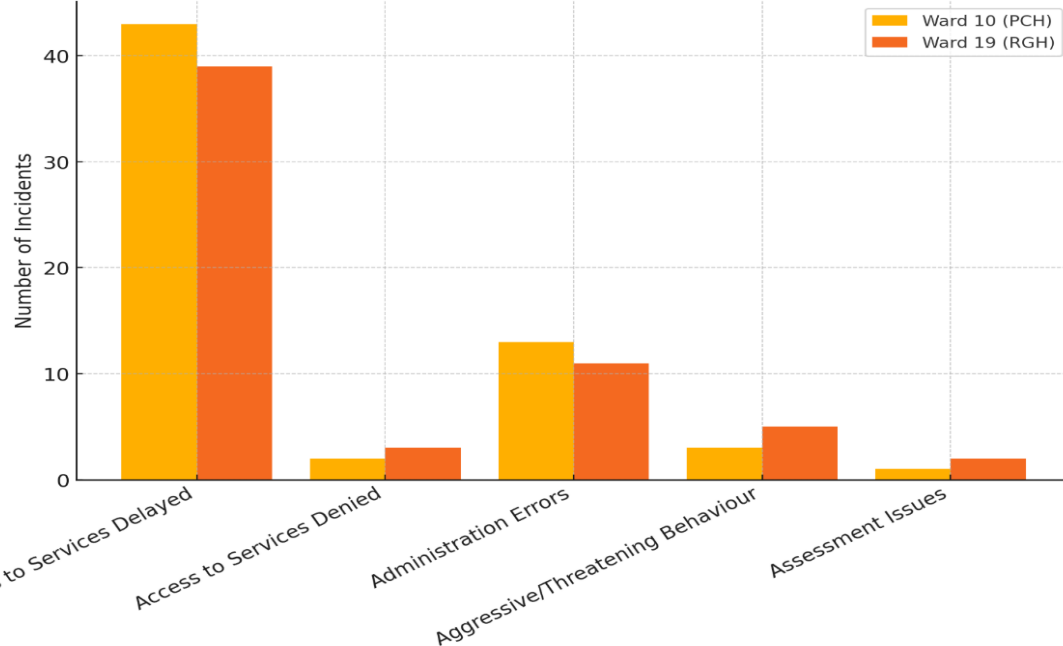
Leadership Shift: Initially led by management, huddles now encourage team-led discussions.

Ward Integration: Collaboration between two wards to create a single stroke unit.

Sustained Engagement: Ongoing tracking and escalation of unresolved issues.

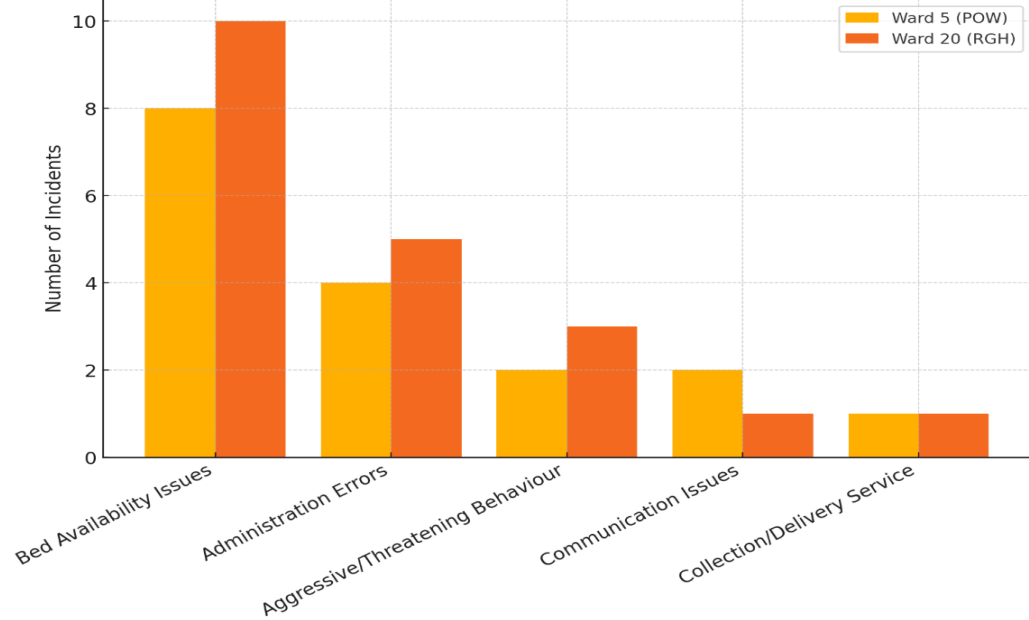
Monitoring and Evaluation

Incident Comparison: Ward 10 vs Ward 19



Incident Type	Ward 10 (PCH)	Ward 19 (RGH)
Access to Services Delayed	43 (Closed: 43, Low Harm: 34, No Harm: 9)	39 (Closed: 39, Low Harm: 30, No Harm: 9)
Access to Services Denied	2 (Closed: 2, Low Harm: 1, No Harm: 1)	3 (Closed: 3, Low Harm: 2, No Harm: 1)
Administration Errors	13 (Closed: 12, Open: 1, Mixed Harm)	11 (Closed: 9, Open: 2, Mixed Harm)
Aggressive/Threatening Behaviour	3 (Closed: 3, Mixed Harm)	5 (Closed: 4, Open: 1, Mixed Harm)
Assessment Issues	1 (Low Harm)	2 (Low Harm)

Incident Comparison: Ward 5 vs Ward 20



Incident Type	Ward 5 (POW)	Ward 20 (RGH)
Bed Availability Issues	8 (Closed: 8, Low Harm: 6, No Harm: 2)	10 (Closed: 10, Low Harm: 8, No Harm: 2)
Administration Errors	4 (Closed: 3, Open: 1, Mixed Harm)	5 (Closed: 3, Open: 2, Mixed Harm)
Aggressive/Threatening Behaviour	2 (Closed: 2, Mixed Harm)	3 (Closed: 2, Open: 1, Low Harm: 2)
Communication Issues	2 (Closed: 1, Open: 1, No Harm)	1 (Open, No Harm)
Collection/Delivery Service	1 (Closed, Low Harm)	1 (Closed, Low Harm)



Please do not delete this slide...

Specific Matters for Consideration:

This report will capture the journey the teams and the broader care group have embarked on since the temporary centralisation of services following both estate and medical workforce challenges.
The challenges faced by the current workforce and understanding of current consultation process.
The need for environmental improvements which are both short and long term.

Key Risks / Matters for Escalation:

The Expansion of D4 YCR stroke rehab beds will require additional resource and there is a proposal for investment in AHP workforce which has been submitted as part of IMTP.
The Short-term temporary workforce issues within Physiotherapy due to vacancy and short term sickness absence. Mitigations in place through flexing workforce and appointment of locum.
Medical workforce recruitment remains a risk and ongoing recruitment continues.
Nursing workforce stability remains a risk that the USC group is working through a consultation process on.



Please do not delete this slide...

Recommendation

Consider whether the Committee can seek assurance from the report that all that can be done is being done to mitigate the risks.

Next Steps

Ongoing monitoring and evaluation of the temporary service centralisation



Agenda Item

5.2

Quality, Safety & Experience Committee

Clinical Executive Directors Update Report

Dyddiad y Cyfarfod / Date of Meeting	25/03/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	1. Richard Hughes-Deputy Executive Director for Nursing and Midwifery 2. Dom Hurford-Executive Medical Director 3. Lauren Edwards-Executive Director for Allied Health Professionals and Health Sciences, 4. Philip Daniels-Executive Director Public Health Gethin Hughes-Chief Operating Officer Health
Cyflwynydd yr Adroddiad / Report Presenter <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	1. Greg Padmore-Dix-Executive Director for Nursing and Midwifery 2. Dom Hurford-Executive Medical Director 3. Lauren Edwards-Executive Director for Allied Health Professionals 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 Allied Health Professionals 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
Individuals**

Date

Outcome

(Insert Details)

Click or tap to enter a date.

Acronyms / Glossary of Terms

AHPs	Allied Health Professionals
PCH	Prince Charles Hospital
RGH	Royal Glamorgan Hospital
POW	Princess of Wales Hospital
KPI	Key Performance Indicators
MES	Medical Examiner Service
LPMHSS	Local Primary Mental Health Support Services
PREMS	Patient Reported Experience Measures
PROMS	Patient Reported Outcomes Measures

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

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

Clinical Executive Director update from the Nursing & Midwifery portfolio:

2.1 Positive Update:

1. **Enhancing Patient Experience through Strategic Forums and Operational Groups:** The establishment of the Patient Experience Forum and the Patient Experience Operational Group represents a significant step forward in our dedication to enhancing patient care and satisfaction. The Patients Experience Forum, aligned with the principles of the All Wales Patient Experience Framework (in draft), serves as a strategic platform for in-depth discussions and developing recommendations concerning all facets of patient experience. This forum unites diverse stakeholders, including service user groups (Llais), clinical and operational colleges, ensuring a comprehensive approach to patient care.

In conjunction with the strategic forum, the Patient Experience Operational Group brings together portfolios such as Valuing Peoples' Experience, which concentrates on systematically collecting, processing, and analysing patient feedback. The group leverages various channels, including the "Have Your Say" initiative and Patient Reported Experience Measures (PREMs), to gather valuable insights from patients to convert patient feedback into actionable insights, fostering continuous quality improvement and promoting shared learning throughout the organisation. Together, these

initiatives underscore our commitment to prioritising patient experience at the core of our healthcare delivery.

The forum and the operational group are actively engaged, with promising work plans under discussion. Their progress and outcomes will be reported to the Quality, Safety, and Experience (QSE) committee in the upcoming financial year, further solidifying our commitment to patient-centred care and ongoing improvement.

2.2 Successes

2. **Successful Implementation of the CTM Baby & Toddler Voice Project:** The CTM Baby & Toddler Voice project has been successfully implemented, providing valuable insights and feedback from the community. This initiative aims to improve the quality of care and services offered to young children and their families. The feedback received has been overwhelmingly positive, underscoring the project's impact on enhancing patient experience and engagement. The project involved conducting surveys and focus groups with parents and caregivers to gather their perspectives on the care provided. The insights gained from these discussions have been utilised to make targeted improvements in paediatric care services. These enhancements include better communication with parents and the development of more child-friendly facilities. This project's success has also strengthened relationships between the health board and the community, fostering trust and confidence in the services provided.

2.3 Challenges:

1. Addressing Quality and Safety Concerns:

The Health Board is actively addressing recent challenges about quality and safety following the urgent ward decant at the Princess of Wales Hospital resulting in significant increases in demand and clinical pressures on the Royal Glamorgan and Prince Charles Hospital sites.

To facilitate recovery over the forthcoming six months, the executive team have implemented new measures to enhance service delivery and leadership.

A temporary position combining the roles of Assistant Director of Nursing (Acute Services) and Hospital General Manager has been established for the RGH site.

The individual appointed to this role commenced on February 03 2025, and collaborates with other leaders. This individual will oversee and support the

Head of Nursing for RGH (managerial/professional) as well as the new interim Head of Nursing at the PCH site (professional).

A comprehensive support plan has been enacted. Furthermore, the alignments of Nurse Directors for both RGH and PCH have been temporarily suspended to delineate responsibilities during this transitional period.

To ensure practical support and collaboration, the new Assistant Director of Nursing will report to the Deputy Chief Operating Officer and the Deputy Executive Director of Nursing.

2. **Challenges in quality surveillance:**

One of the primary challenges facing the health board during this period has been maintaining a strategic focus amidst various operational demands. While the organisation is committed to prioritising community care and integrating diverse perspectives into its decision-making processes, the complexities of coordinating efforts across different departments and the necessity of addressing immediate operational issues have made it challenging to sustain this strategic orientation. The health board has been actively pursuing initiatives to enhance community care services and integrate them more effectively with secondary care. These efforts are designed to improve collaboration among healthcare providers and ensure seamless, coordinated patient care. However, the struggle to balance these strategic objectives with the urgent need to tackle short-term operational pressures has presented a significant challenge for the organisation.

The winter months have further strained the health board, particularly affecting Senior and Lead Nurses. They have needed to adjust their portfolios to work alongside medical, allied, and operational colleagues to address substantial flow concerns across both community and acute care settings. Although the critical safety functions were monitored throughout, this shift in focus led to increased pressure and interruption of quality and safety tasks, assurance exercises, and quality KPI monitoring.

Acknowledging the importance of managing both flow and critical quality and safety tasks, the health board is now focused on resetting processes to support flow while concurrently addressing these essential quality and safety responsibilities. This approach seeks to balance meeting immediate operational needs and upholding the organisation's commitment to long-term strategic goals and quality standards.

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:

- HealthPathways Progress
- St David's Award
- First Mortality Board Meeting

3.1 Achievements

HealthPathways Progress

Community HealthPathways is an on-line resource aimed at Primary Care practitioners to provide them with clear and concise guidance for assessment and managing patients. Pathways are developed collaboratively between general practitioners and secondary care 'subject matter experts' that are evidence-based but reflect local service provision. Welsh Government have funded the roll-out of Community HealthPathways across Wales until end of March 2026.

The CTM Community HealthPathways site launched on 10th April 2024 with 58 pathways and 83 request / resource pages. Since then the team has continued to develop pathways and the target of 100 pathways to be localised by the end of March 2025 was achieved in October 2024 and to date, they have 145 pathways and 120 request / resource pages live. The site is currently receiving approximately 3,000-page views per month and as localised content on the site increases it is hoped that more clinicians will be encouraged to use it and find it beneficial.

Research & Development Care Award

Dr Ceri Lynch has been nominated and awarded the St David's Award for excellent care and commitment to Research & Development. The award honoured her leadership of the multidisciplinary Welsh Intensive Care Society Audit and Research Group. It was also for her continued work as an Intensive Care Doctor in Royal Glamorgan Hospital. This is a much-deserved acknowledgment of one of our team.

First Mortality Board Meeting

The first mortality board meeting took place in early 2025. This is an important forum to monitor, shape and improve mortality concerns and issue across the health board. A diverse team of administrative and clinical staff are included in these meetings and we are encouraged by the opportunity for mortality improvements.

3.2 Areas of Focus

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

- Coroner Cases
- Medical Examiner interaction and issues
- Transition Care

Coroner Cases

CTM has been the subject of 13 coroner's inquests in 2025 with 22 scheduled for March. Four of these have been significant with two resulting in the coroner issuing a regulation 28 (prevention of future deaths).

Both regulation 28s involve Princess of Wales Hospital. Responses are being compiled with a focus on ensuring learning is disseminated and embedded within the Health Board.

In compiling responses to the Coroner, it has been established that POW is not an outlier for Wales and that the mortality for POW is the fourth lowest in Wales.

For the future learning from Coroner's inquests and disseminating learning, this will be part of the function of the Mortality Board.

Medical Examiner interaction and issues

There are escalating pressures within Death Certification Process and necessary actions are currently being taken. In February 2025 the Executive Medical Director wrote to Medical Examiner Service for Wales to acknowledge the issues and detail the improvements being made.

The three areas identified and highlighted were:

1. Issues directly with the way the MES works
2. Delays within CTMUHB
3. How the MES impacts on CTMUHB for our population

Transition Care

There is a clear need to address children's' care as they move to adult care. A new group is in the process of being set up in CTM, to establish areas that are being addressed and those specialty areas that have not started this transition work. There is also a CTM wider group forming to develop a pan-Health Board approach with good governance compliance.

Section 4 ALLIED HEALTH PROFESSIONS (AHPs)

Successes

Public Health Dietetics hosted multiple stakeholder events including a recent launch of the Rhondda and Taf Ely PIPYN project, which saw over 100 partner organisations attend and commit to a whole system approach to healthy weights for Children and Young People in CTMUHB.

AHPs continue to support service developments across a wide range of services across the Health Board and beyond, these include: The Enhanced Community Care service model, Primary Care and Community service redesign, children's weight management.

Some AHP services have commenced roll out of Text and Remind to improve timely communication to patients and improve outpatient clinic utilisation.

The AHP-led Rapid Access and Admission Avoidance model is focused on early intervention to avoid deterioration and prevent unnecessary and potentially harmful admissions into hospital. To date, Occupational Therapists (Ots) have supported the prevention of 169 avoidable admissions/ambulance conveyances into hospital.

AHP staff (Speech & Language Therapy (SLT) and Dietetics) have been instrumental in the health board-wide improvement work in the area of nutrition and hydration in response to **Coroner inquests** learnings over recent years. Under ratification of the renewed Nutrition and Hydration Steering group, policies and Standard Operating Procedures (SOPs) are being written or revised; a successful ward-based project at PCH is now rolling out across CTM (to reduce risk of variation/harm at mealtimes); and there is shared learning with regards to nutrition and hydration related incidents and near misses. It is anticipated that a nutrition and hydration assurance committee will be implemented in due course.

Psychological Therapies Waiting List Initiative bids were entered to NHS Exec in October 2024. However due to delay in feedback from NHS Exec all original bids were no longer viable in time frame. New bid entered December 2024 for £15K was approved 31 December. Three x 9 session stabilization groups are being held Saturday morning by Bridgend LPMHSS before end March 2025. This will result in approximately 45 patients being taken off the waiting list.

PCMhSS G-TEP pilot (Group-Traumatic Event Protocol) 8-week pilot is to be commenced March 2025 in Bridgend area. The team is currently reviewing waiting list to select service users from waiting list. Evaluation will include PROMS and PREMS.

Formulation Clinic commenced across CTM offering enhanced assessment and psychological formulation to 'complex cases' to guide intervention options and enhance accuracy for waiting list allocation.

Intensive Complex Post Traumatic Stress Disorder (PTSD), 2-week pilot commented on 3rd February 2025 within the Community Mental Health Teams. Evaluation will include PROMS, PREMS and staff feedback.

PeriNatal Mental Health Service is engaging in a virtual pilot of Acceptance and Commitment Therapy (ACT) Group: This group aims to encourage the woman to think about what they value most and how to align our lives to this. The course will help to learn new ways of accepting uncomfortable thoughts and emotions and how to act.

AHP Advancement - AHPs continue to celebrate the quality of care they provide with a selection of posters and abstracts being selected for a range of conferences: CTM Research & Development (R&D) conference, Macmillan National conference, AHP National conference.

Podiatry Service featured within the January Oral Statement made by the Cabinet Secretary for Health and Social Care, in relation to accessing primary care. "In Cwm Taf Morgannwg University Health Board, urgent diabetic foot waiting times have reduced from four weeks to 48 hours" [Oral Statement: Access to Primary and Community Care Services \(21 January 2025\) | GOV.WALES](#)

Two members of the Adult Weight Management Service were recently invited to give evidence to the Health and Social Care Committee's inquiry on preventing and reducing obesity.

The Health Psychology lead for Critical Care has been elected as the Psychology Professional Representative on the Welsh Intensive Care Society Council.

HEALTHCARE SCIENCES (HCS)

Successes

Audiology Clinical Educator of the Year Award

Charlotte O' Connor, Chief Audiologist at Princess of Wales Hospital, was recently awarded Audiology Clinical Educator of the Year Award from Swansea University.

This award recognises Charlotte's passion for teaching along with her desire to motivate and develop our audiology workforce of the future.

Successful Reaccreditation of Echocardiography Princess of Wales Hospital in Cardiac Physiology has recently obtained reaccreditation for Echo quality, Transthoracic echo (TTE), Transoesophageal echo (TOE), Stress echo, and Training to BSE Proficiency standard following its 10-year British Society of Echocardiography (BSE) inspection for reaccreditation.

The BSE departmental accreditation is a recognised benchmark of quality and demonstrates that the Echo Department meets quality standards and aligns to CTM's 2030 strategy goal of improving care.

For Awareness

Healthcare Science Week is an annual week of celebration and awareness raising of the many careers in healthcare science. This year's event takes place between the 10th and 16th March and will be celebrated at CTM through a series of videos showcasing the work of some of our healthcare sciences in CTM.

Section 5 Public Health Update

Pension Credit

The Pension Credit initiative was developed by the concerns about increase vulnerability in older people due to fuel poverty and the well published link between living in cold home and worsening health and wellbeing with its aim to increase the awareness and uptake of Pension Credit among eligible individuals in the CTM region. The initiative utilised a range of communication channels (including letters, posters, social media, in person events etc.) through our partners to reach eligible individuals who are residents in the CTM region to raise awareness, sign-posting and referral to support available to apply Pension Credit.

One of the key deliverables for the CTM public health team was working with the health board informatics team to utilise an innovative population health methodology to identify respiratory patients who are the most vulnerable to cold home related health issues and pro-actively contacting them to raise awareness and support their applications for Pension Credit. 205 individuals (70%) of those successfully contacted who were eligible and not already receiving Pension Credit were either signposted to the Welsh government online application portal and/or directly referred to our partners (Care and Repair or Registered Social Landlords (RSL) for those living in RSL accommodation) to receive support in applying Pension Credit. Further evaluation for the impact of the initiative is scheduled for late 2025

Healthy Weight

Overweight and obesity are the among the biggest contributors to ill-health and premature death in CTM. Our unhealthy food and activity environments now mean that 1 in 8 five-year-olds and 1 in 3 adults in CTM are living with obesity.

A range of work is being undertaken across the health board, and with regional partners. The Healthy Weight Steering Group (reports to Creating Health) is bringing this work together in a Road Map to Healthy Weight, which will be developed over the next six months. The Road Map will map to the national Healthy Weight: Healthy Wales strategy and encompass:

- Healthy Environments – working across the region to understand our residents and our communities initiate joint action to improve our food and activity environments.

- Healthy People – working with individuals and families to achieve and maintain a healthy weight through our weight management services.
- Healthy Settings – developing CTMUHB as a healthy weight organisation, through our food offer, healthy travel charter and staff wellbeing. Acting as a healthy weight Anchor Institution to support partners in their healthy weight work.
- Leadership and enabling change – working with national partners to ensure we get the change we need for our region to better create a healthy environment for our residents.

The Road Map will map out our direction as a Health Board over the short, medium and long-term and consider key challenges including

- Scale of change needed to our regional environment and long-term commitment.
- Mismatch between capacity of weight management services and population need and supporting those facing long waits (>2,500 on adult level 3 waiting list currently).
- Development of pathways to ensure equitable access for novel anti-obesity medications.
- Current and future workforce implications of overweight and obesity.
- Health board expenditure on consequences of obesity.

Sexual Health & HIV

- HIV continues to be a public health issue in CTM. In the three months of December 24 - February 25 there have been 5 new diagnoses of HIV, compared to 5 in the preceding 12 months.
- Contact tracing and analysis of missed opportunities for diagnosis is underway.
- A significant proportion of new diagnoses in CTM are late stage, with opportunities for earlier diagnosis often missed.
- The HIV Action Plan for Wales 2023–2026 aims to eliminate new HIV transmissions by 2030 and reduce stigma faced by individuals living with HIV.
- As part of the Action Plan, Health Board regions are asked to join the Fast Track Cymru network and establish local HIV collaboratives.
- At the February Regional Partnership meeting CTM joined the Fast Track Cymru Network, and the CTM Fast Track Steering Group will work to produce and implement an action plan over the coming months.
- The initial priorities for the Steering Group are increasing access to testing, education and prevention.



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 <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	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 <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /</i> Equality and Welsh Language <i>Have you undertaken an Equality and Welsh Language Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	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 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 <i>(Pobl / Ariannol) /</i> Resource Impact <i>(People / Financial)</i>	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

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



Agenda Item

5.3a

Quality, Safety & Experience Committee

**Highlight Report from the Children & Families Care
Group Quality, Safety and Experience Meeting
held on 13th February 2025**

Dyddiad y Cyfarfod / Date of Meeting	25/03/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Suzanne Hardacre, Director of Midwifery & CYP Nursing Mohammed Elnasharty, Medical Director Carl Verrecchia, Service Director
Cyflwynydd yr Adroddiad / Report Presenter	Suzanne Hardacre, Director of Midwifery & CYP 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
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms

ADBB (study)	Alarm Distress Baby Scale. A scale for assessing relational withdrawal in infants between 0 and 24 months of age, with 8 observation items.
BFI	Baby Friendly Initiative
CCN	Community Children's Nursing
CTM	Cwm Taf Morgannwg (University Health Board)
CYP	Children and Young People
GIRFT	Getting It Right First Time
HCL	Hybrid Closed Loop
HV	Health Visiting
ND	Neurodevelopment
PCH	Prince Charles Hospital
POW	Princess of Wales Hospital
QSE	Quality, Safety & Experience
RGH	Royal Glamorgan Hospital
SEHS	School Entry Hearing Service
SN	School Nursing
SSN	Special School Nursing
UNICEF	United Nations International Children's Emergency Fund
USW	University of South Wales
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 13th February 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 highlight report 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 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	• Neonatal Unit at Princess of Wales re-opened on Monday 10th February, Maternity Services re-opened on Monday 17th February. • 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. • 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). • Implementation of children’s continuing care packages delayed to fixed term contracts being offered. Trained staff leaving for permanent positions in neighbouring health boards. Agency is being used for 4 packages creating additional pressure within the community children’s nursing team to ensure appropriate governance and training. Care Group are working through a plan to recruit substantively.
Advise	• Residual issues with the loss of paediatric ward18 at the Royal Glamorgan Hospital (RGH) to accommodate adult patients due to the roof repairs at Princess of Wales Hospital (PoW). Mitigating actions being worked through with many already in place, some estates issues outstanding. Child protection medical assessment room requires capital input. • The Maternity Unit at Prince Charles Hospital (PCH) achieved full Unicef Baby Friendly Initiative (BFI) on 21st February 2025, this coincides with the launch of the Health Board Infant Feeding Strategy. • 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 are now being explored. • Children and Young People (CYP) teams are working through plans to develop an immunisation workforce with Public Health and Health Protection Teams. Comments awaited with consideration for any alternative models by working in partnership. • GIRFT (Getting It Right First Time) meetings reinstated to work through solutions to efficiency and care provision in gynaecology. Outsourcing for selected gynae cases continues whilst theatre capacity is reduced from POW roof incident. Planned to have allocated sessions in the forthcoming Vanguard unit at RGH. Robotic surgery cases have progressed well following initial few sessions. • 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.
Assure	• Quality Statement for Maternity and Neonatal Services and Patient Experience Framework published 11th February 2025. NHS Executive are producing a self-assessment template for Health Boards to ensure services are aligned. Launch events being held across Wales in March. • Phased implementation of Hybrid Closed Loop (HCL) pumps for children with Type 1 diabetes has begun, this will ensure the service meets NICE recommendations (TA947, 2023). • Care Group Health Visiting Oversight & Improvement Board took place on 19th February 2025, majority of actions from industrial action now closed (Plan available to view on request). Health Visiting Dashboard launched to monitor performance and compliance. • Health & Safety team supporting a review of Entonox exposure levels across maternity services. This will involve environmental and personal monitoring. • The Neurodevelopmental (ND) team are continuing to deliver a sustained improvement in the waiting times and Meetings with NHS Executive colleagues has now been reduced to



fortnightly as we are providing assurance that the plan is on track. There are no patients waiting at 104 weeks and are on trajectory for the end of March.

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 provision	16

Descalate

Risk 5755 project now completed.

Risk 5712 The Industrial Action has concluded.

Inform

- Health Visitors Week 3-7th March. Events took place across the Health Board.
- Digital Informatics Midwife presented their Florence Nightingale Foundation project of 'Digital Exclusion' at 'Rewired' conference in Birmingham 19th March 2025.
- Several roadshows planned over the next few months to disseminate the Infant Feeding Strategy across all Care Groups and with families.
- Successful application to be a research site for the next phase of the Institute of Health Visiting, Alarm Distress Baby Scale (ADBB) Study. Cwm Taf Morgannwg are the only site in Wales participating. The Royal Foundation Centre for Early Childhood is funding Phase 2 in partnership with University of Oxford.
- Heads of Midwifery attended University of South Wales (USW) and Cardiff University streamlining events in February.
- Labour Ward Obstetric Consultant 'hot week' – commenced at Prince Charles Hospital (PCH) in February.
- Safe Prescribing in paediatrics & MatNeo Equality, Diversity & Inclusion / Digital inclusion presentations received at Care Group QSE meeting in February (slide packs available on request).



	- Care Group leadership team-building events being arranged for June with support from Army colleagues. - Successful charitable bid for installation of 'sky tiles' and active birth equipment to improve environment of care and promote active labour within midwife led settings.
Appendices	

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 <i>150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)</i>	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality</i> <i>(Duty of Quality Statutory Guidance (gov.wales))</i>	Whole-systems Perspective
	If more than one applies please list below: - Culture and Valuing People - Leadership - Learning, Improving and Research
Dolen i Feysydd Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality</i>	Safe
	If more than one applies please list below: - Timely - Effective



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



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Maternity Metrics

26/02/2025

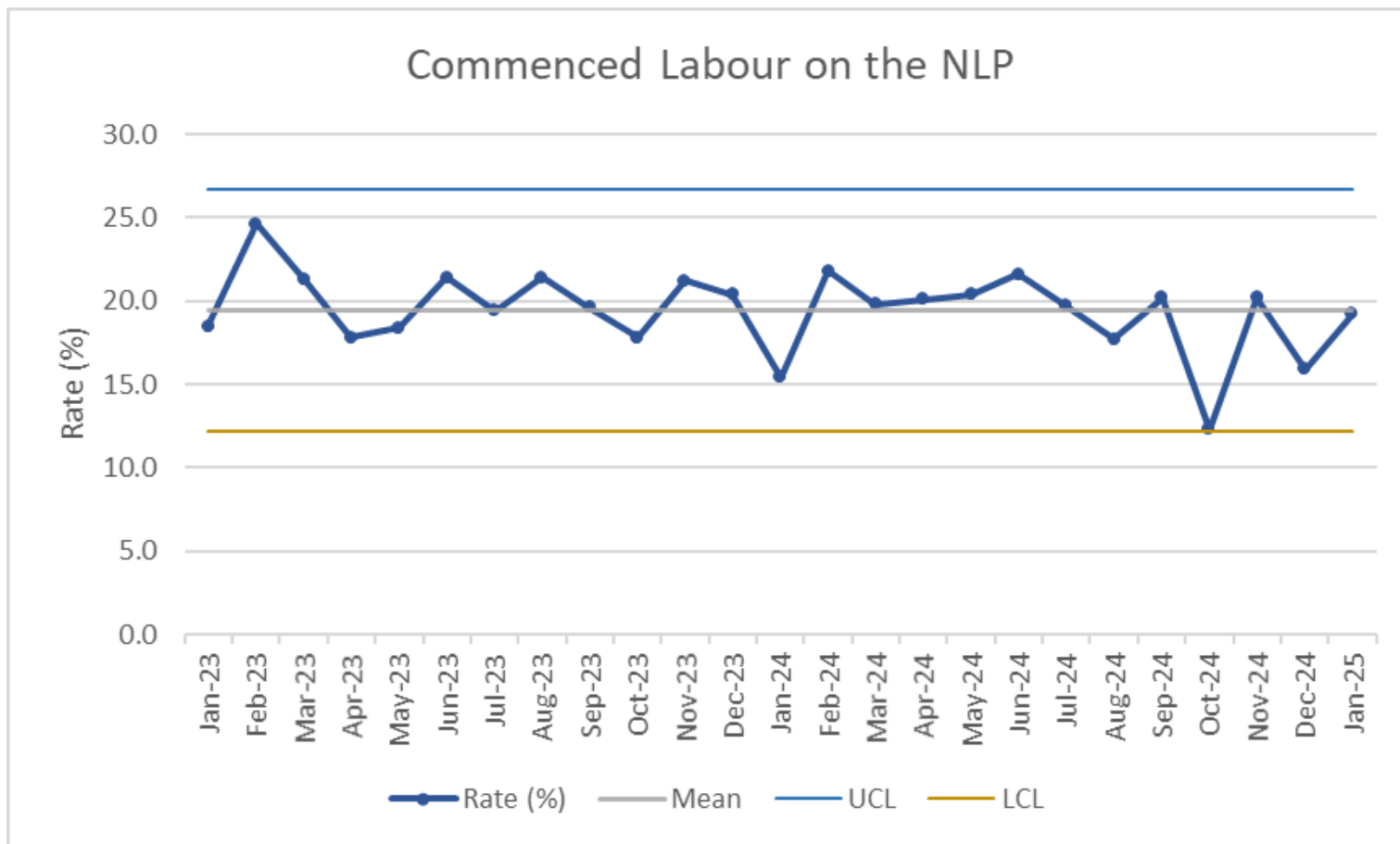
Maternity Metrics by Exception

The data shown on the following slides are for January 2023– January 2025 unless otherwise stated.

These data from September 2024 should be viewed with the caveat that during the temporary POW closure, a proportion of women in spontaneous labour birthed in neighbouring health boards, whilst planned caesarean births and most women having induction of labour birthed in PCH.

Maternity metrics are routinely reviewed through WESEE, which is being refreshed to ensure data are routinely reviewed at service level and appropriate actions set.

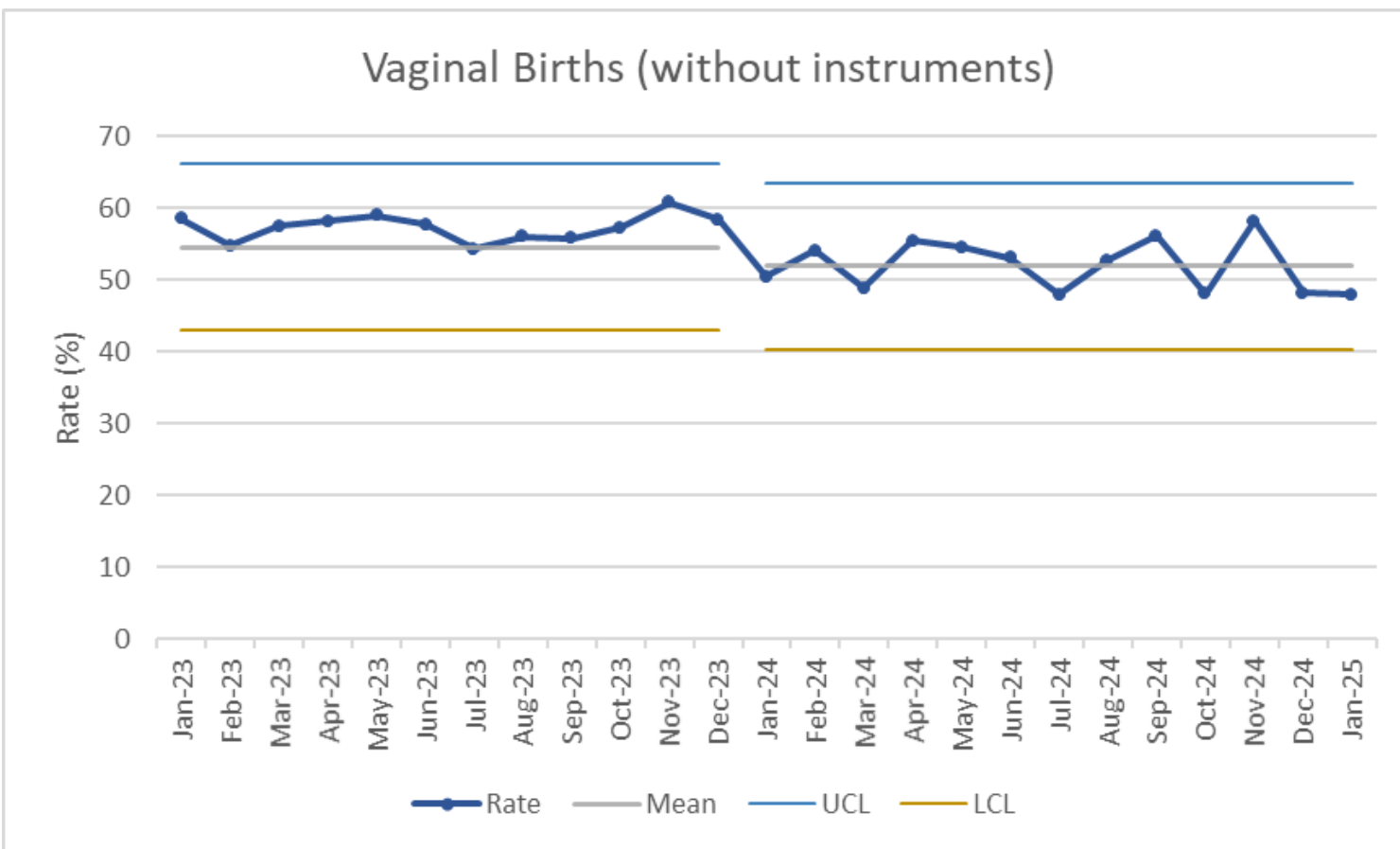
Rate of Women Commencing Labour on the NLP



The median rate is stable at **19%**.

In January 2025, the rate was **19%**.

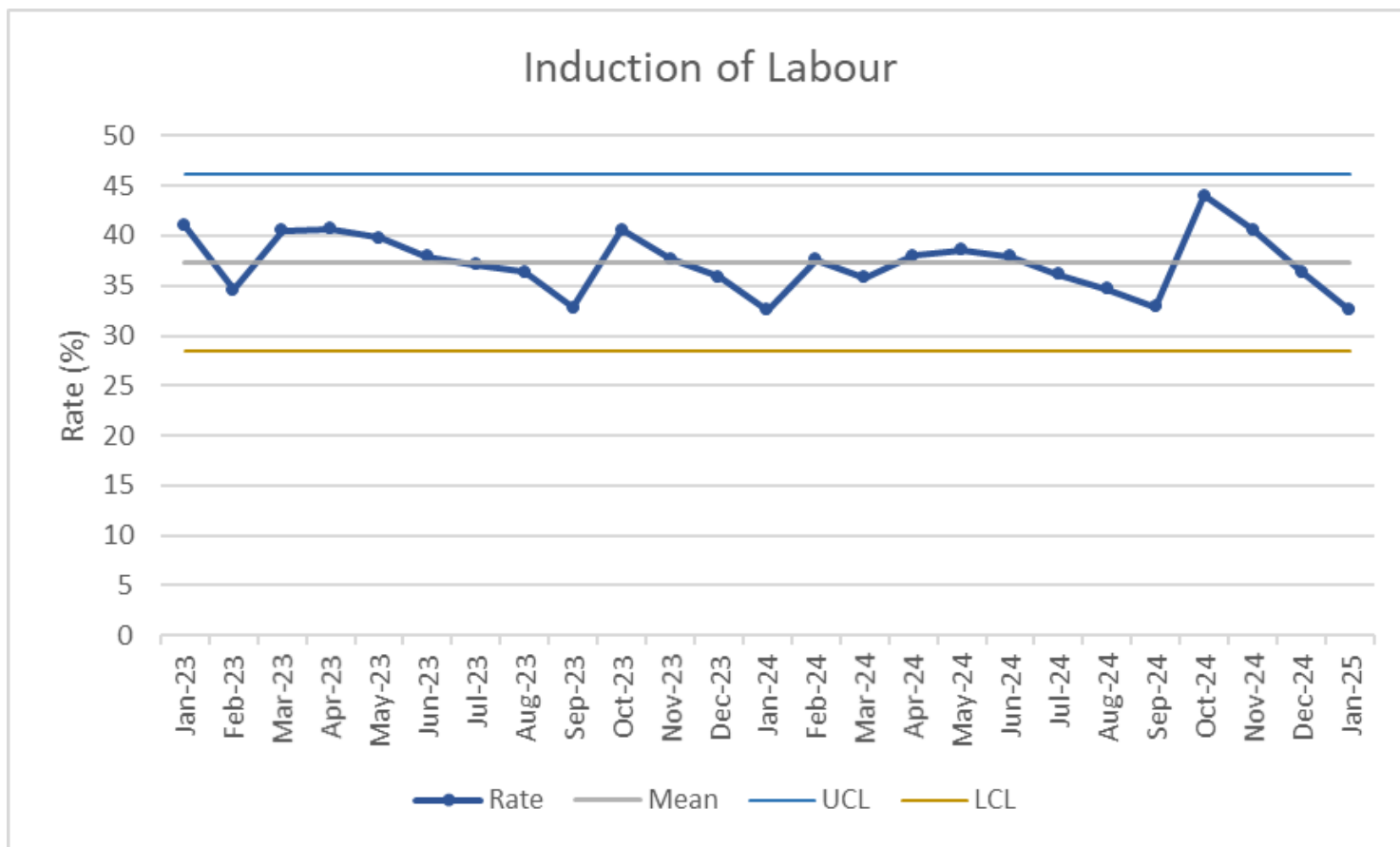
Rate of Spontaneous Vaginal Birth



The median rate has decreased from **55%** to **52%** as of January 2024.

In January 2025, the rate was **48%**.

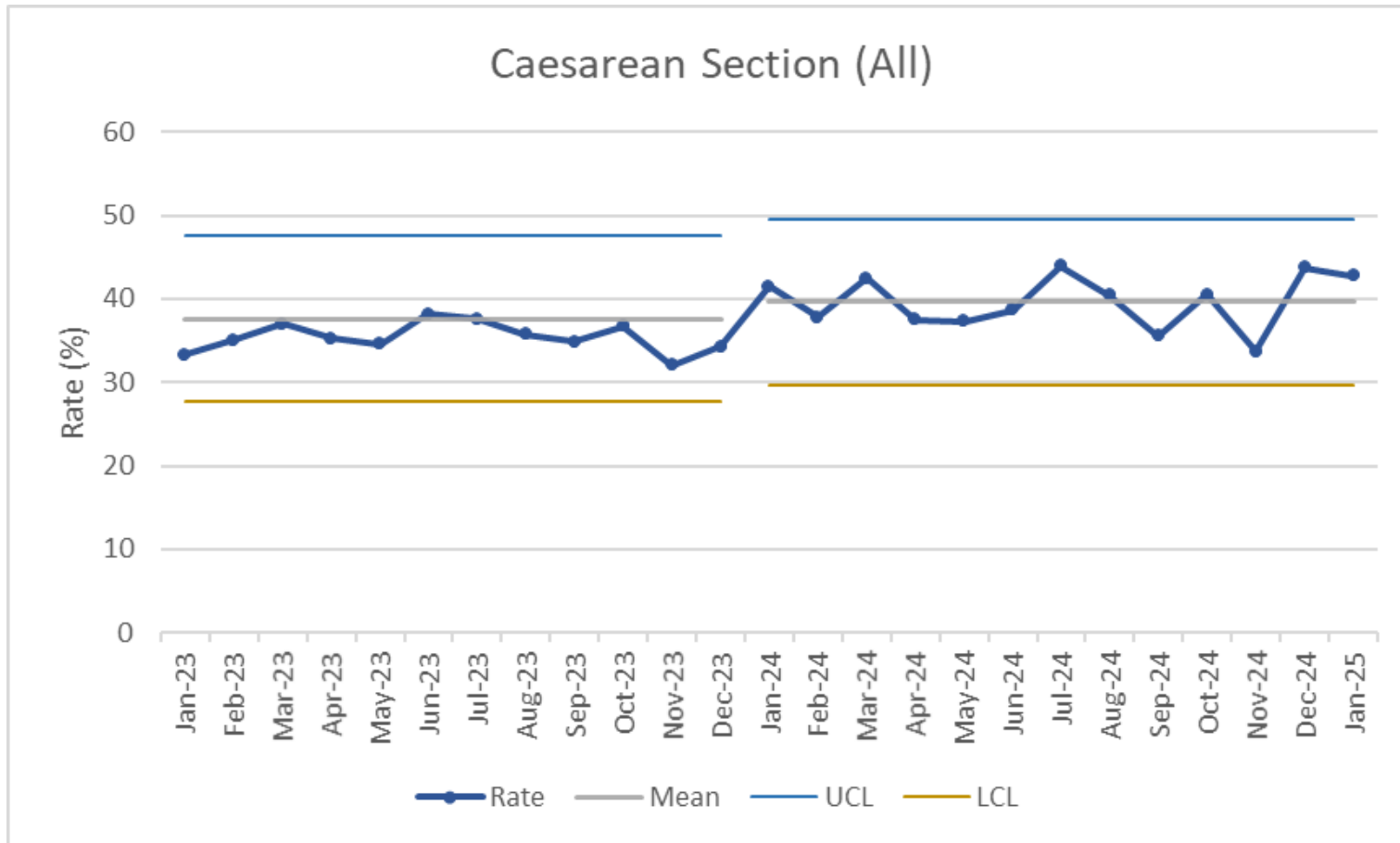
Rate of Induction of Labour



The median rate has remained stable at **37%**.

In January 2025, the rate was **33%**.

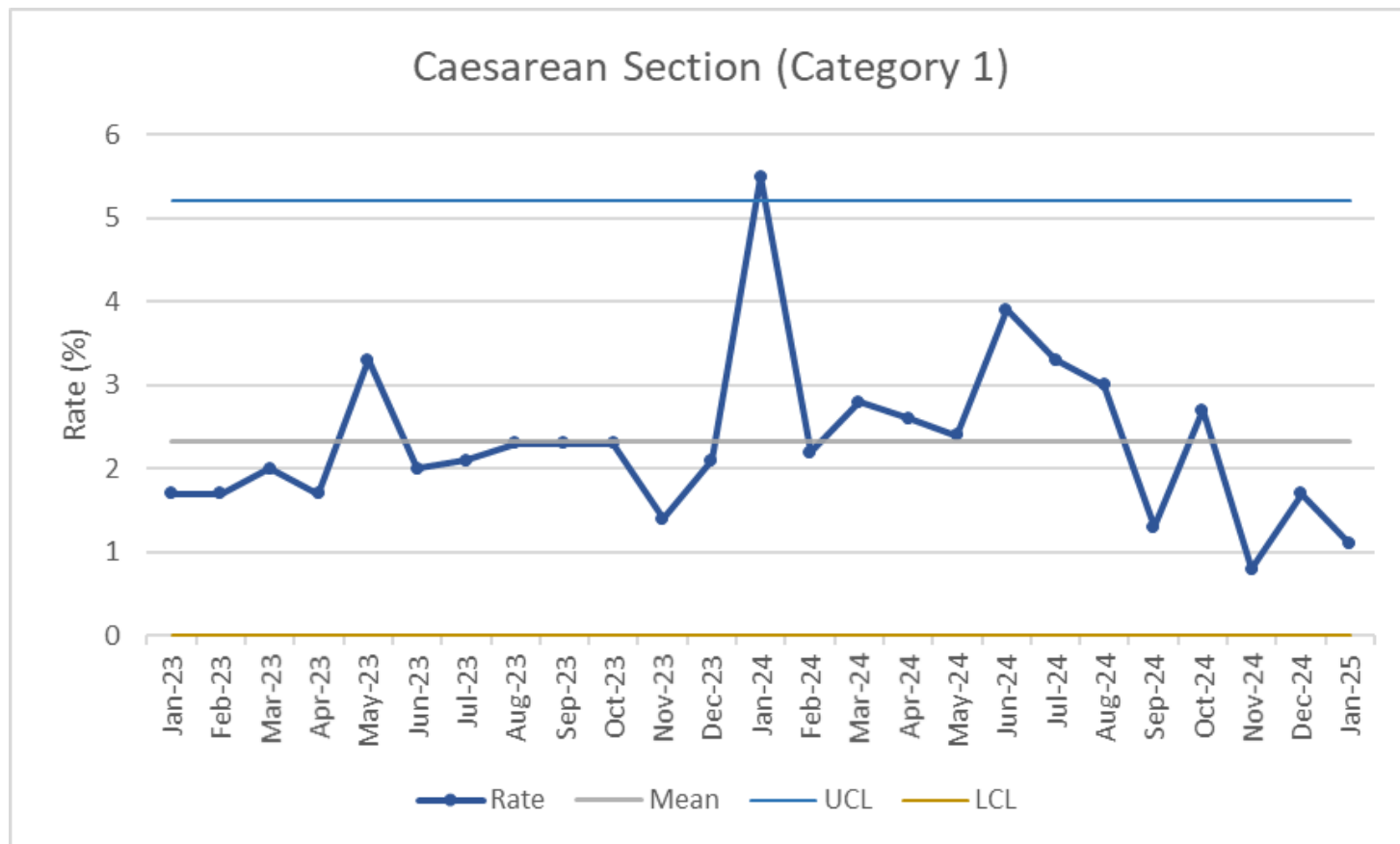
Caesarean Births



The median rate increased from **38%** to **40%** in January 2024.

In January 2025, the rate was **43%**.

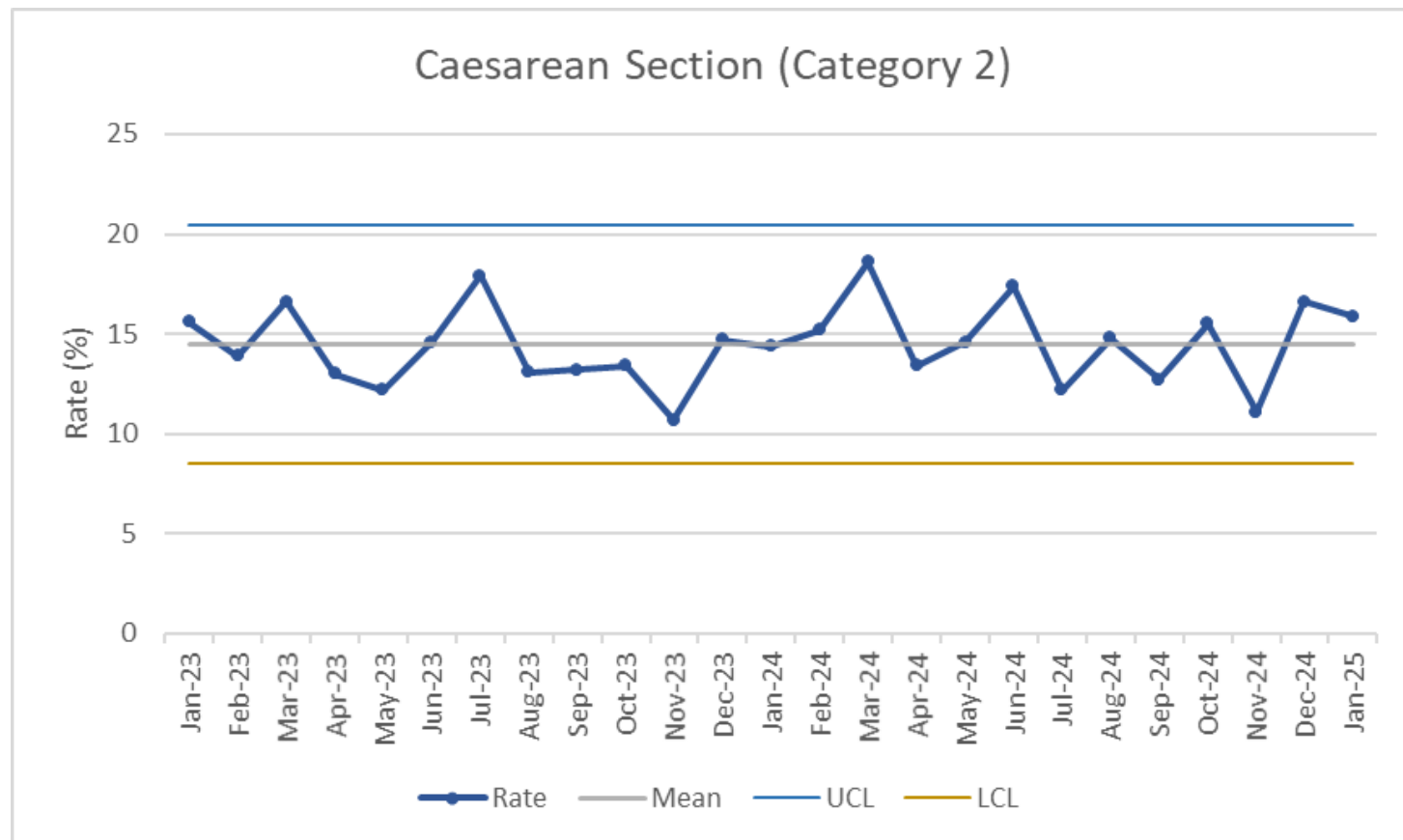
Caesarean Births – Category 1



The median rate is stable at **2.3%**.

In January 2025, the rate was **1.1%**.

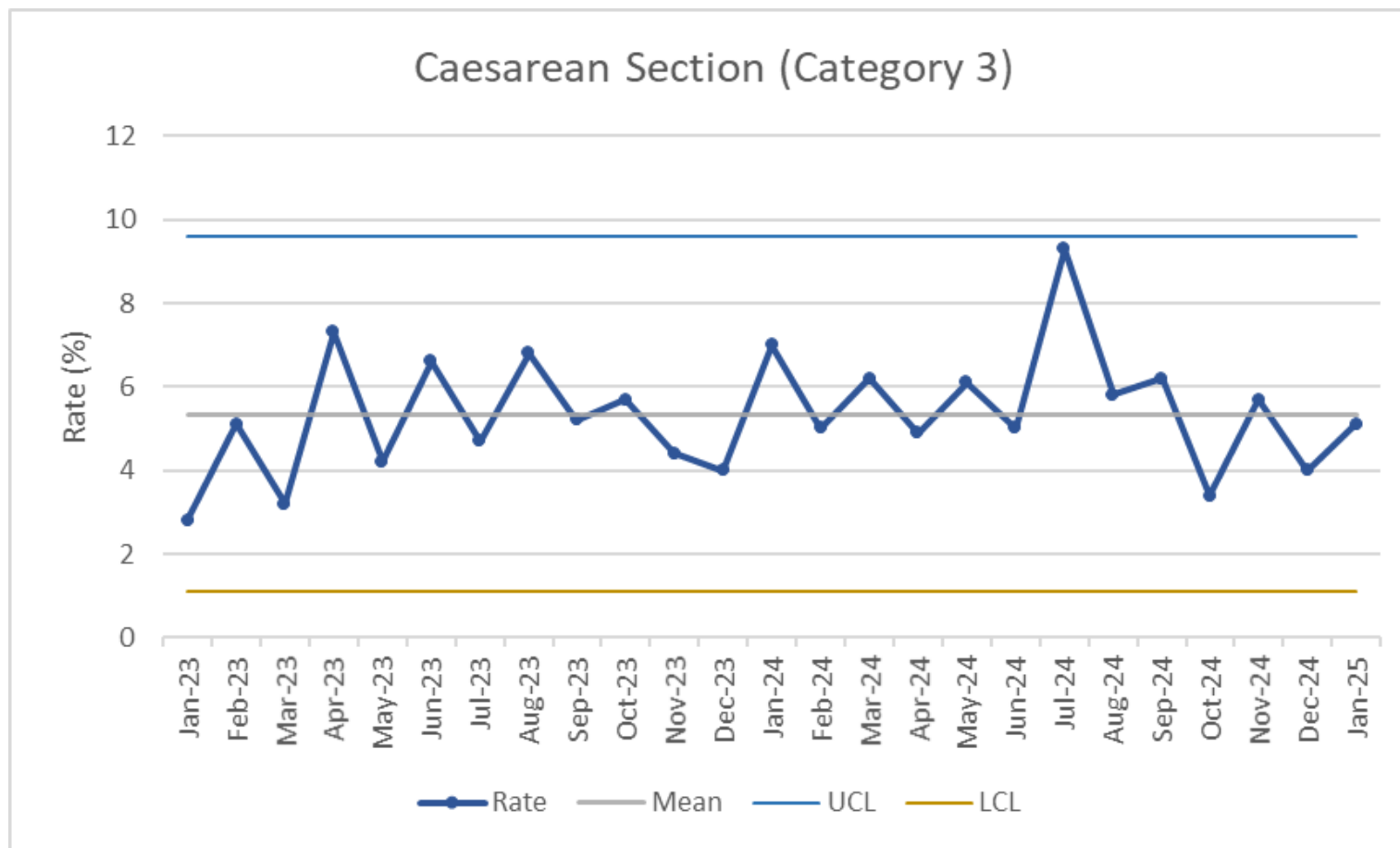
Caesarean Births – Category 2



The median rate is stable at **15%**.

In January 2025, the rate was **16%**.

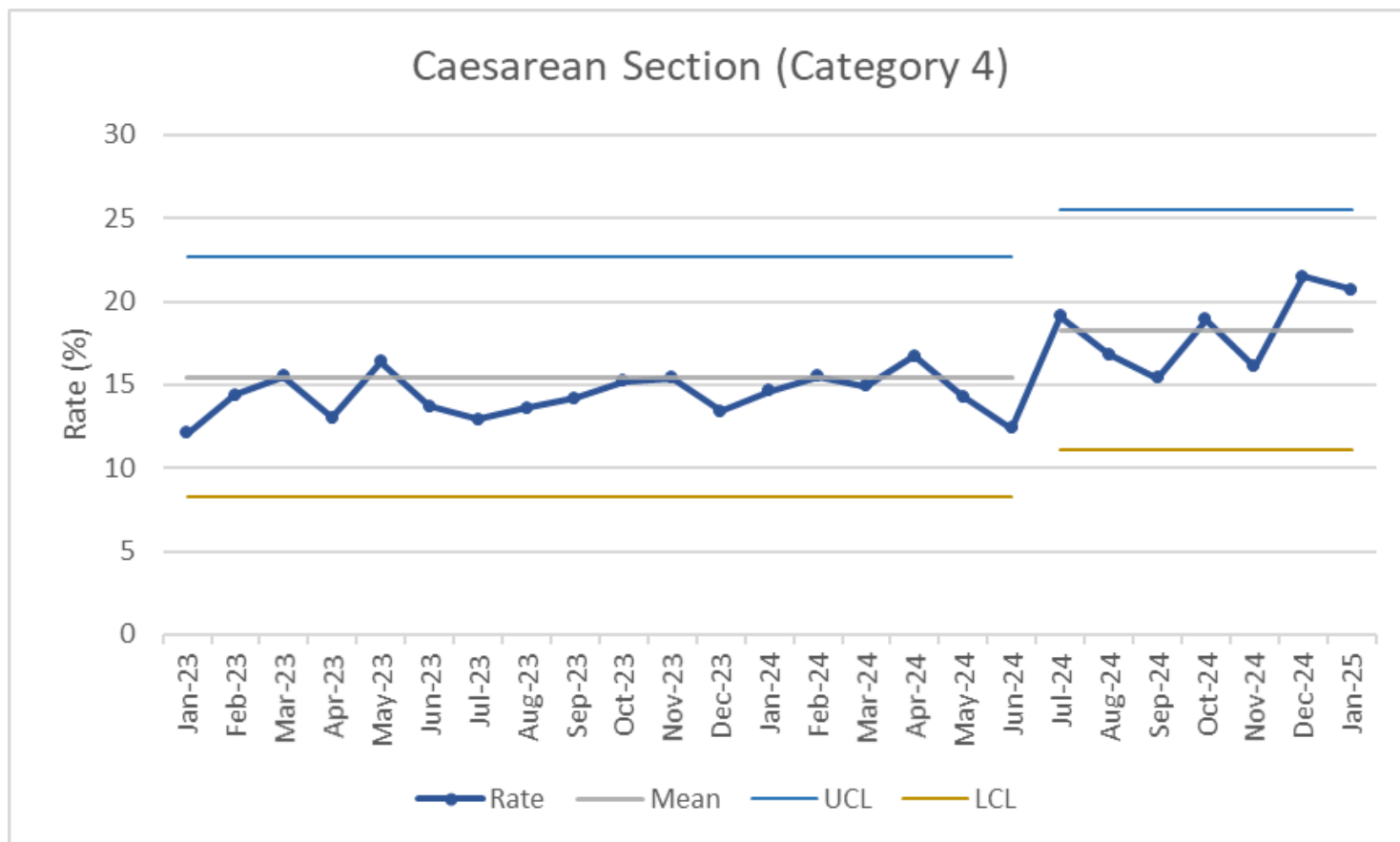
Caesarean Births – Category 3



The median rate is stable at **5%**.

In January 2025, the rate was **5%**.

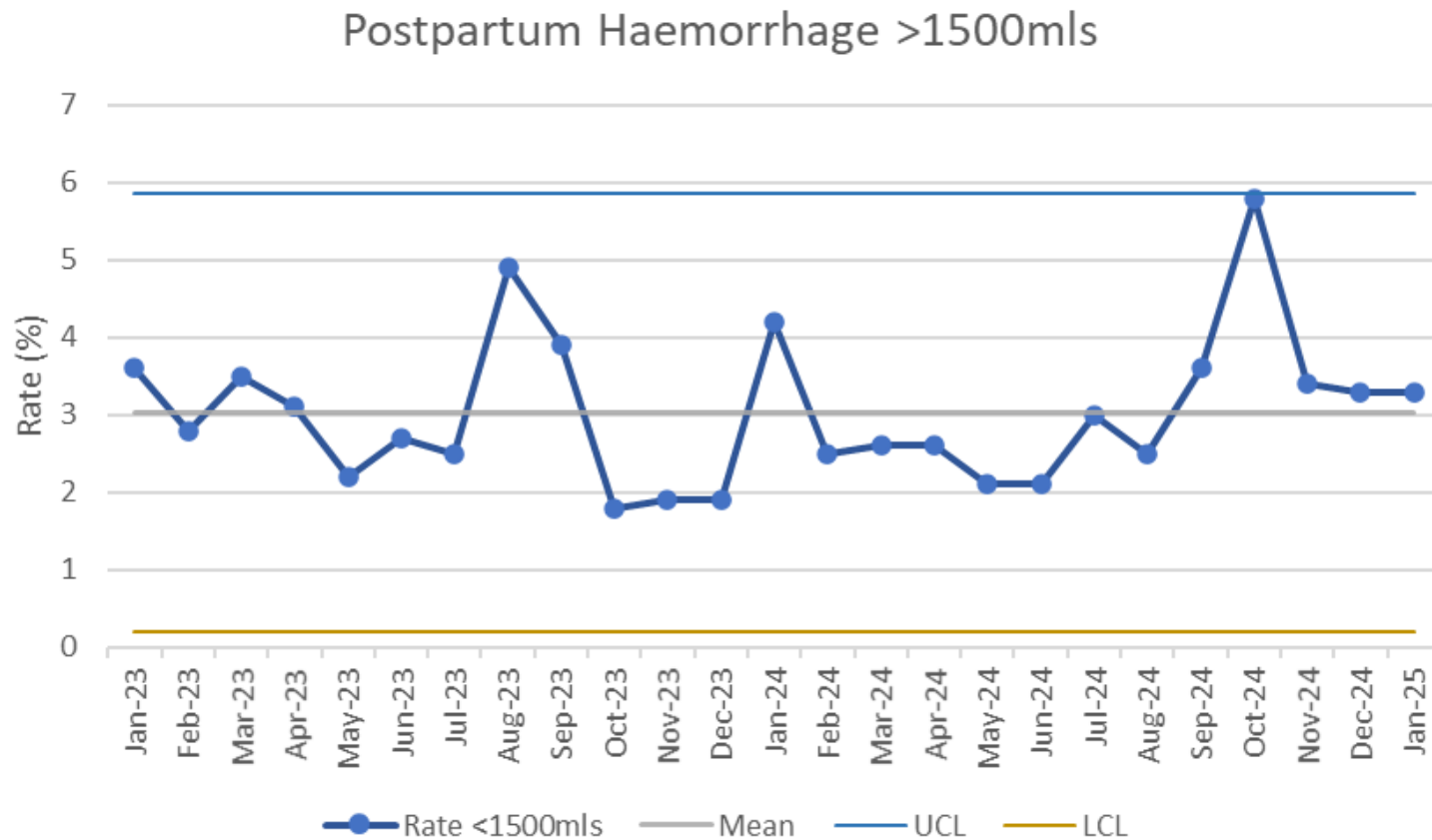
Caesarean Births – Category 4



The median rate increased from **16%** to **18%** in July 2024.

In January 2025, the rate was **21%**.

Postpartum Haemorrhage $\geq 1500\text{ml}$ (Major Obstetric Haemorrhage)



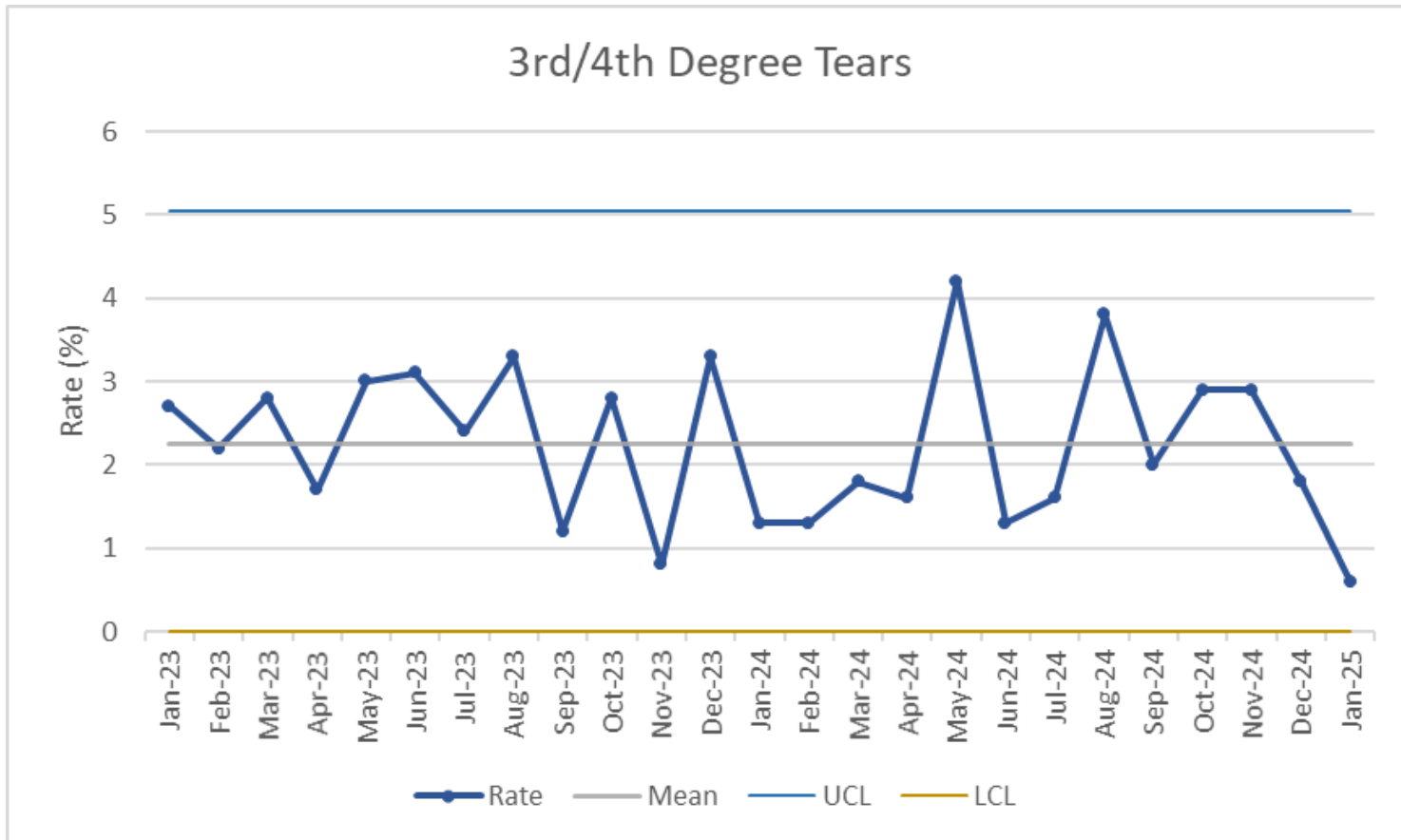
The median rate has remained stable at **3%**, in line with expectation.

In October 2024, the rate was **5.8%**. **This was outside normal variation.**

In January 2025, the rate was **3.3%**.

This should be interpreted in acknowledgment of the rising intervention rates.

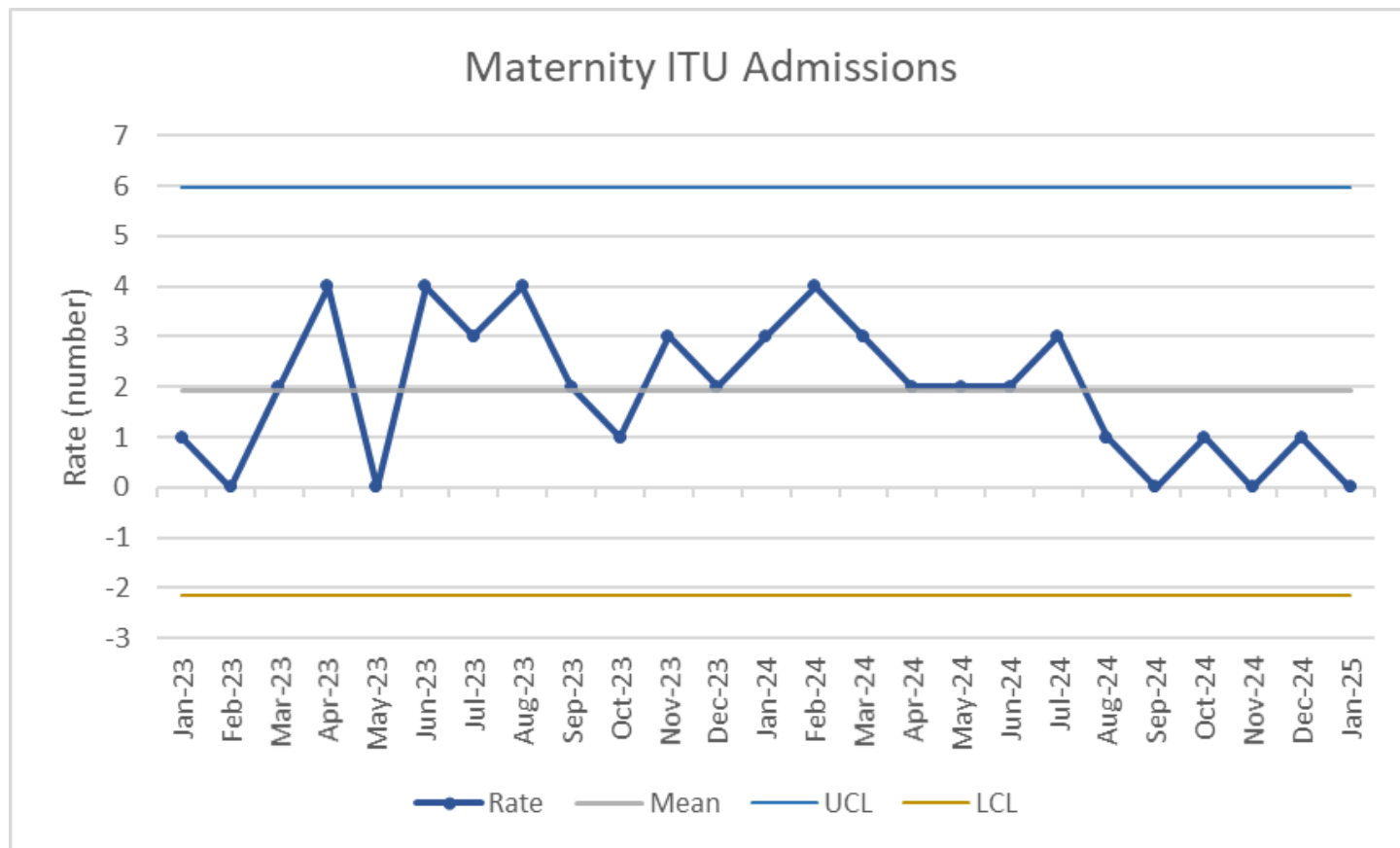
3rd and 4th Degree Tears



The median rate has remained stable at **2.3%**.

In January 2025, the rate was **0.6%**.

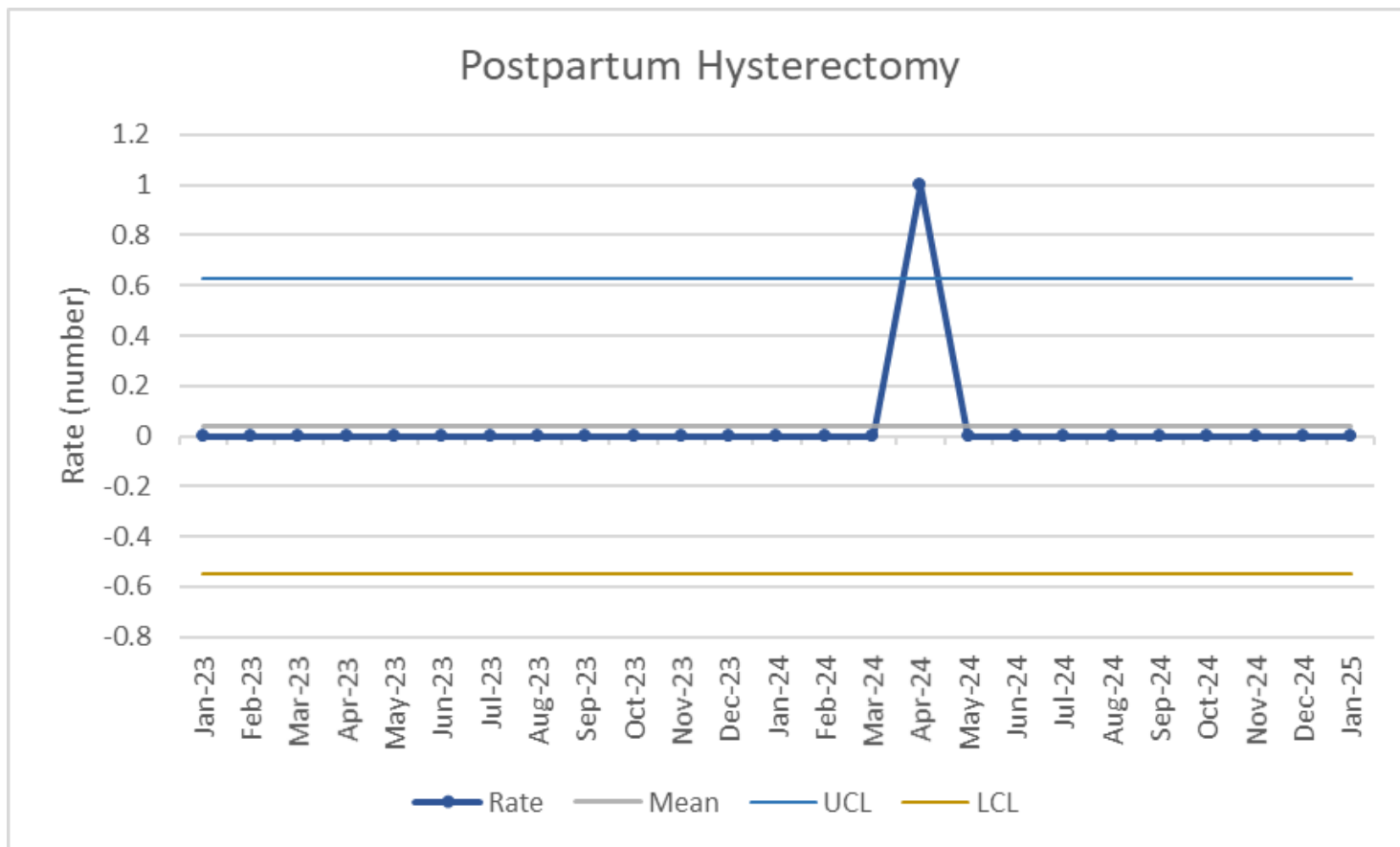
Maternity ITU Admissions



The median rate has remained stable at **2**.

In January 2025, the rate was **0**.

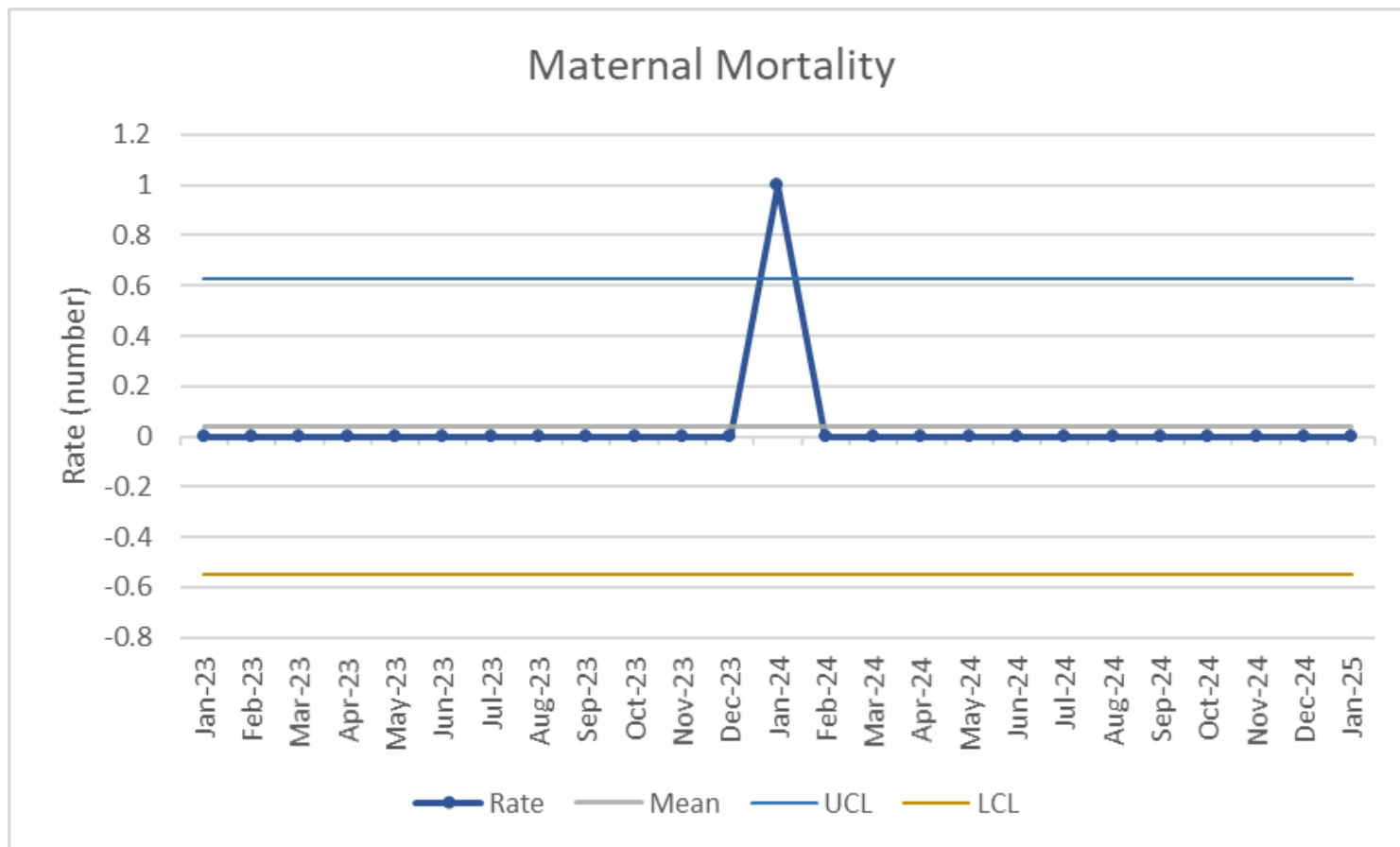
Postpartum Hysterectomy



The median rate has remained stable at **0**.

In January 2025, the rate was **0**.

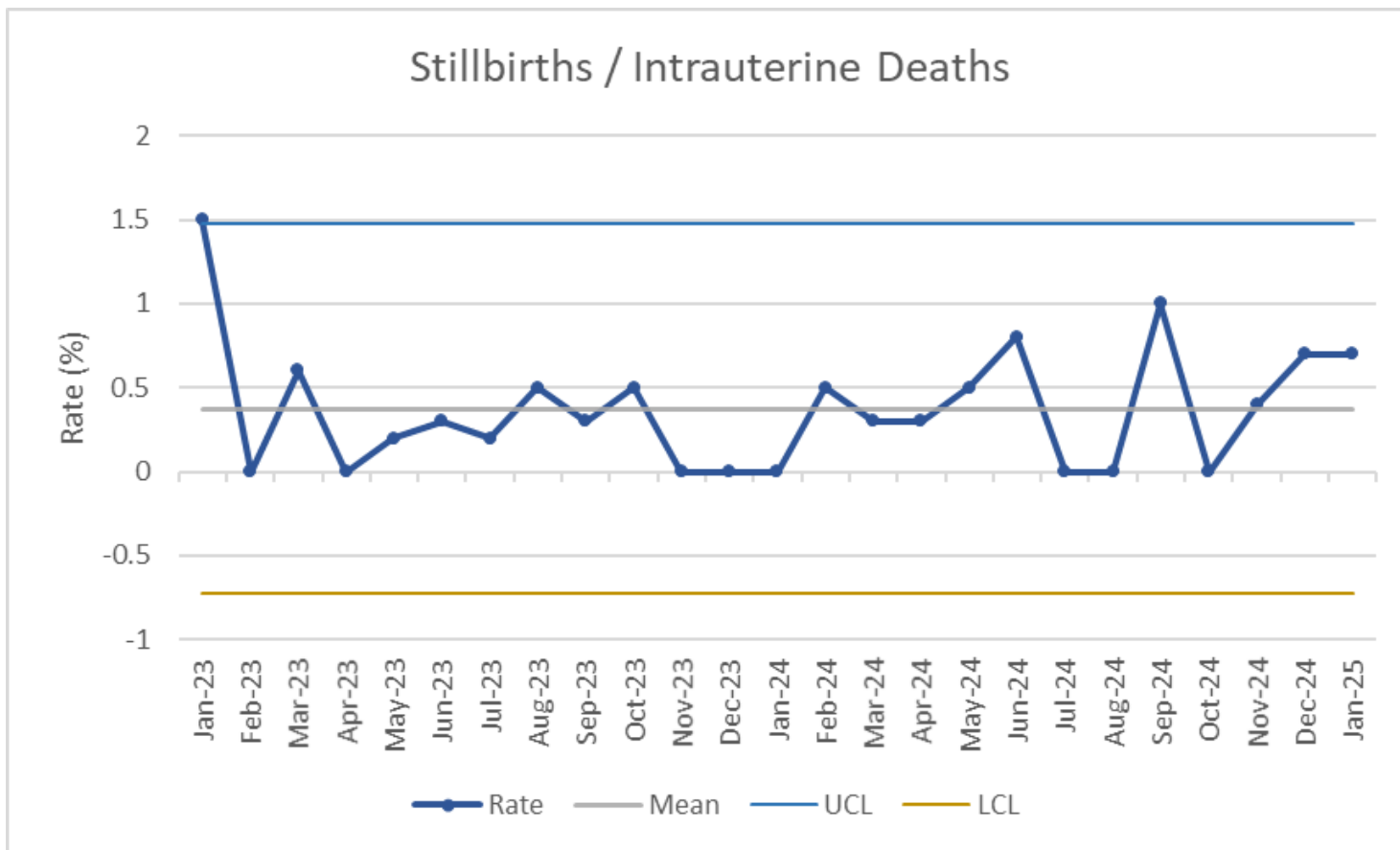
Maternal Mortality



The median rate has remained stable at **0**.

In January 2025, the rate was **0**.

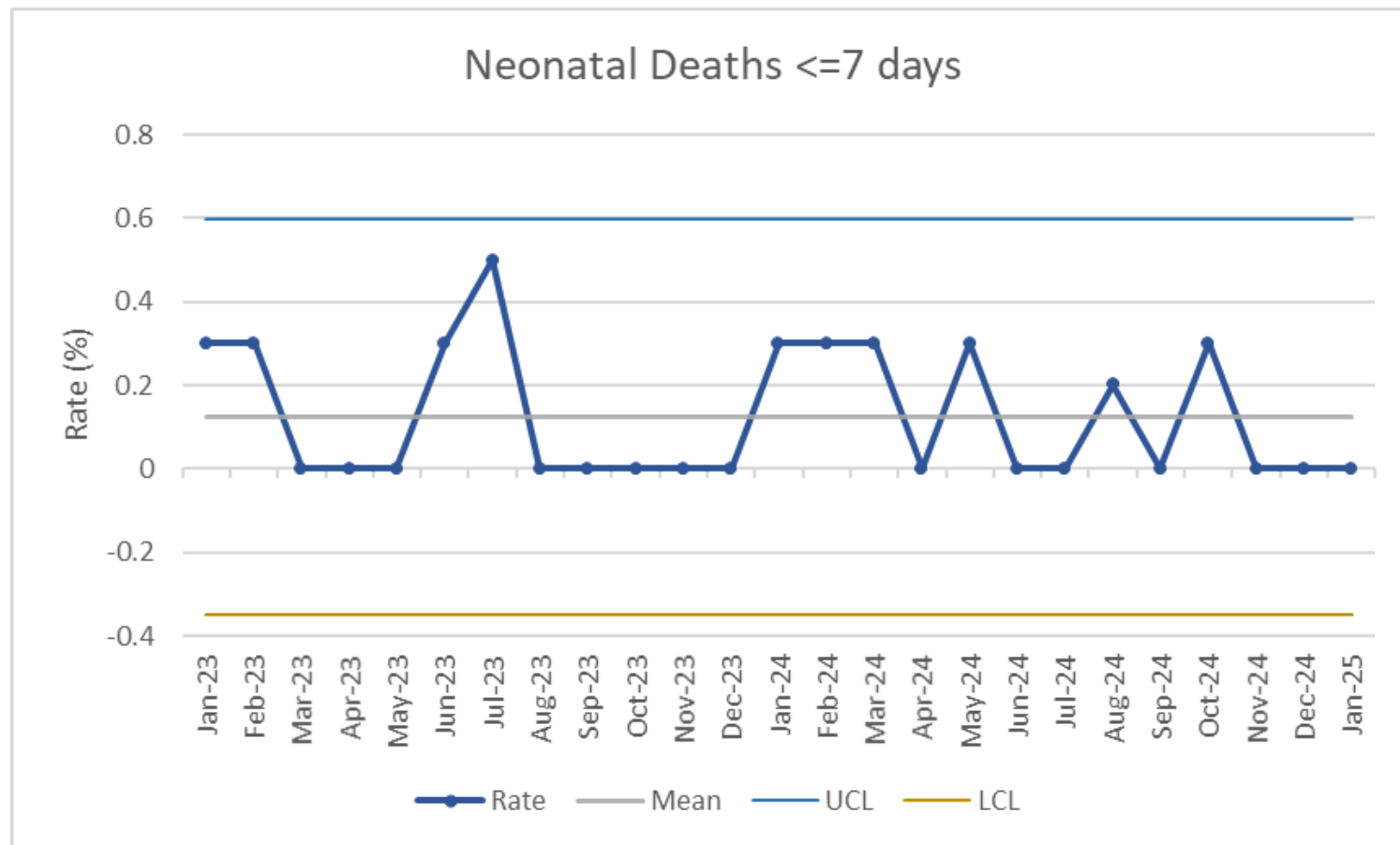
Stillbirths / Intrauterine Deaths



The median rate has remained stable at **0.4%**.

In January 2025, the rate was **0.7%**.

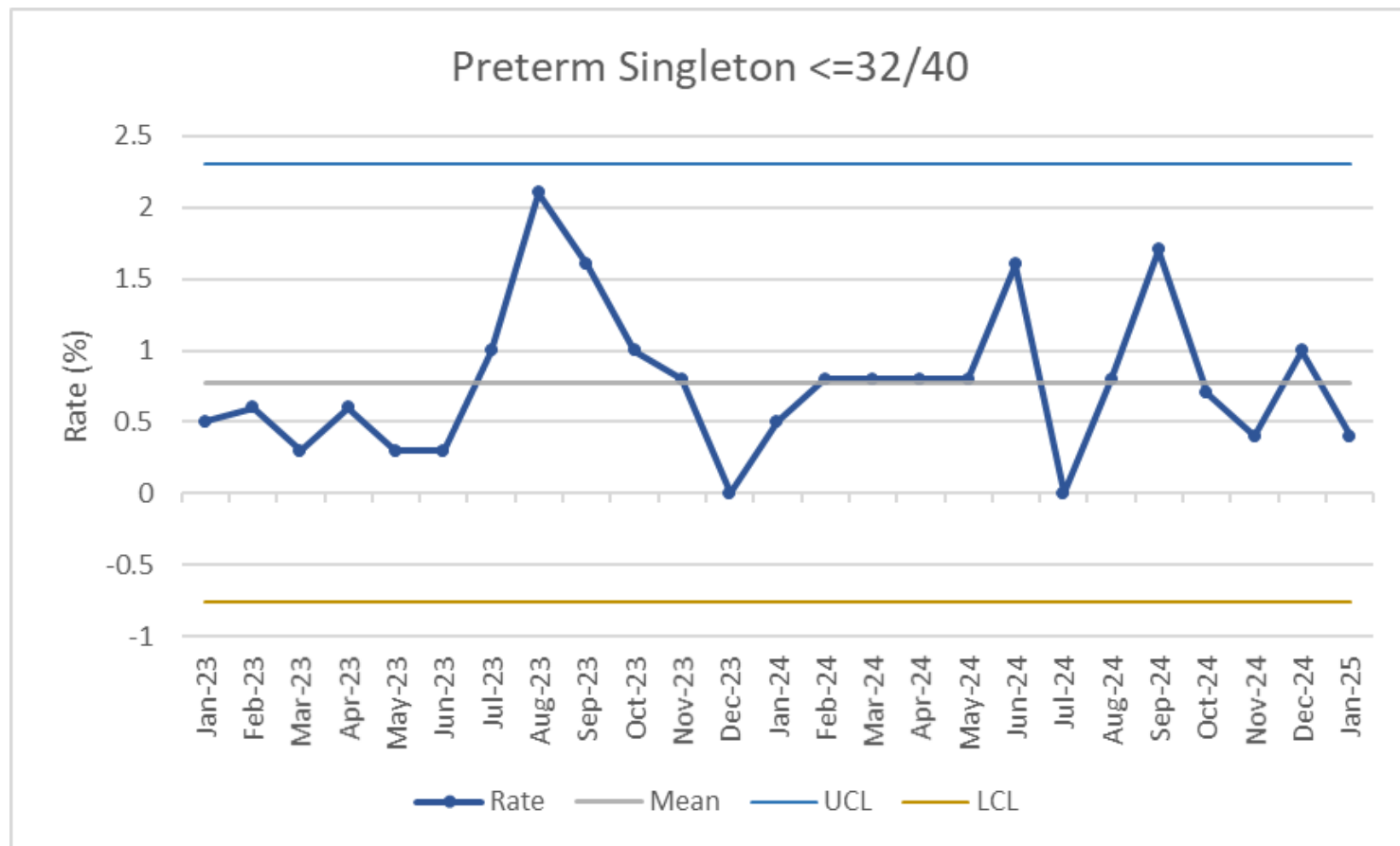
Neonatal Deaths ≤ 7 Days



The median rate has remained stable at **0.1%**.

In January 2025, the rate was **0.0%**.

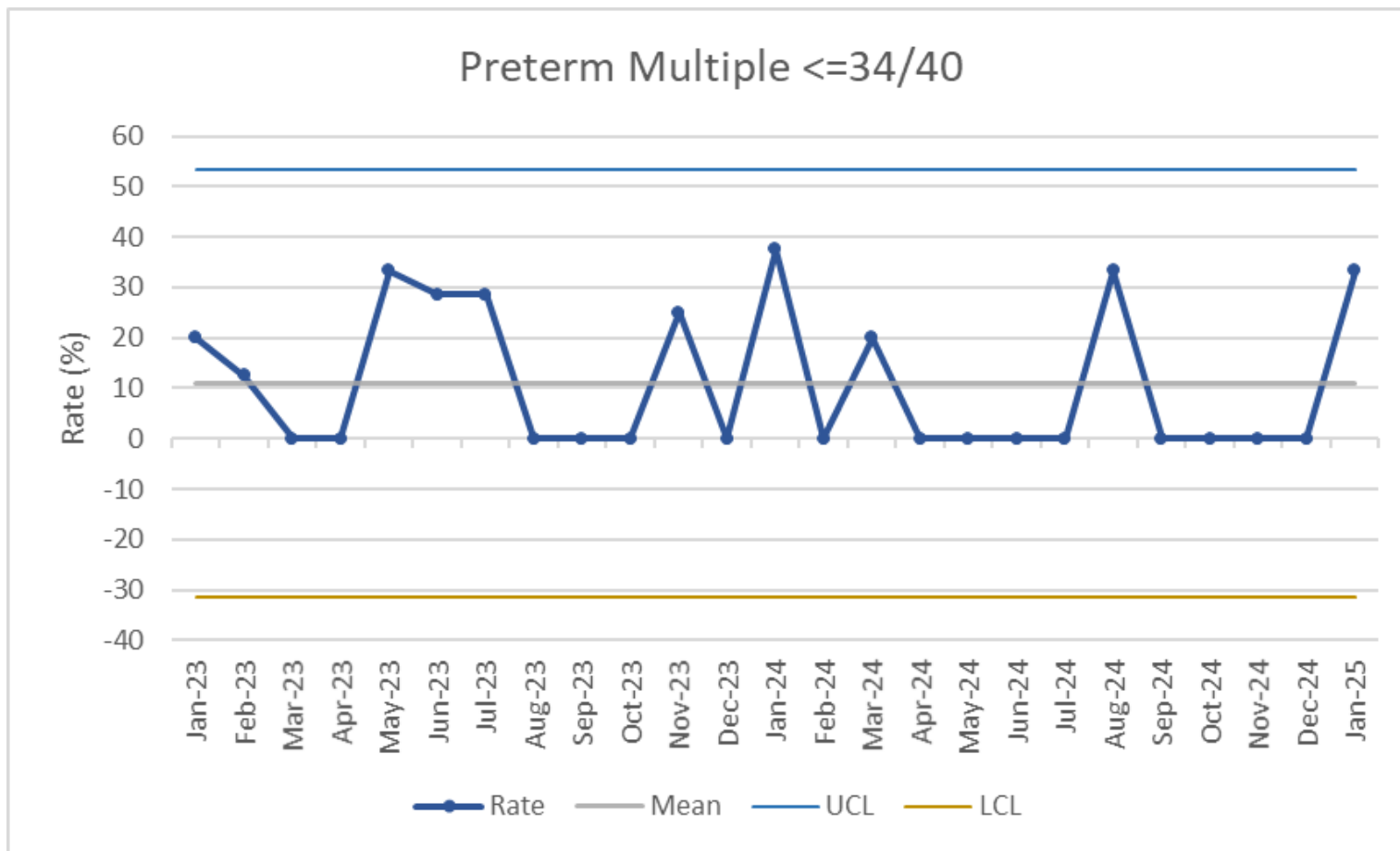
Preterm Singleton Births $\leq 32/40$



The median rate has remained stable at **0.8%**.

In January 2025, the rate was **0.4%**.

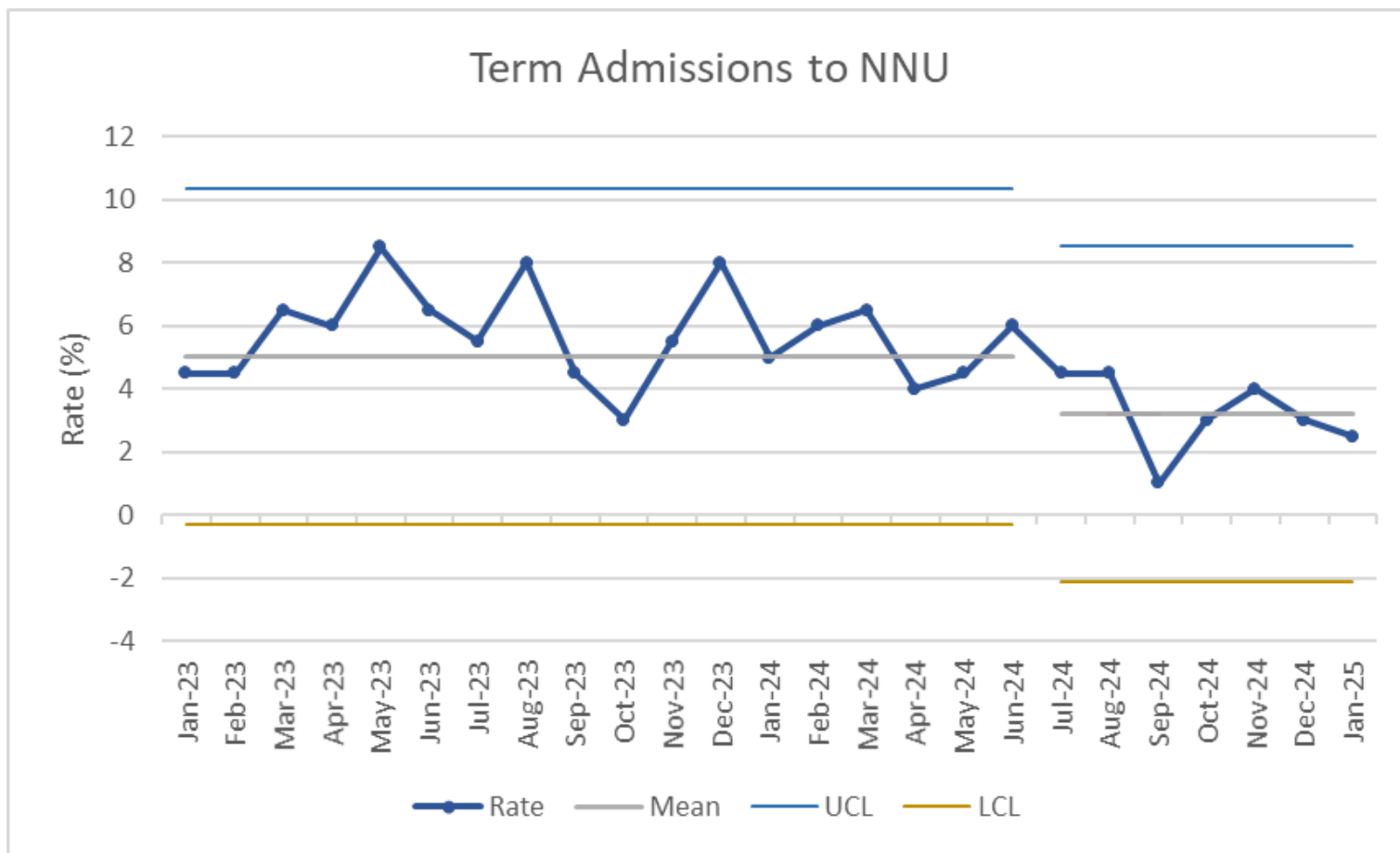
Preterm Multiple Births $\leq 34/40$



The median rate has remained stable at **10.9%**.

In January 2025, the rate was **33.3%**.

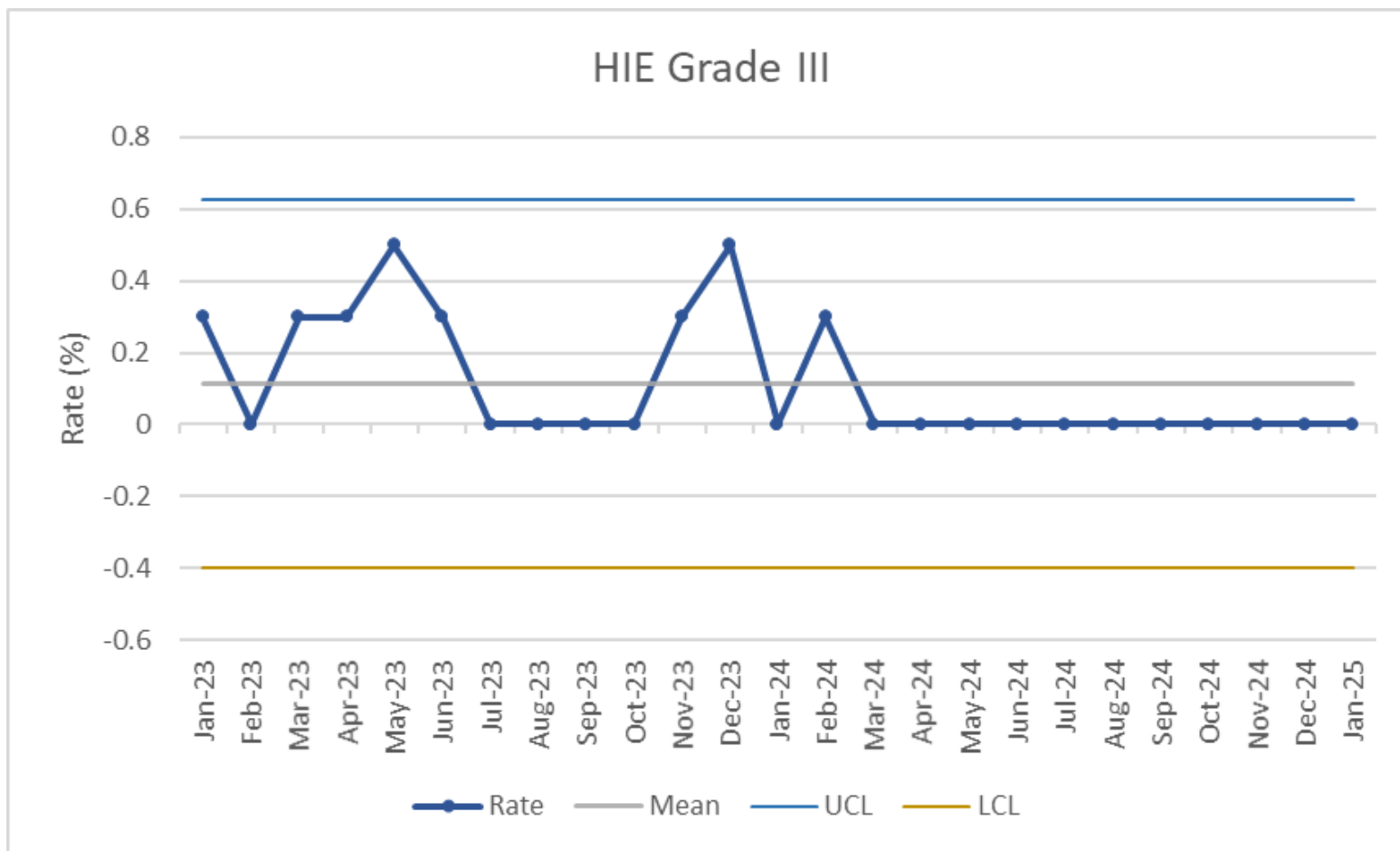
Term Admissions to NNU



The median rate decreased from **5%** to **3.2%** in July 2024.

In January 2025, the rate was **2.5%**.

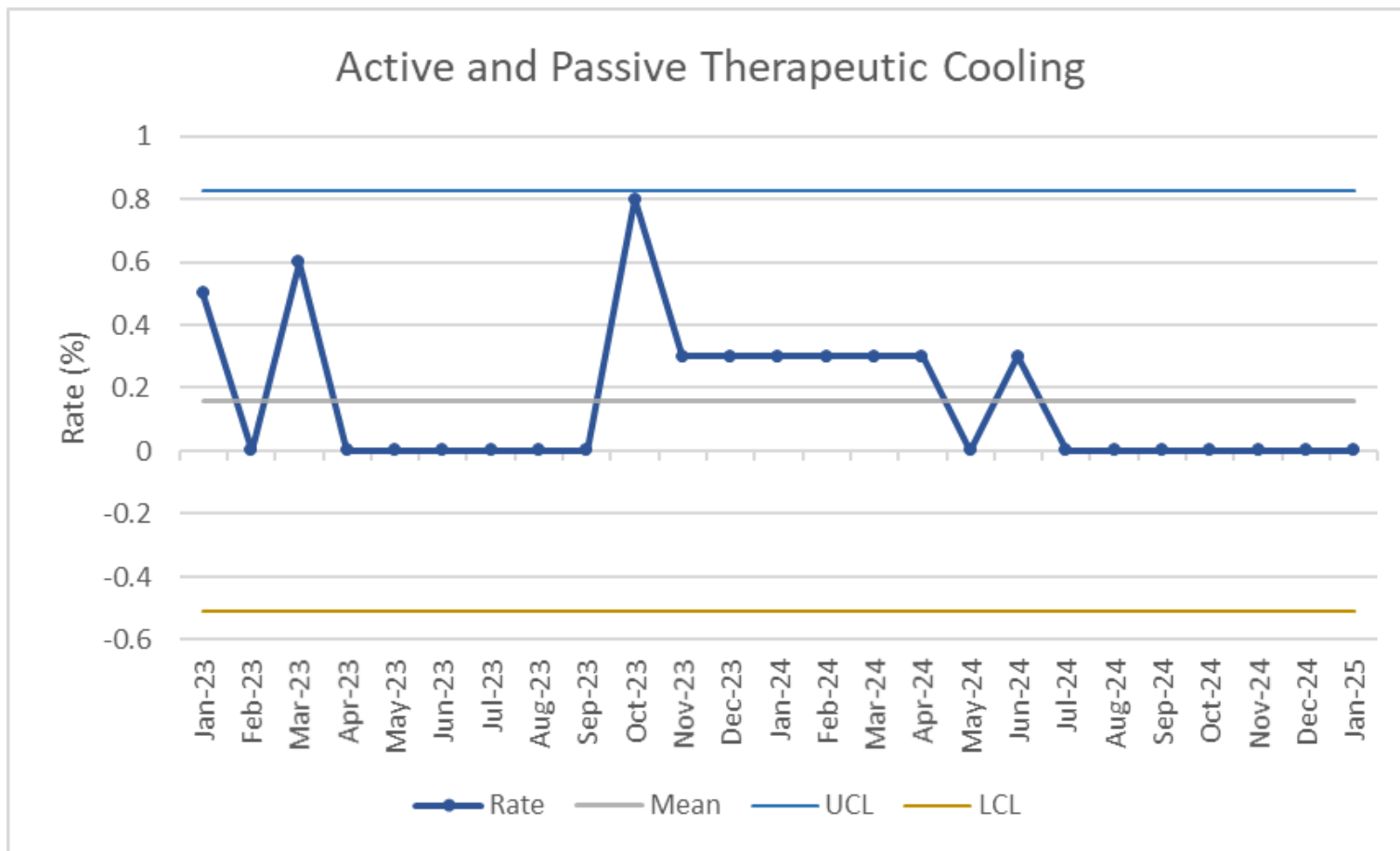
Hypoxic Ischaemic Encephalopathy Grade III



The median rate has remained stable at **0.1%**.

In January 2025, the rate was **0%**.

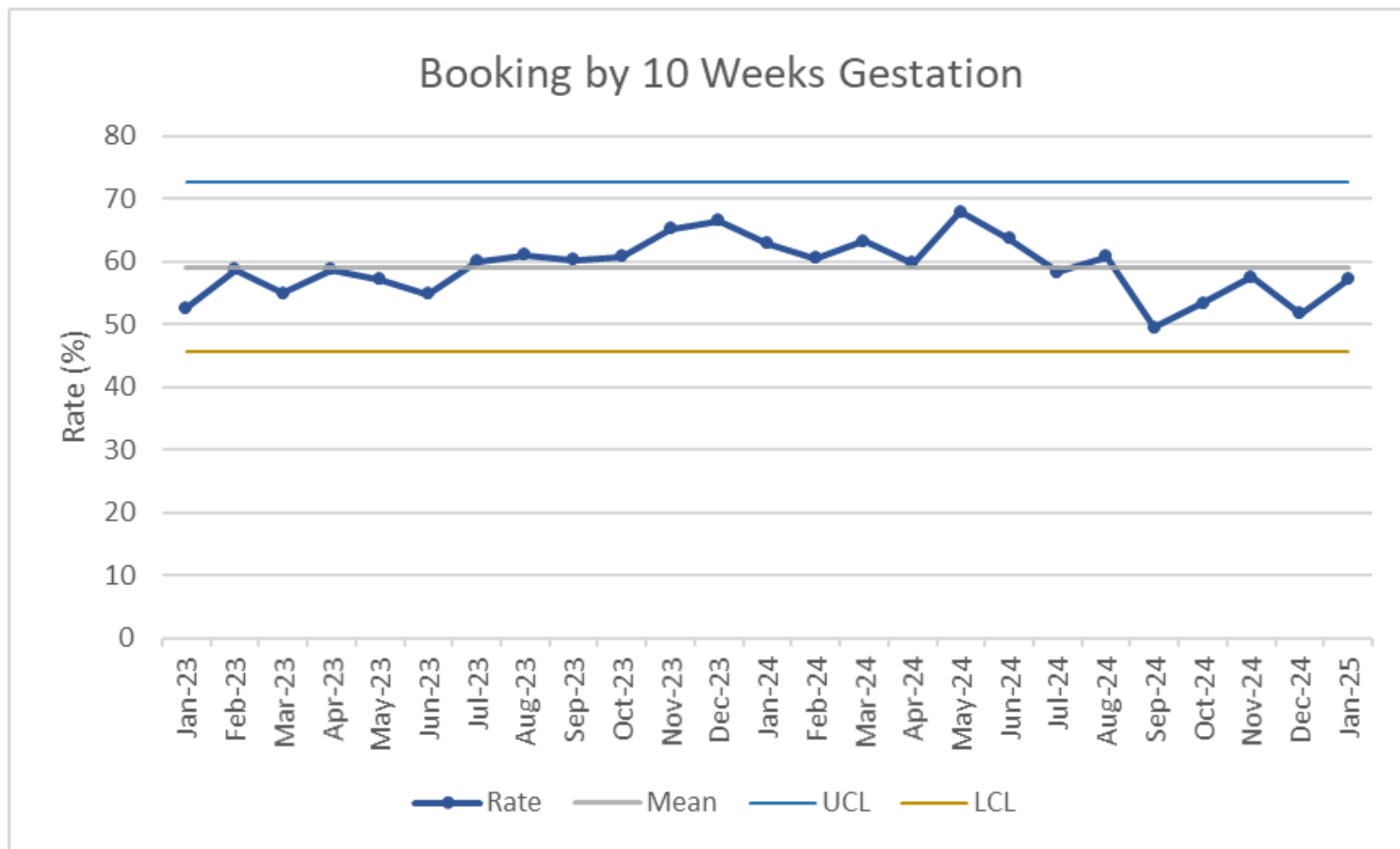
Active and Passive Therapeutic Cooling



The median rate has remained stable at **0.2%**.

In January 2025, the rate was **0%**.

Booking by 10 Weeks Gestation



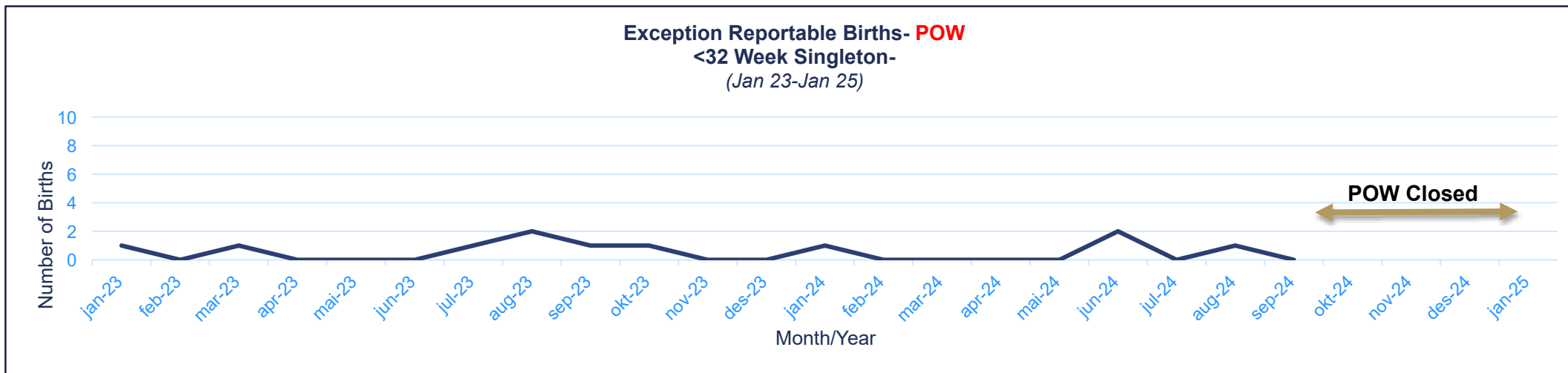
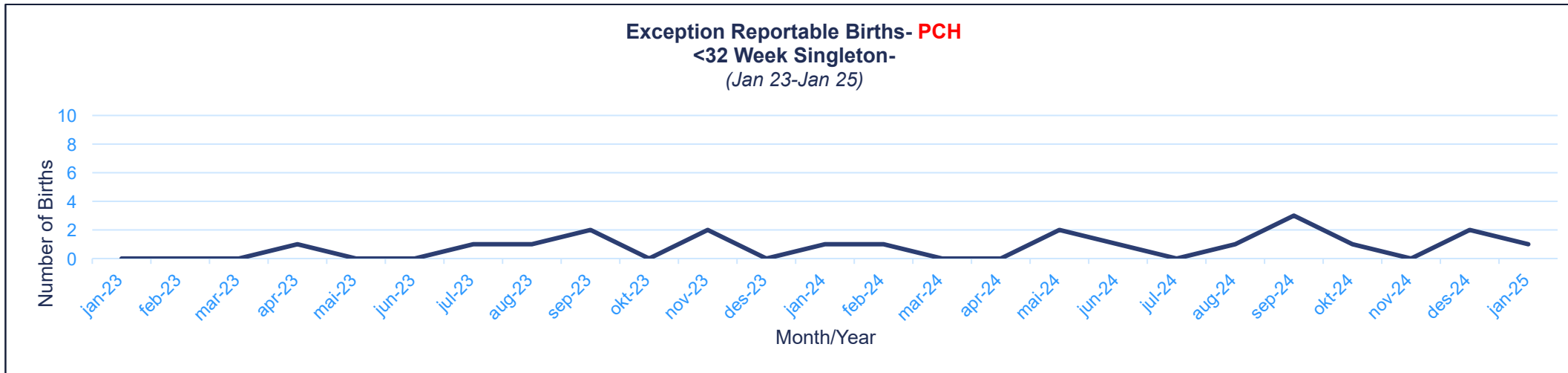
The median rate has remained stable at **59%**.

In January 2025, the rate was **57%**.

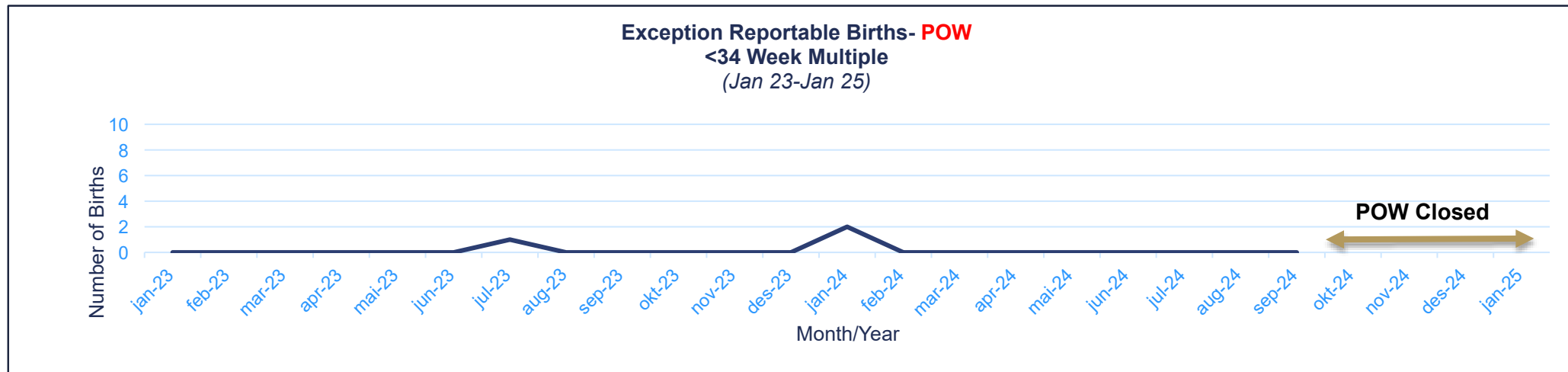
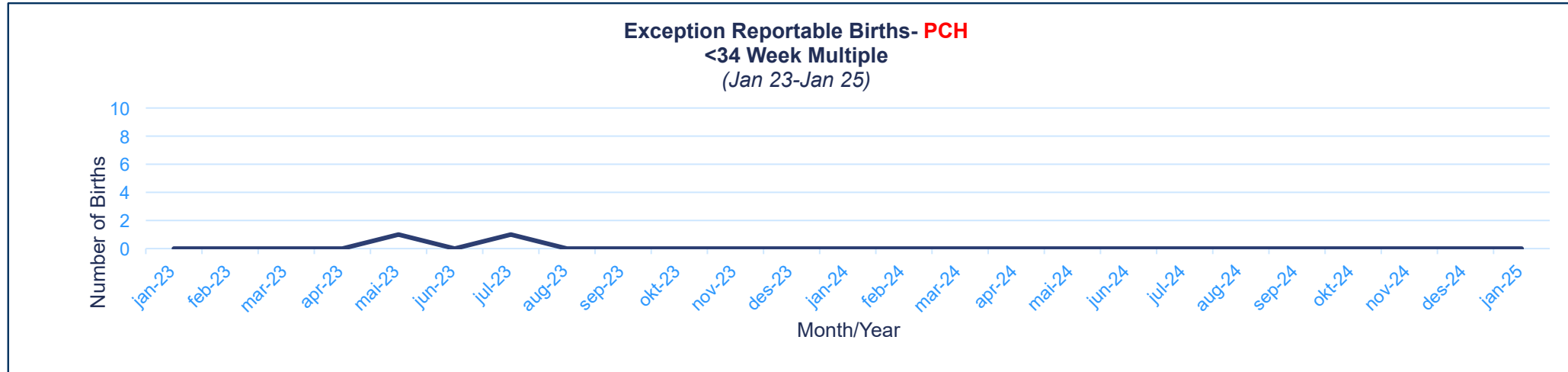
Neonatal Data Metrics- March 2025

Exception reportable births
Term admissions

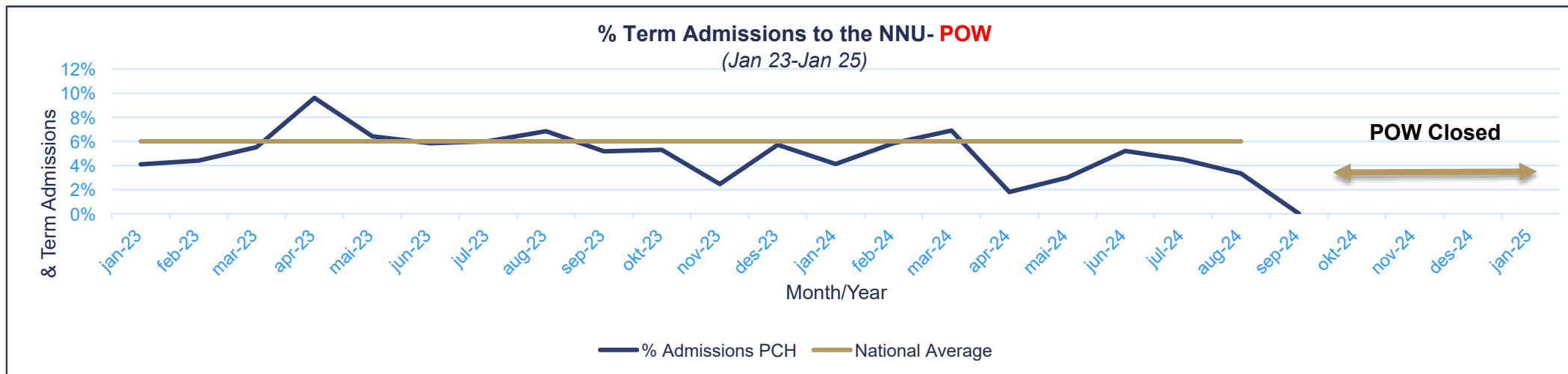
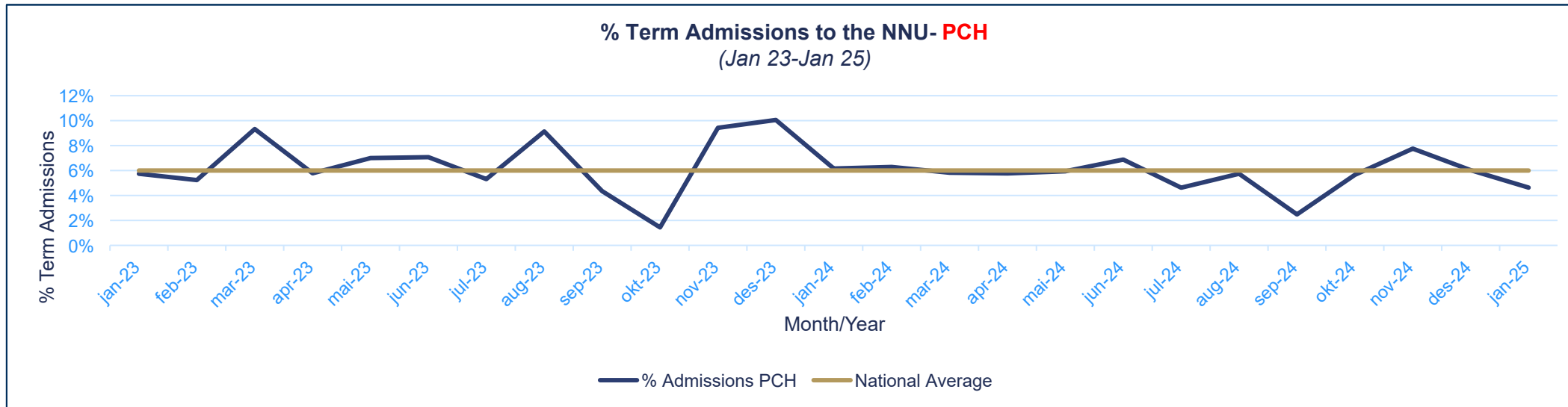
Exception Reportable Births- <32 Week Singleton (Jan 2023-Jan 2025)



Exception Reportable Births- <34 Week Multiple (Jan 2023 - Jan 2025)



Term Admissions (%) *(Jan 2023 – Jan 2025)*





Agenda Item

5.3b

Quality, Safety & Experience Committee

**Highlight Report from the Unscheduled Care Group
Quality, Safety and Experience Committee**

Dyddiad y Cyfarfod / Date of Meeting	25/03/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Emma James, Unscheduled Care Nurse Director Owen Weeks, Unscheduled Care Medical Director & Head of Quality & Patient Safety
Cyflwynydd yr Adroddiad / Report Presenter <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Emma James, Unscheduled Care 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
Quality, Safety and Experience Committee	13/02/2025	



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 13th February 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 and Experience Committee (QSEC) 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

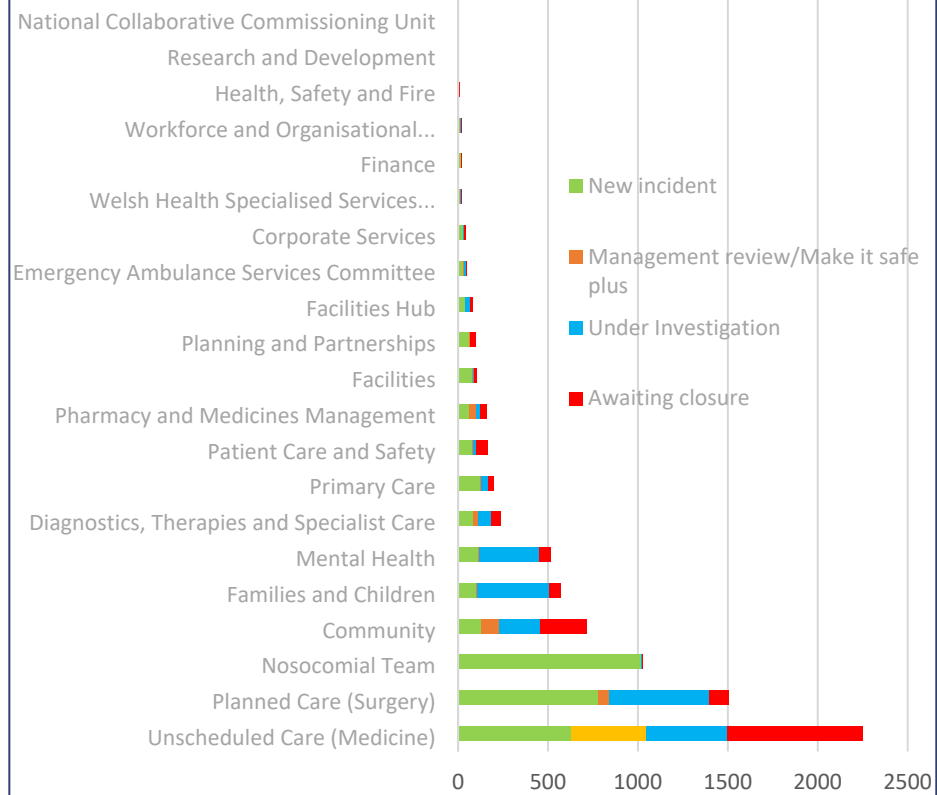


3. Highlight Report

Alert / Escalate	Further temporary relocation of MDU to ward 10 required at RGH site to support the ability to deliver essential planned care activity whilst we await the implementation of the Vanguard unit. This has required a temporary reduction in MDU activity which is being monitored daily however this has also allowed the opportunity for detailed monitoring and evaluation of the day unit service in order to inform future service planning.
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 target has decreased in January 2025 to 63%, this is due to the challenges faced across NHS Wales with the services being extremely busy, resulting in the Health board declaring business continuity. Currently, there are 21 open complaints and 5 over the 30 day compliance. This is an increase from 13 to 21 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 February'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 3rd March 2025 - there is a rigorous approach to daily assurance checks by either the 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	A rigorous approach to incident management within the care group has been implemented over the past 12-18 months with monthly plans requested by the Nurse Director from teams to provide assurance on timely incident management and to allow more real time analysis of incidents with an aim to commit to live incident management and where possible real time resolutions focused on listening, learning and improving.

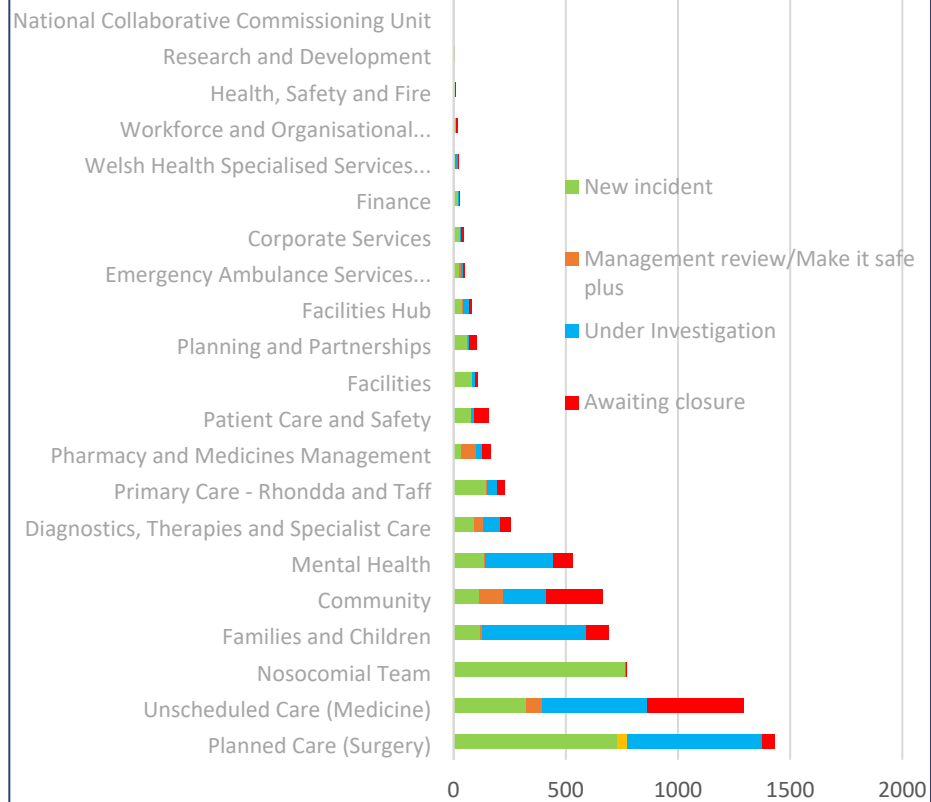


Total Open Incidents By Care Group @ 03.02.24



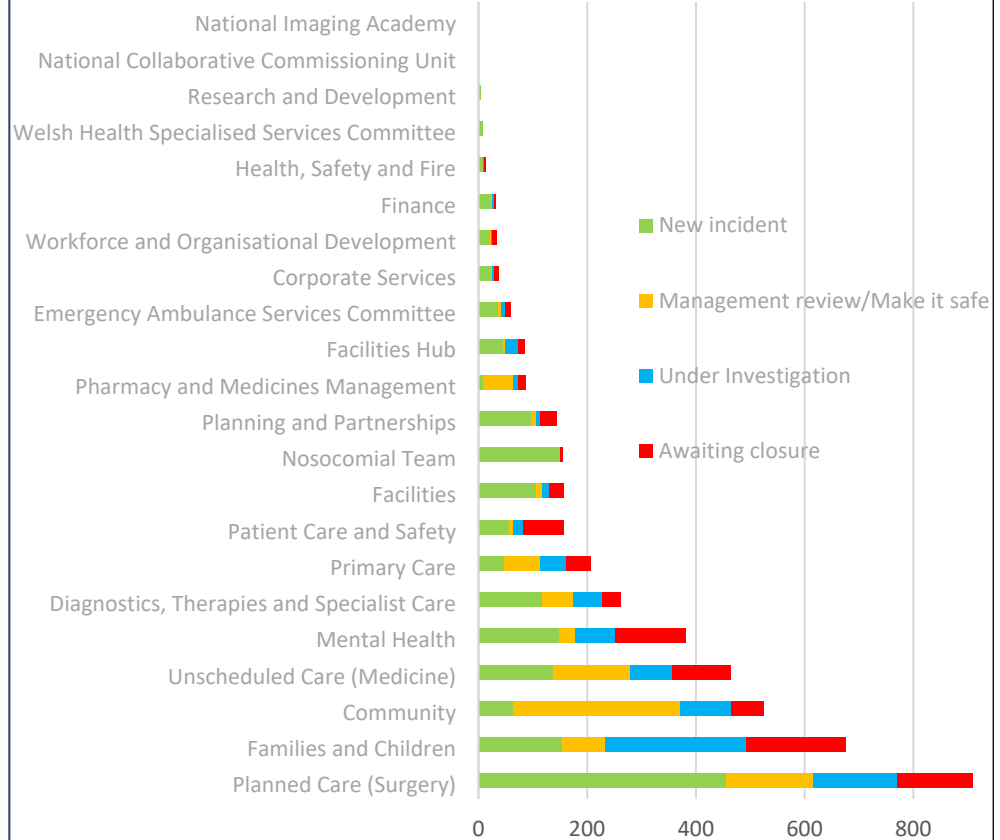


Total Open Incidents By Care Group @ 30.08.24

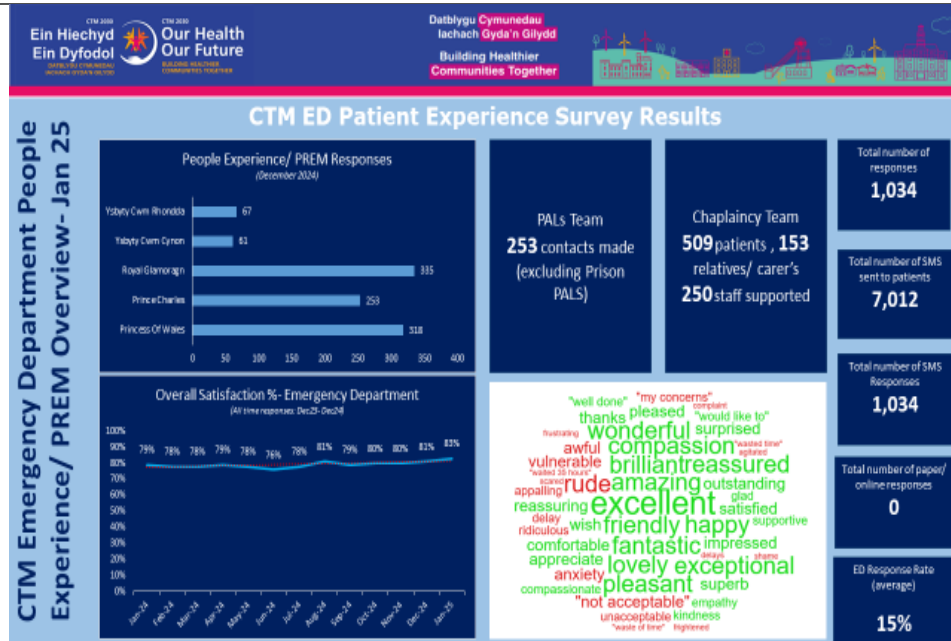




Total Open Incidents By Care Group @ 03.03.25



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.

YGT

The capital expansion works are ongoing at YGT with a phased approach to additional capacity coming online.

We continue to receive hugely positive feedback from staff, patients and relatives on the environment here and the positive impact this has on the ability to deliver high quality care. The nursing team are developing more detailed patient information leaflets and patient video's/ stories to alleviate any anxieties relatives may have around their family member's moving here as part of the next step in their care journey.

Stroke

We have also been continuing ongoing work with the PAL's team in relation to capturing experience data relating to the temporary centralisation of stroke services. These will be explored in more detail in a spotlight report as part of this committee.



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.

Due to SSNAP changes there is still no QIM report available. This continues to be an All Wales issue and is why we are working on pulling data internally for the monitoring and evaluation reports.

Since the temporary move of Stroke Services from POW/PCH to RGH we have implemented a weekly Stroke Re-design meeting to ensure short to medium-term planning for Stroke Services is looked at, at pace with all key stakeholders.

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
- 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
- The ability to report data has been disrupted by a combination of the changes in how SSNAP requires data to be recorded

Progress so far:

- Nursing teams collaboratively working together to review rosters across both wards to support safe staffing across the Acute Stroke Unit
- 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 job out to advert with interest from potential candidates
- 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) - Reduction in long waiting patients and on track to clear all 104+ week patients by end of March 2025 - Daily ward huddles implemented which cover '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 - Meeting held on Wednesday 19th February with Cardiff & Vale (C&V) colleagues to establish next steps for regional Stroke Service for South Central Region Immediate actions: - Paper to be presented to Executive Leadership Group (ELG) on 03/03 - Work streams to be set up based on outcome of ELG
Appendices	

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 (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) /	Leadership
	If more than one applies please list below:



Link to Enablers of Quality (<i>Duty of Quality Statutory Guidance (gov.wales)</i>)	
Dolen i Feysydd Ansawdd (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) / Link to Domains of Quality (<i>Duty of Quality Statutory Guidance (gov.wales)</i>)	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 <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: ☒	No: ☐
	Outcome:	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /</i> Equality and Welsh Language <i>Have you undertaken an Equality and Welsh Language Impact Assessment Screening?</i>	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 (<i>Pobl /Ariannol</i>) / Resource Impact (<i>People / Financial</i>)	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 and Experience Committee is asked to **NOTE** the highlights outlined in section 3 of this report.



Agenda Item

5.3c

Quality, Safety & Experience Committee

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

Dyddiad y Cyfarfod / Date of Meeting	25/03/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Nurse Director, Planned Care
Cyflwynydd yr Adroddiad / Report Presenter <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	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	
ICU	Intensive Care Unit
ACCTTO	Anaesthetic, Critical Care, Theatres, Trauma & Orthopaedic (Directorate)

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 17th February 2025.
- 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

- Impact of the critical incident in PoW for elective arthroplasty and glaucoma surgery.
- Mitigation
- ICU in POW has now moved into a temporary ward (11) releasing the Ophthalmology theatres to recommence surgery. These theatres reopened on 27th January 2025
 - Temporary relocation of Medical Day Unit (MDU) in RGH into a small area on the Day Surgery Ward (Ward 10 in RGH) to allow the restart of elective arthroplasty (end January 25).
 - Vanguard modular Day Surgery Unit (4 theatres, recovery and 18 bedded ward) will go live on 4th April 25.
 - Ward 10 in RGH will move into the Vanguard to create a larger (17 beds) elective arthroplasty ward, which will allow MDU to return to its original location.



Critical Care Capacity

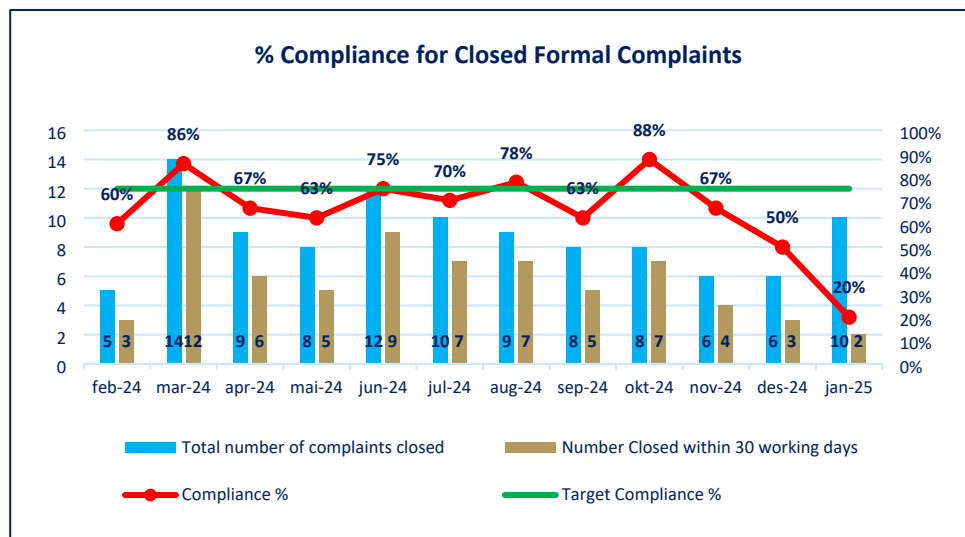
December and January experienced unprecedented surge in admissions to all 3 Intensive Care Units with RGH and PCH particularly high with additional unfunded bed capacity required consistently for an average of 4 weeks. Care Group Directors are now working with Critical Care colleagues to produce a surge plan to ensure guidelines, processes and governance in place. Medical and Nursing workforce business cases being produced to support the increased bed capacity.

Trauma Demand in RGH

Increased Trauma demand following POW Critical Incident and redirection of services to RGH. Challenges in accommodating the volume of patients and accommodating the timely repatriations from the Major Trauma hospitals.

Advise

Complaints Management (Feb 24 – Jan 25)



Significant drop in performance attributed to:

- Higher number of older long standing complaints closed
- Performance reflective of operational pressures across the acute sites.

Trends/themes Identified

- Communication and attitude includes all members of the Multi-Disciplinary Team
- Treatment/Clinical care
- Appointment queries

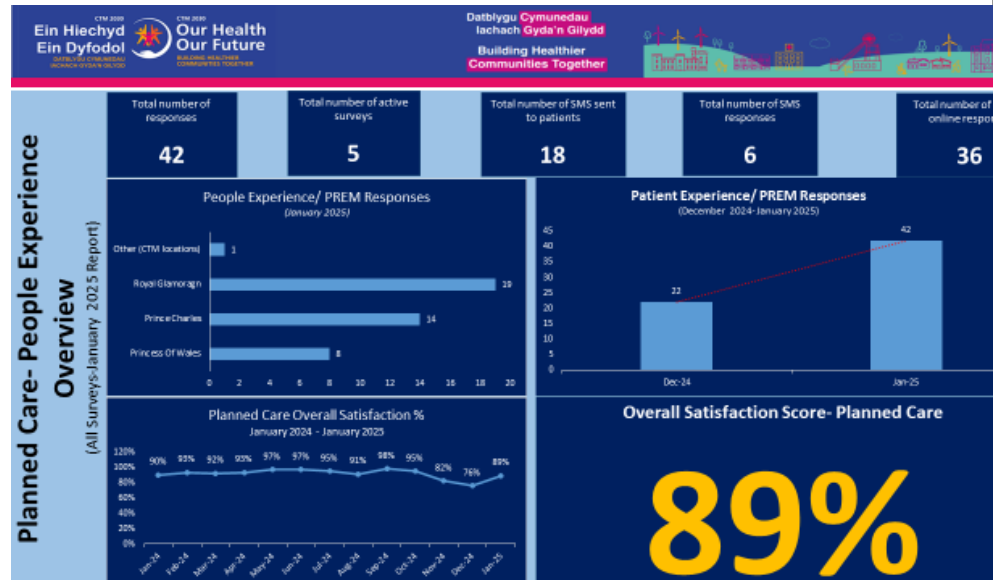


GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

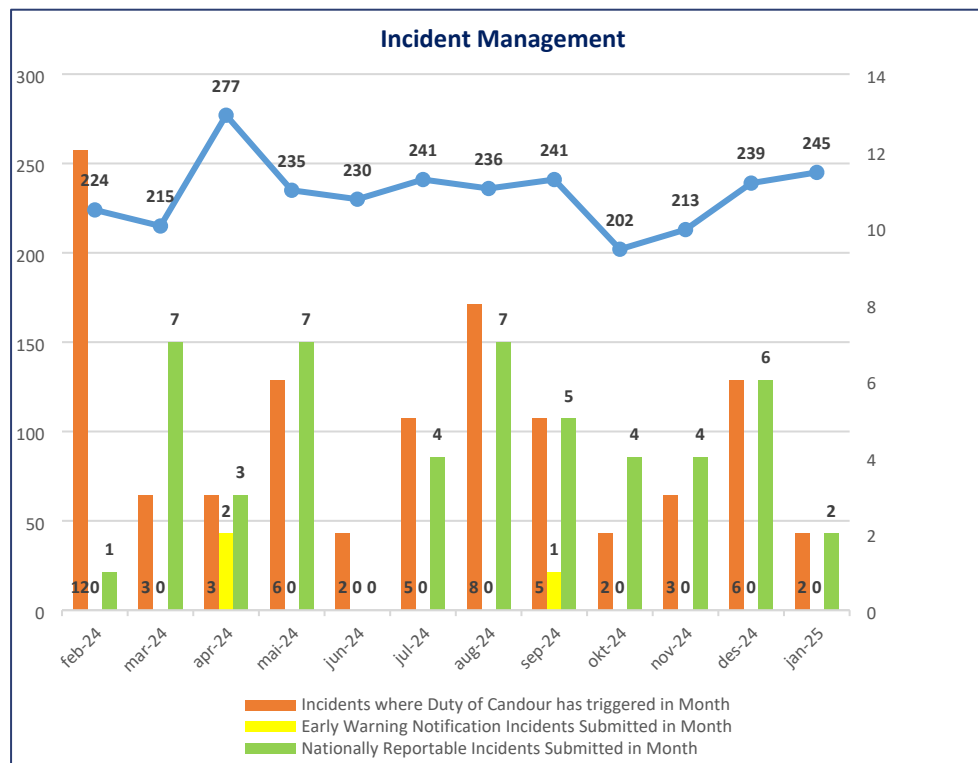
Patient Experience

January 2025 summary from Planned Care Surveys



- Dedicated Dermatology patient experience survey (generic & cancer) now live.

Incident Management (Feb 24-Jan 25)



Newly reported NRIs x 8 (Dec 2024 & Jan 2025)



	• 1 x Never Event (NRI – No Harm) Wrong Site Block Theatre) • 4 x Avoidable Pressure Damage - Unstageable (POW/General Surgery) • 2 x Avoidable Pressure Damage – 1 x Grade 3 & 1 Unstageable (RGH/General Surgery) • 1 x Avoidable Pressure Damage – Unstageable (RGH (moved from POW)/General Surgery) 6 x Avoidable PUs identified at Assurance Panel remain open • 4 x POW (2 x Gen Surgery/2 x ACCTTO) • 1 x RGH (ACCTTO) • 1 x PCH (Gen Surgery) •
Assure	• No outstanding AMaT action plans for PCH and PoW • Ward 5,6,7 in PCH and Ward 8 and 10 RGH have achieved Bronze Ward Accreditation • SURGICUBE installed in POW Ophthalmology Unit to increase glaucoma surgical capacity. Aiming to go live first week March. • Endoscopy Services via the Vanguard Unit will commence first week of March 25.
Inform	Patient Story Senior Nurse presented a Patient Story regarding a terminally patient in PCH Ward 6. This story is also being presented at CTM UHB Formal Board meeting. Staff Experience Initiative led by Snr Nurse for Planned Care in PCH as part of wider PCH Surgical Show Care event, captured staff feedback via QR code in relation to key questions for nurses working on the wards, 'what's it like working as a nurse in surgery in PCH' via a QR code. Plan is to share this wider across Planned Care to capture staff's feedback.  staff%20feedback%20PCH.pptx
Appendices	

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 (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) / Link to Enablers of Quality (<i>Duty of Quality Statutory Guidance (gov.wales)</i>)	Whole-systems Perspective
	If more than one applies please list below:
Dolen i Feysydd Ansawdd (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) / Link to Domains of Quality (<i>Duty of Quality Statutory Guidance (gov.wales)</i>)	Choose an item.
	Effective Safe Timely Efficient Person centred Equitable
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / Quality</i> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:



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

4.0 Recommendation

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



Agenda Item

5.3d

Quality, Safety & Experience Committee

Highlight Report from the Mental Health and Learning Disabilities Care Group

Dyddiad y Cyfarfod / Date of Meeting	25/03/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Head of Mental Health Nursing
Cyflwynydd yr Adroddiad / Report Presenter <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Mental Health and Learning Disabilities Care Group 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	
AMAT	Audit Management and Tracking system

CMHT	Community Mental Health Team
CTM	Cwm Taf Morgannwg University Health Board
C+V	Cardiff and Value University Health Board
HIW	Health Inspectorate Wales
HMIP	His Majesty's Inspector Prison
HMP	His Majesty's Prison
IPC	Infection Prevention and Control
MHA	Mental Health Act
MH	Mental Health
MHIT	Mental Health Inreach Team (At HMP Parc)
MHLD	Mental Health and Learning Disability
MOJ	Ministry of Justice
NRI	Nationally Reportable Incident
OPMHS	Older Peoples Mental Health Services
PMVA	Prevention and Management of Violence and Aggression
QSRE	Quality Safety Risk and Experience Meeting
RAG	Red, Amber, Green
RC	Responsible Clinician
RCRP	Right Care Right Person
SBUHB	Swansea Bay University Health Board
SRU	Supported Recovery Unit
SWP	South Wales Police
YCC	Ysbyty Cwm Cynon

1. Introduction

- 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 QSRE meeting on 12/02/2025.
- 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 MHLD Care Group QSRE 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. Highlight Report

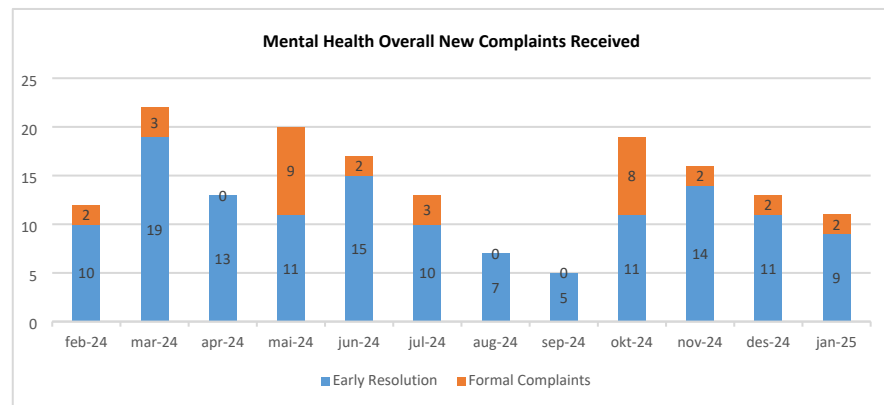
Alert / Escalate	• Medical staffing remains fragile across the whole of Adult MH services and this has recently been added to the organisational risk register with a score of 16. There are significant pressures across inpatient services at Consultant level and particularly in relation to availability of Approved Clinicians. All six CMHTs are currently working at 50% Consultant capacity due to sickness. The Care Group is managing medical staffing with daily scrutiny to identify and communicate pressures and to implement counter measures to release Consultant body. The clinical teams are working with patients, families and advocates to minimise the impact on patients. • The Care Group is responsible for the delivery and update of PMVA Module D training to applicable MH staff. Following an options appraisal the care group has concluded that the current train the trainer model is unsustainable and the only viable option is to commission an external provider to deliver Module D. The current in house training ends at the end of March 2025 and there is a risk that training compliance could fall as the procurement of an external provider takes place, to mitigate against this the Care Group has ensured that as many staff as possible have been trained before March 2025.
Advise	• In January 2025, Ward 7 at YCC, which is an OPMHS ward, were subject to an unannounced 3 day HIW inspection. It is pleasing to report that the feedback was very positive with no Immediate Assurance required. Shortly before this inspection the ward was reviewed through the Care Group's Quality Assurance process, the results of both inspections were similar and the ward reported that the internal review was good preparation for the HIW visit.

	- The Care Group reviews the HIW inspection reports of other MHL services in Wales and where there is applicable learning self-assessments are completed and monitored through the Care Group QSRE. This enables the Care Group to identify themes and trends from HIW in readiness for when HIW visit CTM services. This was evident during the recent inspection of Ward 7 and was complimented by the reviewers. - The In-patient Improvement Board met on 13th February to review progress against the HIW Discharge Review recommendations and to consider the broader programme, which is aligned to the national patient safety programme for mental health. Two recommendations remain outstanding: 1) a unified electronic patient record – the Health Board is currently progressing a procurement exercise and it is expected that full implementation of a single patient record will be January – July 2026 2) review of mental health policies – significant progress has been made on updating all mental health policies; a robust programme of review is now established as well as an updated mental health policy intranet site. There are 9 outstanding policies, which are all under active review. Given the significant progress and in light of the programme becoming more aligned to the national programme rather than providing assurance against external recommendations a decision was made to stand down the Executive chair of the Improvement Board. The chair will now revert back to the Nurse Director. - The implementation of Phase 3 + 4 of RCRP, which relate to the transportation of patients and patients who are detained under S136 of the MHA, will commence 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. The Care Group continues to engage with SWP stakeholder events and is working with C+V UHB and SBUHB to develop a regional response and lobby for a jointly developed S135/6 policy.
Assure	The care group 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 at the end of February 2025. This will now enable the development of a Quality Dashboard

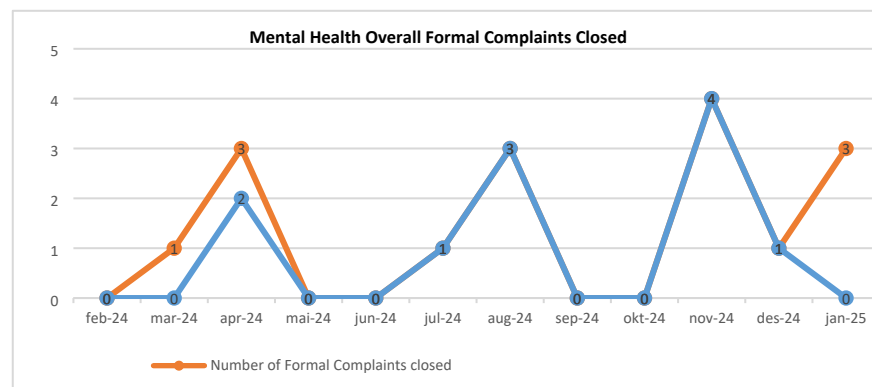


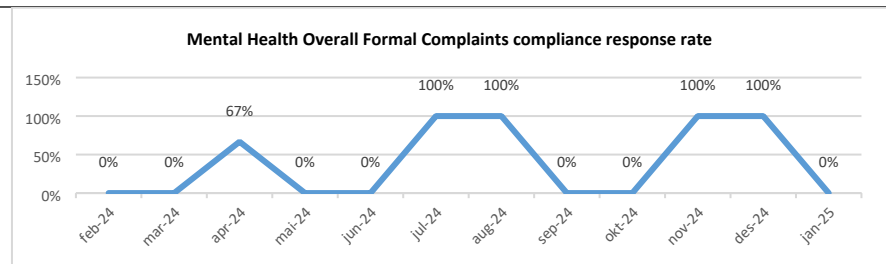
and allow the Care Group, directorates and all group of wards and teams to easily identify themes and trends.

- 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 December and January was 4 in total which has returned to within the mean from the increase reported in the Care Group's last highlight report.



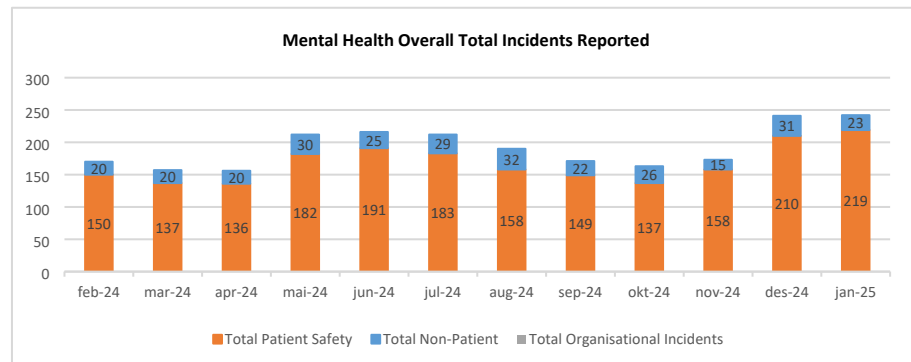
Complaint closure compliance in the Care Group was 0% in October and 100% in November, however, the low volume of formal complaints can artificially skew the reporting and contributes to a perception of variation in closure compliance performance in the Care Group.





At the end of January there were 3 open formal complaints (down from 7 at the end of December (the 2-year mean is 7)).

- The Datix incidents reported this period, 247 in December and 257 in January are above with the 2-year mean of 198, this is due to the high acuity areas of high acuity in Ty Llidiard as detailed above.



- There are 5 open NRIs (up from 4 since the last report, the 2-year mean is 5).

There was 1 new NRI reported during this period.

- All the MHL D wards are now using AMAT. Compliance with ward audits as of the end of October is shown below.

Project	No. audits	Current compliance	Improvement	Overdue actions
Health & Safety	2	100.0%	▲	1
Health and Care Standards	2	98.1%	▶	0
Infection Control	14	98.5%	▶	1
Medicines Management	2	100.0%	▼	6
Patient Safety	17	87.7%	▶	25

There is 100% compliance in all project areas apart from Patient safety which is at 88%.



	There are 25 overdue actions in the Patient Safety category, up from 21 in the last reporting period. Of these 25, 17 are RAG rated green with 8 RAG rated as amber, these relate to IPC estates issues. No actions are rated as red. Performance against these audits is monitored in the individual directorate's QSRE meetings.
Inform	- Work to replace 3 sets of doors in adult inpatient services which has been escalated to committee in previous papers has now been completed. - A recent review involving HMIP and HIW identified areas of good practice for the MHIRT around discharge support, and noted relevant points for future action relating to a review of substance misuse (both clinical and psychosocial) and the mental health resource required. - In March the Wales Mental Health Leadership Exchange will bring together leaders from across the Welsh health and care system as part of a series of activity that supports information sharing and innovation. The Care Group is hosting a knowledge exchange entitled "Diversifying the Workforce" which will showcase how the Care Group improved recruitment and efficiency in outpatient care which in turn improved experiences of waiting. - The Care Group has implemented a mentorship programme for newly registered nurses led by the Senior Nurse for Professional Development. The aim of the programme is to support new registrants as they transition from student to staff nurse and ultimately positively impact recruitment and retention.
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 <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality (Duty of Quality Statutory Guidance (gov.wales))</i>	Learning, Improvement & Research
	If more than one applies please list below: Culture and valuing people Learning, improvement and Research Leadership
Dolen i Feysydd Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality (Duty of Quality Statutory Guidance (gov.wales))</i>	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 <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / Quality Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg <i>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?</i>	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please include rationale below:



Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau (Pobl / Ariannol) / Resource Impact (People / Financial)	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

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



Agenda Item

5.3e

Quality, Safety & Experience Committee

Highlight Report from the Primary Care and communities Care Group

Dyddiad y Cyfarfod / Date of Meeting	25/03/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Nurse Director, Primary Care & Communities
Cyflwynydd yr Adroddiad / Report Presenter <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	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



CD	Controlled Drugs
COPD	Chronic obstructive pulmonary disease
CTM	Cwm Taf Morgannwg
DN	District Nurses
GA	General Anaesthetic
GMS	General Medical Services
GP	General Practitioner
HB	Health Board
HCSW	Health Care Support Worker
HIW	Health Inspectorate Wales
HMP	His Majesty Prison
HMIP	His Majesty Inspection of Prisons
IPC	Infection Prevention Control
LMC	Local Medical Council
POW	Princess of Wales Hospital
RGH	Royal Glamorgan Hospital
SOP	Standard operating procedure
WG	Welsh Government
WGOS	Welsh General ophthalmic services
YCC	Ysbyty Cwm Cynon Hospital
YCR	Ysbyty Cwm Rhondda Hospital

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 14th February 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.
 - 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: • Paeds GA: As a result of issues on the POW site and the decanting of services across the CTM footprint, the service has lost access to its 2 regular GA lists in RGH and the availability of adhoc lists across other hospital sites has considerably reduced. Current waits are 187wks, with 722 children on the list- the waiting times cause children to have repeated urgent care/absent from school due to swelling and pain/ repeated antibiotics prescribed • An urgent GA list runs once a month, where up to 6 children can be treated. This service remains on the risk register and an updated report will be drafted for Committee in May.
Advise	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. District Nursing Activity Civica – work is being undertaken to understand the significant increase with cancelled visits. From approx. 5,000 per month to 12,000 per month. New codes have now been approved and a data impact assessment been completed with support from IT team. This will identify the reasons for cancellations and the rescheduling of calls. DN Transcribing (phase 2) - New All Wales SOP for all medication (including controlled drugs) shared – piloted in Swansea Bay HB. SOP to be shared with LMC and GP colleagues for comments and plans for new pathway to support District Nursing service. Discussions with LMC have been arranged. Lymphoedema Service – Operational Lead continues to address these referral breaches; the waiting list remains at a high but positive progress is being made to address these issues. An ongoing action plan remains in place. Ysbyty Cwm Rhondda - Ward D4 achieved a white award in the accreditation visit, which has resulted in immediate actions implemented.

	Primary Care - Primary Care – A risk has been identified in relation to failure to secure an alternative Clinical System for GP practices on Vision. This is a significant risk to the 29 GP Practices who remain using Vision whilst awaiting transition to EMIS. Heads of Primary Care are seeking engagement from the National Emergency Planning Team in addition to Health Board Level and Practice Level Business Continuity Planning. 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 robust plan needs to be in place to progress this work, WG have requested sight of this plan. Dental Services home office inspections for controlled drugs license applications were carried out on 22nd and 23rd January at Keir Hardie, Dental Teaching Unit, Quarella Road and Treharris. The service is now completing follow-up actions as a result of the visit which are due for submission on 07/12/2025. The clinics will continue with current approved practices/SOPs for managing CD's whilst any outstanding actions are completed prior to approval of the new licence and all outstanding actions completed. Parc Prison • Prison Estate Issues - Navigating the physical environment of the facility can pose barriers for staff to provide health care. The need for appropriate and increased space requirements with suitable IT and network capabilities are restricting service expansion and improvement. Office space continues to pose barriers to the team. G4S colleague's advise that a plan is in place to scope out room vacancies to support healthcare staff to be on site however the team have reduced provision to offer 5 days onsite senior leadership until this issue is addressed. • Incidents, a strategy has been established with the Deputy Director of G4S to lower the number of operational reported incidents and ensure that incidents are investigated within a timely manner.

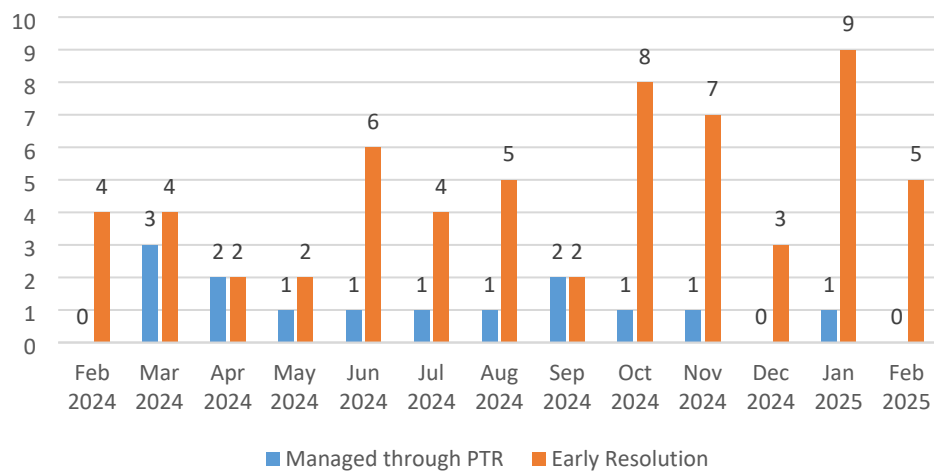


HMIP Unannounced Inspection at HMP Parc On 13th January 2025, HM Inspectorate of Prisons (HMIP) arrived on site to begin an unannounced inspection of HMP Parc. The inspection included a full review of the primary care, mental health, dental and pharmacy services provided on site and included inspectors from HIW and the General Pharmaceutical Council. The team are awaiting the report.

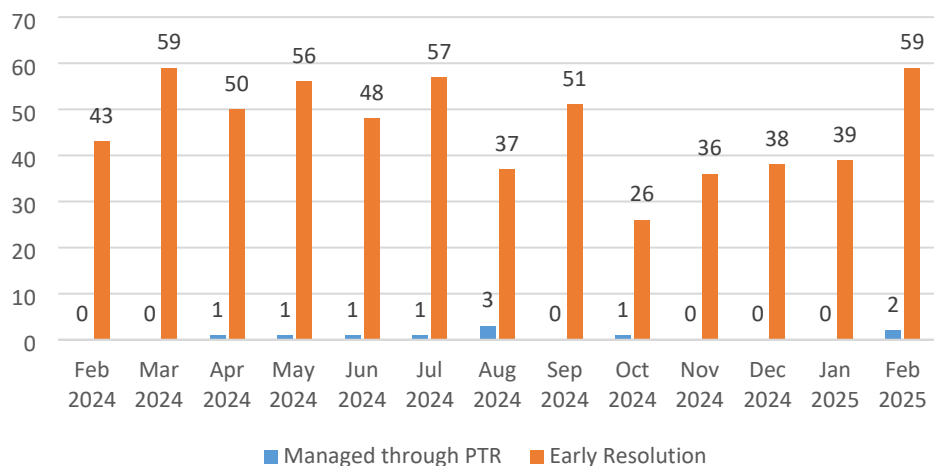
Assure

Concerns

Primary Care and Community Concerns



HMP Parc Prison Concerns





	Wound Clinic Service – Senior Nurse recruited for Bridgend will professionally lead wound clinic model review and new developments. Working group set up to look at pathways to support the medical advice and support for staff within wound clinics and their routes of escalation as an interim. Antibiotic audit for 4 weeks undertaken during January/February 2025 for community teams, including DN's, Lymphoedema and Podiatry. Review of finding being undertaken alongside Pharmacy and the Navigation Hub. Bladder and Bowel service - work ongoing to review incontinence products supported by the paediatric team. The work will scope and review the current ordering cycle pattern and the governance management in place after providing products. The team have met with colleagues in Swansea Bay to discuss their model, which identified an opportunity for a pilot to have service improvements for the health board through an integrated approach. Community Hospitals - Medication Assurance panel commenced and found to be very beneficial especially from a learning from events perspective. Dental Service - Following a recent expression of interest exercise, 11 practices have been awarded in totality £1m to increase activity in practice. This will enable 4,000 patients throughout 2025 to be allocated to these practices. • This will improve patients accessing NHS dental services and reduce impact on those needing to use the urgent access helpline Robust monitoring of practice activity will take place throughout 2025/2026 and the team will look to recycle any underactivity that comes back into the HB as a result of underperformance.
Inform	District Nursing Team Leader Event – a very successful day was held with the team, 51 staff members were in attendance. The event included new models of working, shared learning and current practice models. Spirometry service - the team are scoping and reviewing the current service for adults with an Asthma diagnosis. Respiratory Team – Discussions are in place regarding a pilot being undertaken for 3 months across Merthyr and Cynon localities with the Navigation Hub to prevent avoidable admissions via COPD Virtual Ward.



	District Nursing - Launch of the new Peer Coach Advocacy Team planned for April 2025. GMS Unified Contract Assurance Framework (UCAF) has been established and Desk Top Reviews for all Practices have been undertaken. The desktop reviews identified that 3 practices were selected for a "Full Governance Visit" which will be an in-depth whole day visit undertaken by a multi-disciplinary team to including the Clinical Director (GP) and Medicines Management which will cover all 12 Quality Standards. Tynycoed Surgery had a HIW visit undertaken on the 14th January 2025 the report is awaited. Cwm Garw surgery has a HIW visit scheduled for March 2025 HMP Parc Prison A Health and Social Care Needs Assessment (HSCNA) has been completed which better understands the health needs of the resident population in Parc and to assess the extent to which the current need and demand for health and social care in the prison establishment were being met. An action plan for improvement has been created and will be shared in due course. YCC - Ward 5 building work has commenced. First phase will provide an additional 6 beds then remaining work will be completed to increase bed capacity to 15 beds. Ward 5 will be an extension of Ward 4 and will increase from 25 beds to 40 beds in total. Seren Awards received Bladder and Bowel Team, a registered nurse received the award for their professionalism and care. The at Home service, a HCSW was commended for their skills and care delivery provided to patients. Lymphoedema service, a registered nurse for their excellent leadership and skills shown. Accreditation awards - Wards A1, B2, C3 in YCR and wards 1,2,3 and 4 in YCC achieved Bronze award in accreditation visit.
Appendices	Nil to add

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 (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) / Link to Enablers of Quality (<i>Duty of Quality Statutory Guidance (gov.wales)</i>)	Learning, Improvement & Research
	If more than one applies please list below: Culture and valuing people Leadership
Dolen i Feysydd Ansawdd (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) / Link to Domains of Quality (<i>Duty of Quality Statutory Guidance (gov.wales)</i>)	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 <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / Quality</i> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:



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

5.3f

Quality & Safety Committee

Highlight Report from the DTPS QSRE

Dyddiad y Cyfarfod / Date of Meeting	25 March 2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	DTPS Team
Cyflwynydd yr Adroddiad / Report Presenter	Dr Sally Bolt, Clinical Director
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 3rd March 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**

Pathology

- LIMS 2.0:** The overarching risk in relation to meeting the project timelines has already been escalated to the organisational risk register. The project timeframe is tight and there are significant concerns regarding the resource required to deliver this project safely within expected timeframes. Due to the significant number of defects and failure to meet specified functionality requirements, the UAT phase was extended to January 2025. Following further delays in End to End testing and defects, this has been extended to the end of April 2025. This is a significant burden on Pathology staff, as additional staff time and effort has been required to re-test functionality once the fixes have been put in place. There are instances where defects are still detected with a need for a third (and on occasion more) round of testing. All Pathology departments have risks recorded in relation to staff resource, with the extension of UAT and resource burden is exacerbating these risks in terms of managing competing priorities, staff morale and staff burnout. A presentation articulating the issues, risks and current mitigations was presented at Operational Management Board (OMB) in February 2025 and also in Executive Leadership Group in March 2025. The Health Board is liaising with DHCW around the current build and mitigation plan as this has significant risks in relation to the Health Board go live date in October 2025. Key milestones have been given by the Programme Board and progress will be escalated through OMB in April 2025 if there are still concerns in relation to confidence in build and defects.
- Impact of MES Reform on Mortuary Services:** New regulations came into force on September 9th, 2024, whereby all non-coronial deaths are independently scrutinised by the Medical Examiner Service (MES). This has resulted in some administrative changes to the death certification process, leading to increase length of stay for the deceased. This has had a significant impact on capacity across all sites, leading to escalation in accordance with the Mortuary Escalation Plan. Due to these pressures, there has been a number of transfers between body stores to create sufficient capacity. This introduces risks around Human Tissue Authority (HTA) compliance. We are working on areas where we can try and streamline the issues within our control to help the pathway.
- Due to seasonal increases in death rate and significant delays in death certification, the Mortuary has consistently experienced occupancy above previously recorded levels



(currently 34% above winter 22-23 level). As a result, the Mortuary capacity risk has remained high. To manage capacity, the deceased are currently being transferred between Appropriate facilities within the Health Board, and a temporary mortuary facility is currently being utilised. This requires the viewing facility in RGH to be decommissioned in order to host the temporary facility. Delays in death certification has a significant impact on flow through the mortuary, and more importantly a detrimental effect on bereaved families who wish to make arrangements for their loved ones. Several complaints have been received in relation to this. Delay in death certification is significantly impacting the Mortuary capacity risk, and support is required to promote prompt death certification throughout the Health Board. Executive Medical Director has supported the Care Group with targeted messaging to individual teams and escalating the issue externally. Concerns have also been raised from some bereaved families in relation to the increased length of time for death certification, we are currently in the process of adding some additional information regarding the death certification process to the bereavement support page on the CTM website.

- **All disciplines – impact of movement of patients in relation to POW roof issues**
- Emerging issue around patient pathway in Ysbyty George Thomas (YGT) and expectations upon particularly Pharmacy. Meeting request with clinical leadership in Unscheduled Care (USC) to clarify pathway.

Allied Health Professions (AHPs)

The relocation of services to RGH, predominantly in relation to stroke services, continues to result in a higher-than-average number of clinical incidents being reported, albeit with a decreasing trend (27 incidents reported in November 2024, reduced to 21 in January; the monthly average is 12).

The service relocation has resulted in an increased acuity of patients on RGH site and has impacted on staff. Capture of unmet need between November and January shows that on average 37% of physiotherapy clinical contacts were unable to be delivered due to lack of workforce capacity. Clinical prioritisation and enhanced clinical decision making are in place, supported by senior Clinical Leads. Workforce models have been revised to maximise capacity, including rehab staff 'in-reaching' to reduce length of stay within the acute setting. The increasing risk to quality of care and staff well-being has required appointment of short-term agency staffing.



Advise

AHPs

Continued delay in the funding for AHP neonatal workforce being allocated to AHP budget is resulting in continued resource gap in meeting British Association of Perinatal Medicine (BAPM) standards, as the service is not staffed to meet the clinical needs of neonates. This has been proposed as one of the investment priorities for the Integrated Medium Term Plan (IMTP).

Radiology

The CT mobile in situ from 02/10/24 for 12 weeks to reduce CT waiting times and alleviate pressure on the DGHs was successful in eradicating the backlog waits for CT Scans. We will deliver the Welsh Government Target of no patients waiting over 8 weeks at the end of March 2025 which is a significant step in improving the patient pathway to quicker treatment.

- Corporate Risk 5590 – radiopharmaceuticals procurement. This risk has now been reduced as we have a service level agreement in place with Swansea Bay UHB as the regional supplier.
- 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

Paperless Reporting: The Pathology department plans to introduce paperless reporting. This is being driven by the LIMS 2.0 implementation, supports the CTM goal of becoming a greener organisation, increases administrative capacity, and eliminates the risk of paper reports being lost in transit. All Pathology results are transmitted electronically, but it has become apparent that there is still a reliance on paper reports in some areas. A workshop was held at the start of December with a broad range of representation, including those that solely use electronic reporting and those that still rely on paper reports, helping us to understand some of the concerns around paperless reporting from a clinical perspective. There are a number of associated risks with issuing paper reports, and we have recently highlighted a trend in information governance incidents related to the issuing of paper reports, such as reports going to the wrong location and a damaged report that was returned to the laboratory by Royal Mail. The incidents would have been avoidable if electronic reporting systems were being used.

Clinical Haematology: A risk has previously been escalated within the Care Group relation to reduced new patient (NP) capacity, this



was due to sickness and annual leave primarily at RGH. The risk was being mitigated by employing a locum consultant who unfortunately left for another position in December. The reduced consultant capacity at RGH has meant that there is once again very limited capacity to take on new patients, and Haematology cancer performance and **referral** to treatment (RTT) performance is being impacted on until a new colleague commences in April. An additional locum consultant has a planned start date for 10th March, and recruitment of a further locum is in progress. Once both locums are in place there will be improved consultant capacity to review new patients and increase clinic capacity. A Clinical Haematology transformation project is currently underway, reviewing the service with a view to improving resilience to meet current and future demand. A business case has recently been submitted, outlining the proposal.

Clinical Engineering

Currently, there is only three days of band 3 bed management provision at PoW site with no identified funding to support five day cover. Delays associated with this lack of provision could impact patient flow and quality of care. Options to provide 5 day cover are being considered.

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 medicines 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 planned April 2025
- Initial scoping exercise around potential for cost savings in care homes being investigated; 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. These have been escalated to homecare providers as complaints



Assure	<u>Radiology</u> • The NOUS waiting list continues to reduce and is on track to deliver the welsh government target of no patients waiting over 8 weeks at the end of March 2025. <u>Medicines Management</u> CD audits: Target= 100% Current figures for completion of CD audits are: • <u>PCH</u>: 100% [Previous Quarter 100%] • <u>POW</u>: 38% [Previous Quarter 67%] • <u>RGH</u>: 41% [Previous Quarter 100%] • <u>YCR</u>: 100% • <u>YCC</u>: 100% • Further deterioration in POW from previous quarter. This is potentially due to the situation with the roof in POW and movement of pharmacy staff, with teams prioritising direct patient care over regular auditing. However, since this data reported, there has been an increase in numbers • RGH have a day planned for theatres audit on 13th march which should increase numbers <u>Pathology</u> • Cellular Pathology: An incident was reported where four dermatology biopsy samples had gone missing in transit from YCR. A RAPID review meeting was held to determine the risk to the patients involved and found no harm was caused. The samples have since been found and all samples were still able to be processed, albeit with a slight delay in reporting. • Electronic requesting for GUM clinic: There has been a historical trend of transcription error for requests received from GUM clinics, primarily due to the poor quality of handwritten forms increasing risk of human error when entering the request into the Pathology LIMS. The Integrated Sexual Health (ISH) service has recently procured an electronic requesting system, and pathology departments are currently working with ISH to support implementation of the system. This will eliminate the risk of transcription error ensuring patients receive accurate and timely results.
Inform	<u>NHS Wales Staff Survey</u> • DTPS had the highest care group response rate to the 2024 NHS Wales Staff Survey, at 45.8%. • The responses were bolstered by work within AHPs, who held engagement sessions with over 500 staff, providing an opportunity to listen to their views following the themes



identified from the previous survey. This resulted in AHP professions having a 140% increase in response rate to the survey this year.

AHPs

- An evaluation of a CTM-designed "Waiting Well" pilot within Paediatric Speech and Language Therapy has resulted in 100% of parents/carers feeling supported when waiting for an appointment for their child's stammering. Parents/carers received a link to an educational resource in video format (produced by the paediatric SLT team) when the child was accepted onto the waiting list. Evaluation showed that after watching the video, parents/carers were aware of what to do and what not to do to support their child, and they fed back that their anxiety reduced whilst waiting. A roll-out to other specialities within SLT is now being scoped.

Pathology

Care After Death Policy: written to support the dignified care of the deceased adult in CTM, ensuring care complies with statutory and regulatory requirements, aligning with the CTM Aging Well/Dying Well agenda.

Memorandum of Understanding (MOU) – Storage & Management of Mass Fatalities: Outlines the roles, responsibilities, and procedures for the storage and management of mass fatalities between Cwm Taf Morgannwg University Health Board and HM Coroner. The MOU aims to ensure an efficient, coordinated, and legally compliant response in the event of a Mass Fatality Incident within the Cwm Taf Morgannwg area.

Compliment: a compliment received from a patient appreciative of the work undertaken 'behind the scenes' in the Cellular Pathology department to ensure the patient receives the result. The patient described how waiting for results was an extremely anxious time and the relief in receiving the result informing that the tissue was not cancerous. The patient went on to say " *Pathology teams are often unseen, but your work is absolutely invaluable. I want you to know that your efforts do not go unnoticed or unappreciated. Your expertise, diligence, and commitment make an enormous difference to patients like me every single day*".

Medicines Management

- Homecare: Haematology Service is very time critical and relies heavily on technician support. Evaluation of previous invest to save proposal underway, with a view to further extension of this in 2025-26.

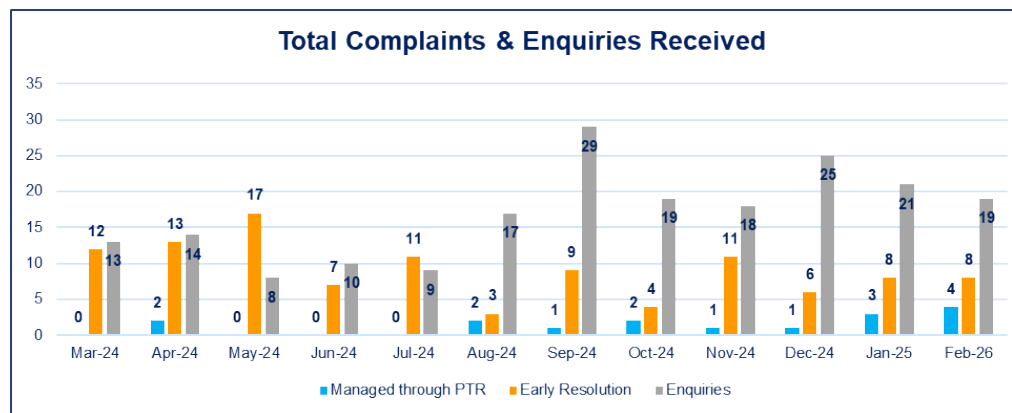


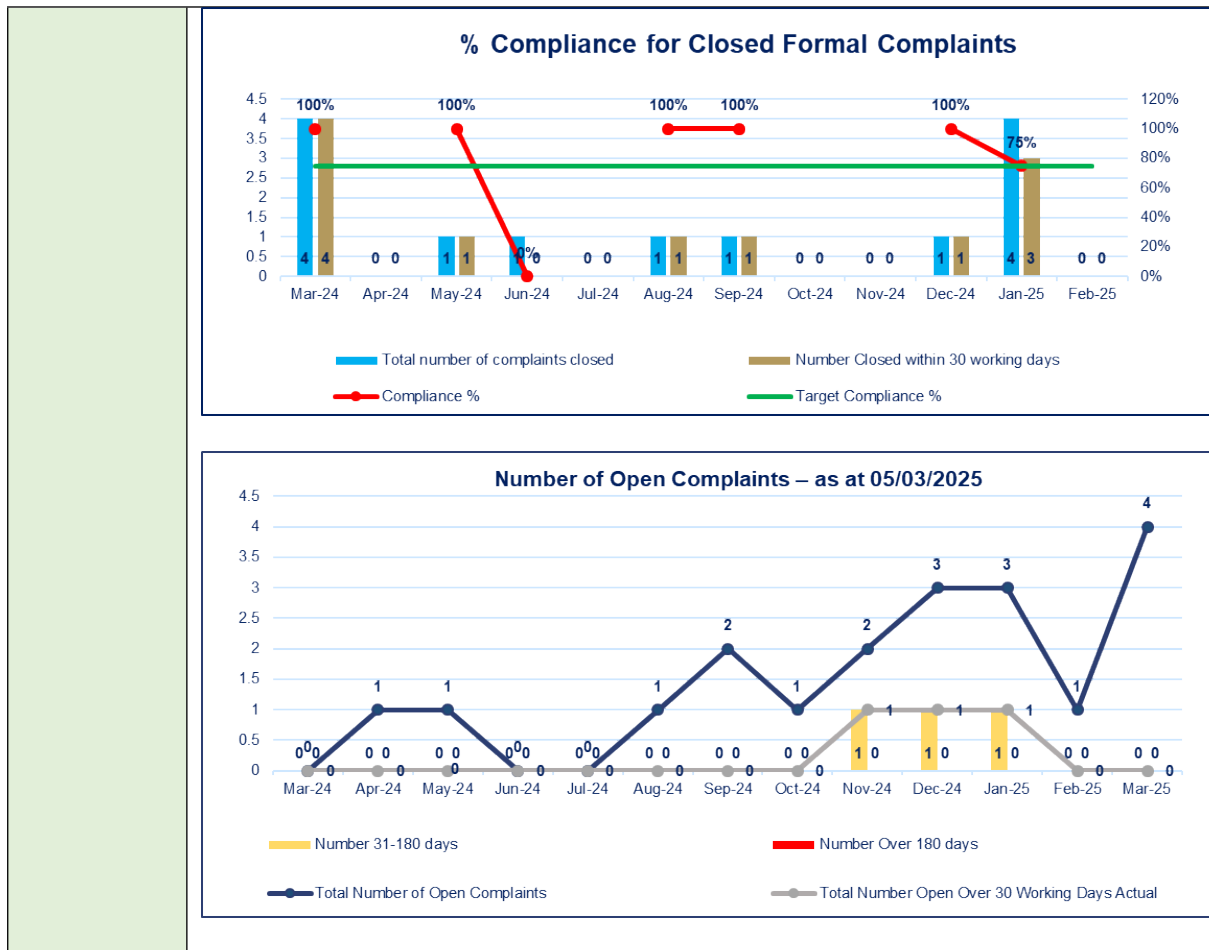
- General Practice Data Protection Impact Assessment (DPIA) and Data Sharing Agreements with General Practice: Medicines Management team are standardising DPIAs and Data Sharing Agreements with Practices. Draft CTM-wide DPIA and Data Sharing Agreements have been developed and submitted for discussion and launch with Head of GMS
- HMP Parc SOP review- 2-year review due December 2024 for all SOPs . Plan in place for review and CD SOPs will need to be prioritised due to HO licence.
- Letter received about Mounjaro availability within CTM. Letter outlining HB position provided and a follow up call with patient
- Position of Home Office licenses

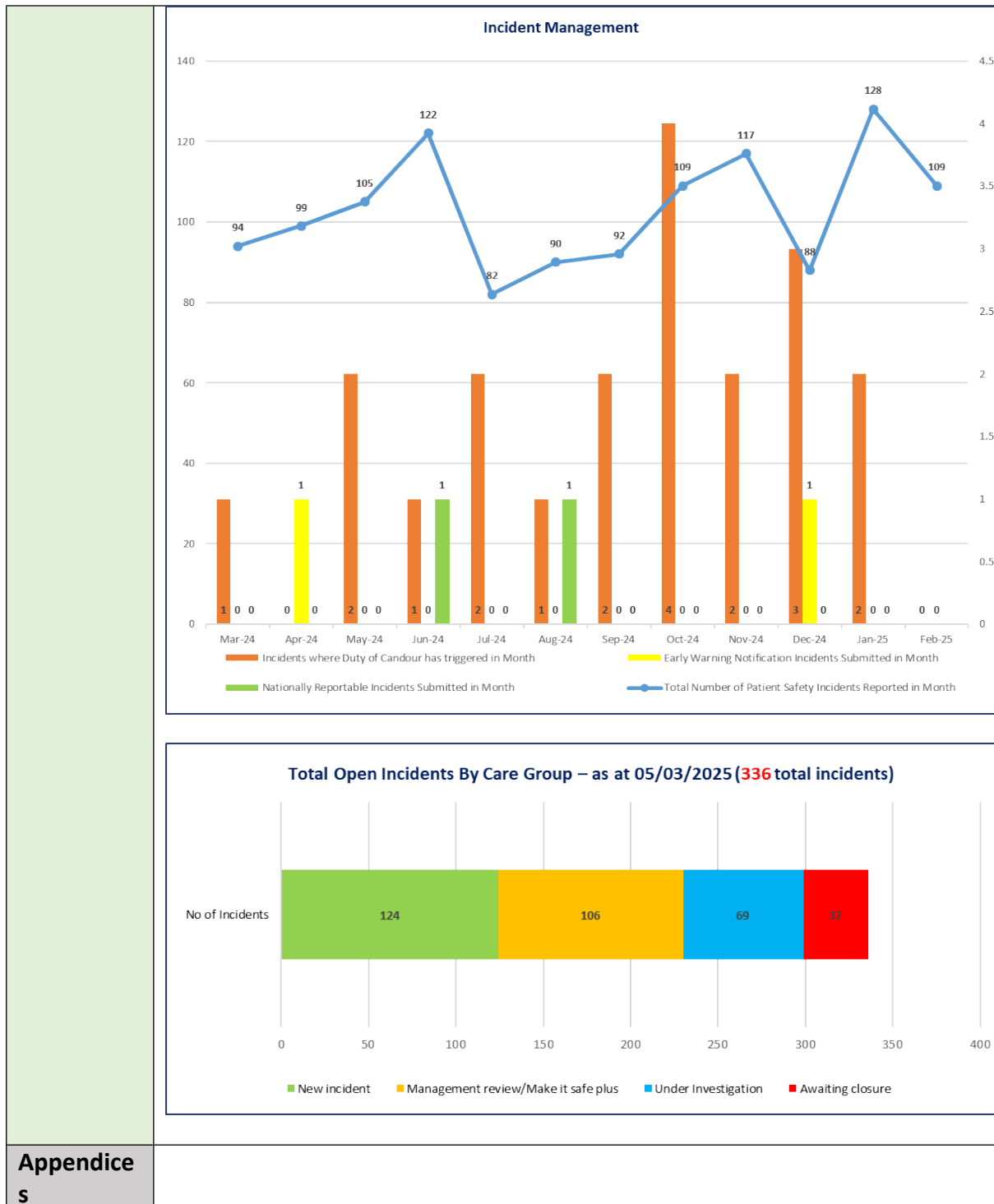
Still awaiting confirmation of license for RGH

- Sanofi withdrawn pharma funded nurse training from 31st march 25. Care groups have been informed of this change
- Diversion risk of GLP1s (used for both diabetes and weight loss)- Counter fraud case in ABUHB alerted to risk of incorrect quantities of GLPs eg. 1 per week instead of 1 per month. Poster developed for Primary Care use and Community Pharmacy. Desktop search undertaken to compare quantities vs items with tech review
- Recent HMP Parc inspection states that "Pharmacy managed well and recommendation regarding oversight and governance achieved (from previous inspection)"
- Pain summit organised by principal Pharmacist for Pain- Attendees included Medical Director, National Clinical Lead, and representatives from Primary Care, Physiotherapy, Occupational Therapy, Health Psychology, Chronic Pain Service, Value Based Care and Improvement Teams. Workstreams developed for the next year

DTPS Complaints Received and Compliance







3. Assessment

Objectives / Strategy

Dolen i Nod (au) Strategol
BIP CTM /

Improving Care



Link to CTMUHB Strategic Goal(s)	
Dolen i Feysydd Strategol BIP CTM /	Living Well
Link to CTMUHB Strategic Areas	
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant /	A Healthier Wales
Link to Wellbeing of Future Generations Act – Wellbeing Goals <i>150623-guide-to-the-fg-act-en.pdf</i> <i>(futuregenerations.wales)</i>	
Dolen i Hwyluswyr Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /</i>	Data to Knowledge
Link to Enablers of Quality <i>(Duty of Quality Statutory Guidance (gov.wales))</i>	
Dolen i Feysydd Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /</i>	Effective
Link to Domains of Quality <i>(Duty of Quality Statutory Guidance (gov.wales))</i>	
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable

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



<i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /</i> Equality and Welsh Language <i>Have you undertaken an Equality and Welsh Language Impact Assessment Screening?</i>	Outcome for Welsh Language: NEUTRAL/	
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 <i>(Pobl / Ariannol) /</i> Resource Impact <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.	

4. Recommendation

- 4.1 The committee is asked to **NOTE** the highlights outlined in section 3 of this report.



Agenda Item

6.1

Quality, Safety & Experience Committee

Patient Safety, Quality & Experience Dashboard

Dyddiad y Cyfarfod / Date of Meeting	25/03/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Head of Concerns & Business Intelligence
Cyflwynydd yr Adroddiad / Report Presenter	Assistant Director of Quality & Safety
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 01.01.25 to 28.02.25 taken from systems on 06.03.25, unless otherwise specified.

Key areas to note in this reporting period are:

- Increase in the number of new complaints and enquiries received
- Decrease in % compliance with the 30 working days for responding to complaints during January 2025. Improved to above National Target of 75% during February 2025.
- Inclusion of Public Service Ombudsman of Wales Information
- Decrease in number of National Reportable Incidents submitted to NHS Wales Executive
- Increase in medication incidents reported
- Decrease in patient fall incidents reported
- Increase in restrictive incidents reported

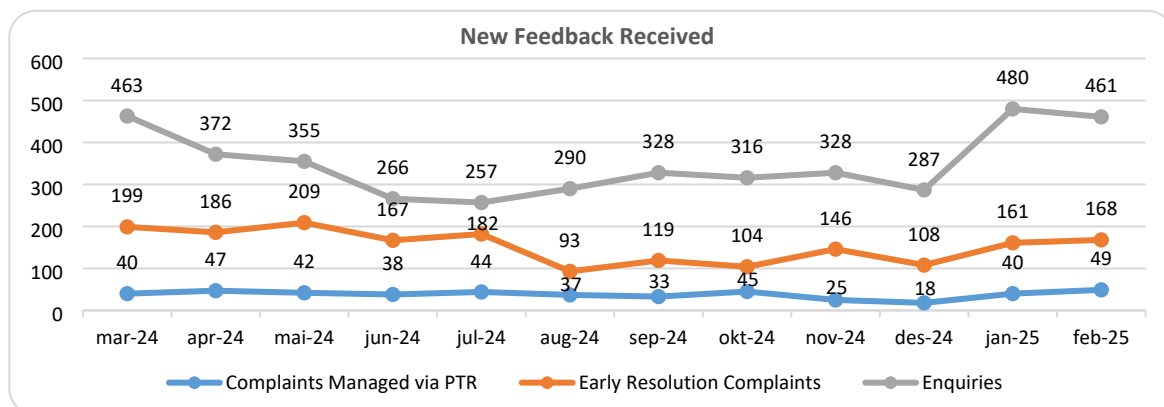
2. Specific Matters for Consideration

2.1 Patient / Service User Feedback

Complaints & Enquiries

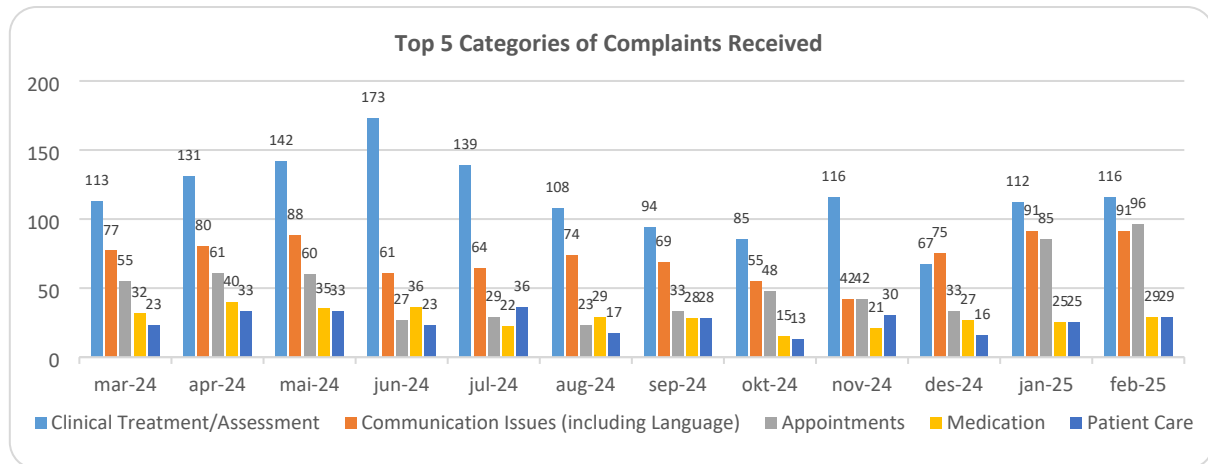
New Complaints Received

Between the 01.01.25 and 28.02.25 the Health Board received a total of 418 complaints and 941 enquiries. Of 418 complaints received, 89 were categorised as formal and managed under the Putting Things Right Regulations (PTR). In comparison with the previous two month period the number of complaints and enquiries received has significantly increased. Initial analysis has identified that the increase relates to Planned Care Services at the Princess of Wales Hospital and the Prison Services.



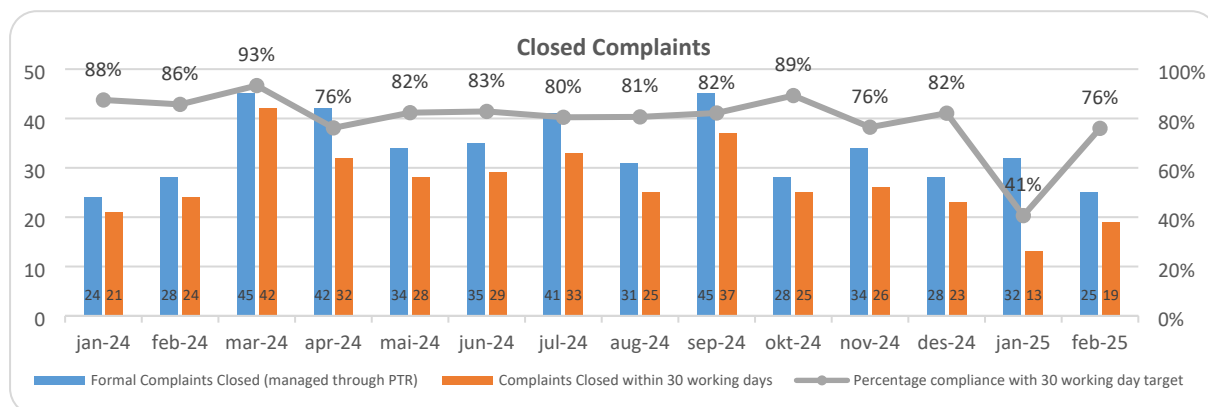
For all feedback (Complaints and Enquiries) received in January and February 2025, accounting for 51% of the feedback received, the top 3 types remain

consistent with previous months. These relate to Clinical Treatment / Assessment (228), Communication Issues (182) and Appointments (181).



Closed Complaints

Within the period of 01.01.25 to 28.02.25, the Health Board closed a total of 62 formal complaints (managed through PTR). During January 2025, focused work was undertaken to address the number of open complaints, specifically those over 30 working days. As a result of this work compliance decreased below the national target of 75% during January 2025. As at 03.03.25, the Health Board had 64 open formal complaints. Of these, 15 complaints were open over 30 working days. The standard operating procedure for formal complaints is currently being reviewed to ensure processes support the effective management of cases within 30 working days.



Public Services Ombudsman for Wales

Open cases

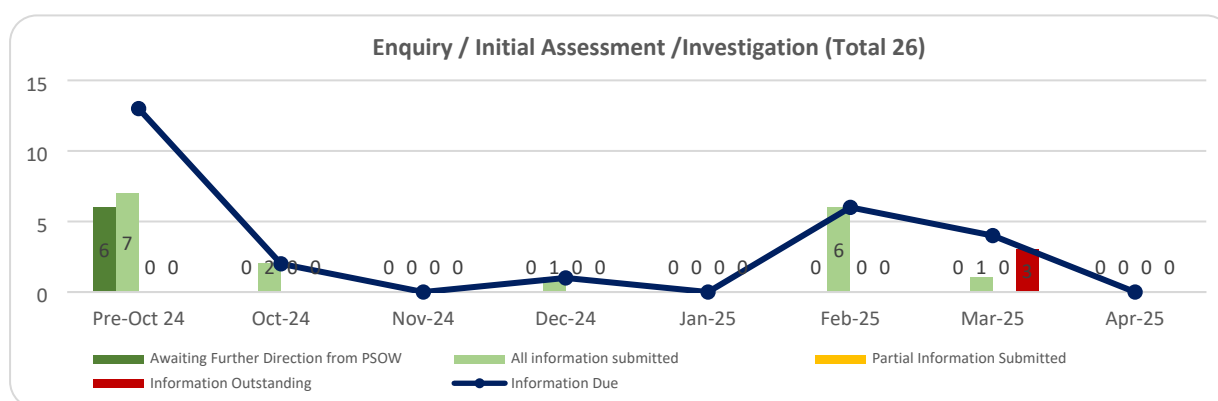
As at the 07.03.25 the Health Board has 72 open Public Services Ombudsman for Wales (PSOW) Cases. Of these, 59 are awaiting a response from the Ombudsman.

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	20	0	12	0	32
Awaiting further direction from PSOW	6	0	1	0	2	9
Information Received	0	0	0	0	0	0
Information Submitted	16	1	0	1	0	18
Information Outstanding	5	4	1	0	0	10
Information Partially Submitted	0	0	0	3	0	3
Total	27	25	2	16	2	72

New PSOW Cases Received

The Health Board received notification of 14 new referrals to the Public Services Ombudsman for Wales (PSOW) between the 01.01.25 and 28.02.25. Of the 14, 12 were received as enquiries, 1 as full investigation and 1 as an early settlement proposal.

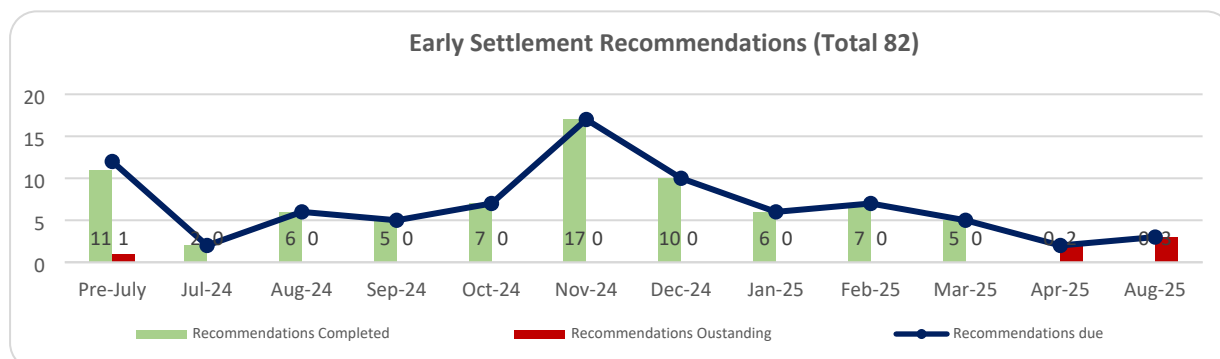
Of the 26 cases, the Health Board currently has at 07.03.25 in the enquiry / initial assessment/investigation stage, 3 cases have outstanding actions. This is reflected in the chart below:



Early Settlement Proposal

During the same period the Health Board agreed 5 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 26 open early settlement cases, with 82

associated case actions. Of the 82 actions, 1 is overdue the deadline agreed with the PSOW.



Final Reports

During January and February 2025, the PSOW issued 3 final reports to the Health Board. Of these, 1 was upheld and 2 were not upheld.

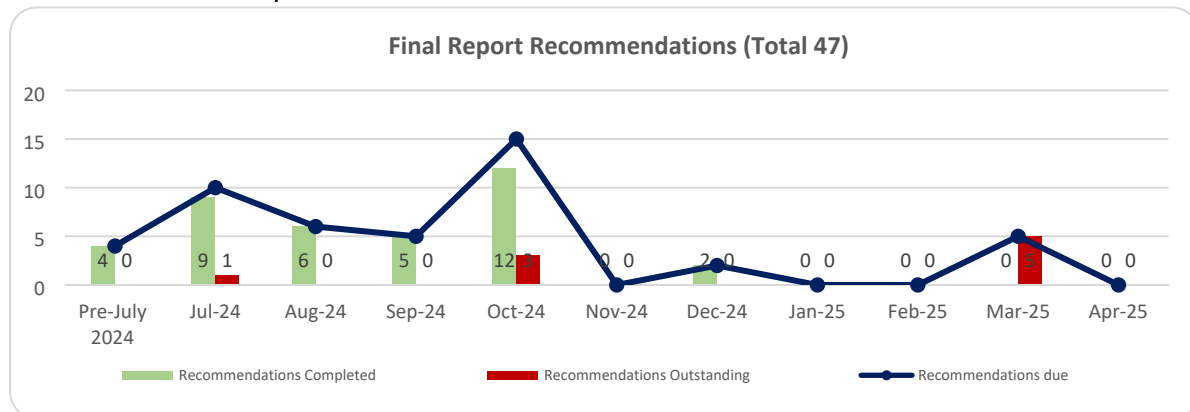
The PSOW issued an upheld case following its investigation as to whether the Health Board's management and care of Miss C in relation to pregnancy loss on 2 August 2023 was clinically appropriate. The Ombudsman's investigation found:

- **Nursing care fell below an acceptable standard**
The PSOW raised concern that given Miss C's blood loss and dizziness, as noted in the retrospective nursing entry, her vital observations were not taken, as these would have highlighted her clinical deterioration and would have alerted the clinicians to the gravity of her condition.
- **Delays and Missed Opportunity to escalate care**
The investigation found that the shortcomings in nursing care were compounded by inadequate record keeping, which meant that clinicians undertaking Miss C's care in the intervening period lacked information about the seriousness of her condition.
- **Inadequate Record Keeping**
The investigation concluded that the shortcomings in nursing care were compounded by inadequate record keeping, which meant that clinicians undertaking Miss C's care in the intervening period lacked information about the seriousness of her condition.

In addition, the report highlighted the PSOW concerns that the Health Board's investigation did not identify failings in the care and management Miss C received on 2 August, including the shortcomings in nursing care and record keeping reflecting a lack of diligence and rigour in the investigation process. It also meant opportunities were missed to properly learn lessons and put things right quickly

and effectively. A copy of the full report is available to Committee Members on request.

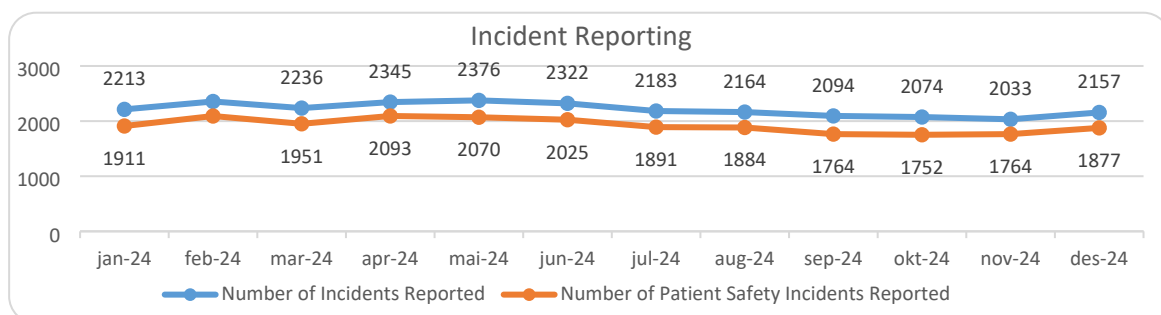
As at 07.03.25, the Health Board has 16 cases which are currently in the final report stage of the PSOW process. These cases have 47 associated recommendations. Of these recommendations, 4 are currently overdue the timescale for completion.



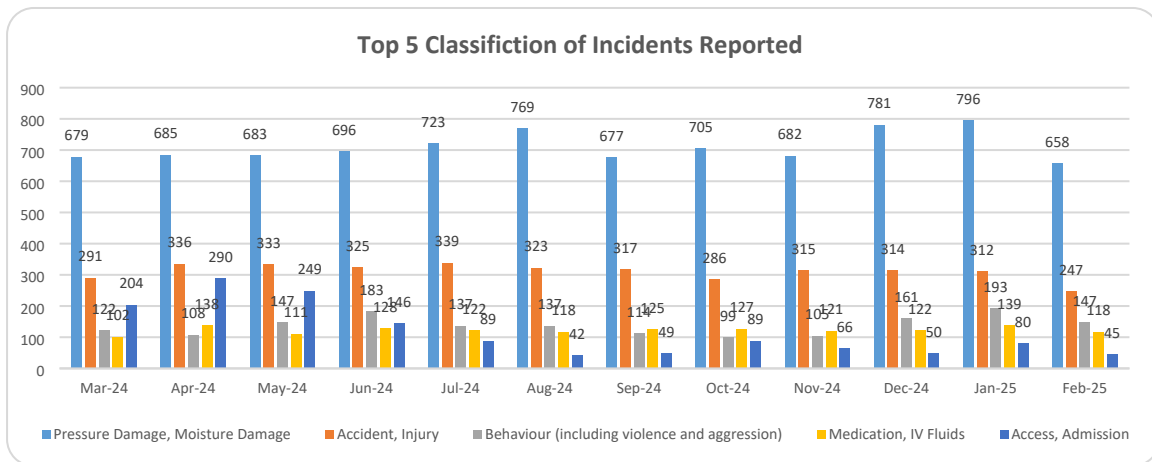
2.2 Patient Safety Incidents

Total Patient Safety Incidents

A total of 4,374 incidents were reported between 01.01.25 to 28.02.25, this represents an increase of 187 when compared with the previous 2 months (4,187). 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 4,374 incidents reported, 87% (3,813) were reported as the patient affected. The trend in incident reporting is reflected in the chart below.

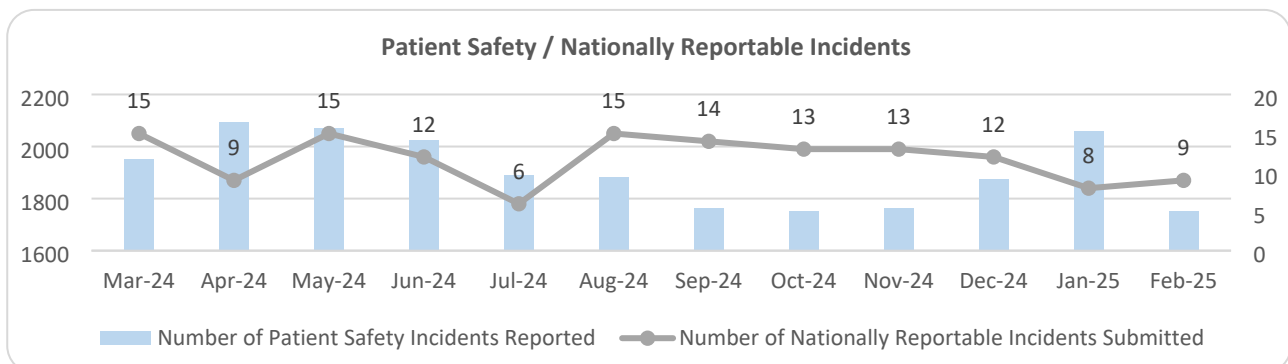


The top 3 types of incidents reported for January and February 2025, linked to a patient affected incident are: Pressure Damage /Moisture Lesion (1,454), Accident, Injury (529) and Behaviour (including violence and aggression) (340). This is consistent with the previous two month period.



Nationally Reportable Incidents

Between 01.01.25 to 28.02.25, 17 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.



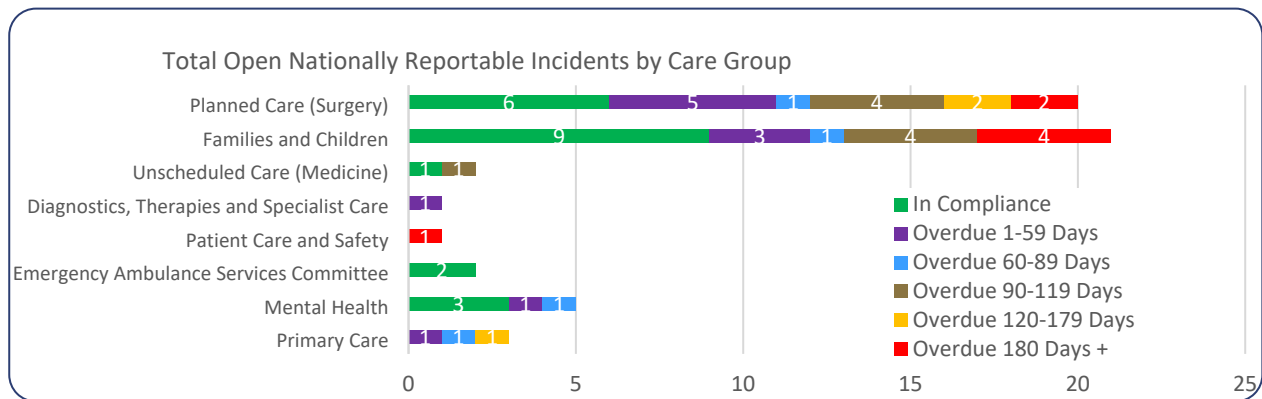
As highlighted in previous reports to Committee, it should be noted that Nationally Reportable Incident data is presented based on the date the notification was submitted to the NHS Executive. The significant decrease in the number of incidents reported during July 2024 can be linked to the transition 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:

	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Total
Access, Admission	2	1	0	0	0	3	2	0	0	0	0	0	8
Accident, Injury	0	0	0	0	0	0	0	1	0	0	0	0	1
Assessment, Investigation, Diagnosis	2	0	1	2	0	2	2	1	0	0	0	0	10



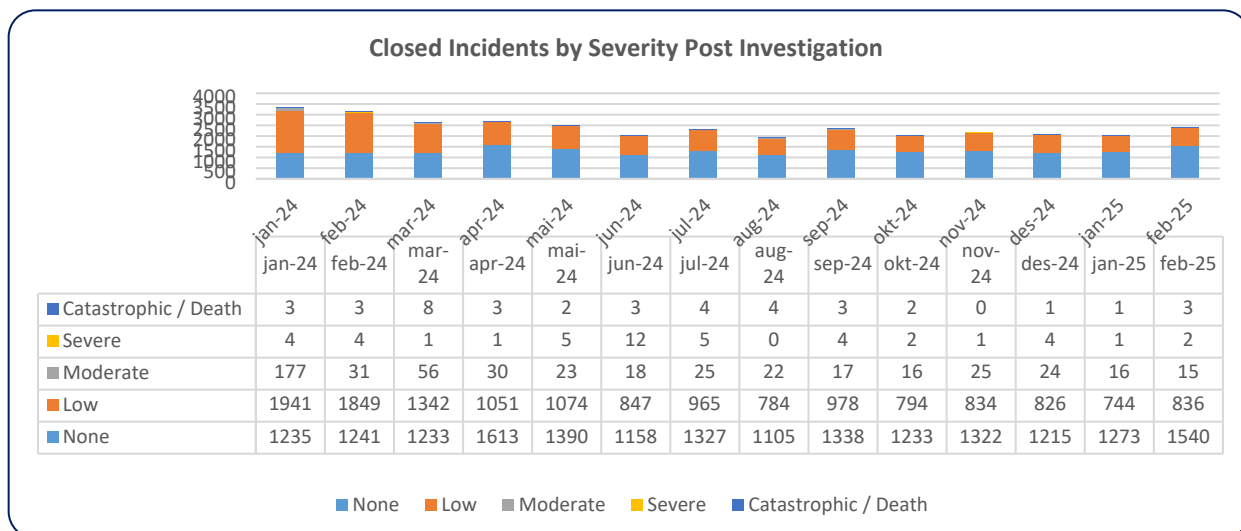
Behaviour (including violence and aggression)	0	1	0	0	0	0	0	0	1	0	0	0	2
Infection Prevention and Control	0	1	0	2	1	1	3	0	0	2	0	0	10
Maternity adverse occurrence	2	4	2	3	0	2	1	3	2	2	4	1	26
Medication, IV Fluids	0	0	0	0	0	1	0	0	0	0	0	0	1
Monitoring, Observations	0	0	0	0	0	1	1	0	0	0	0	0	2
Nutrition, Hydration	0	0	0	0	0	0	0	0	0	0	0	1	1
Patient/service user death	2	0	1	2	1	0	0	0	2	0	1	1	10
Pressure Damage, Moisture Damage	5	1	3	3	4	3	3	8	6	7	2	4	49
Safeguarding	1	0	0	0	0	0	0	0	0	0	0	0	1
Transfer, Discharge	0	0	1	0	0	0	1	0	0	0	1	1	4
Treatment, Procedure	1	1	7	0	0	2	1	0	2	1	0	1	16
Total	15	9	15	12	6	15	14	13	13	12	8	9	141

As at the 07.03.25, the Health Board currently has 55 open Nationally Reportable Incidents, of which 34 are overdue the timescale for completion. A trajectory plan is in place to ensure investigations are concluded and an outcome 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

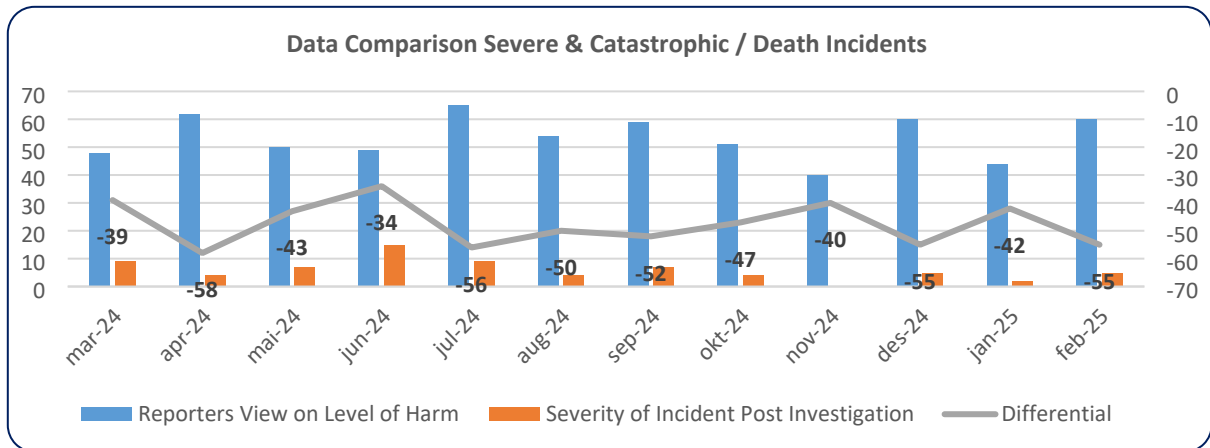
Between the 01.01.25 to 28.02.25 a total of 4,431 patient safety incidents were closed. The 12 month trend is reflected in the table below.



Of the 4,431 patient safety incidents closed, 7 were closed with severity post investigation of severe harm (3) or catastrophic/ death (4). A breakdown of incidents is provided in the table below:

	Mental Health	Diagnostics, Therapies and Specialist Care	Unscheduled Care (Medicine)	Planned Care (Surgery)	Total
Accident, Injury	0	0	1	0	1
Assessment, Investigation, Diagnosis	0	2	0	1	3
Infrastructure (including staffing, facilities, environment, security)	0	0	0	1	1
Nutrition, Hydration	0	0	0	1	1
Patient/service user death	1	0	0	0	1
Total	1	2	1	3	7

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

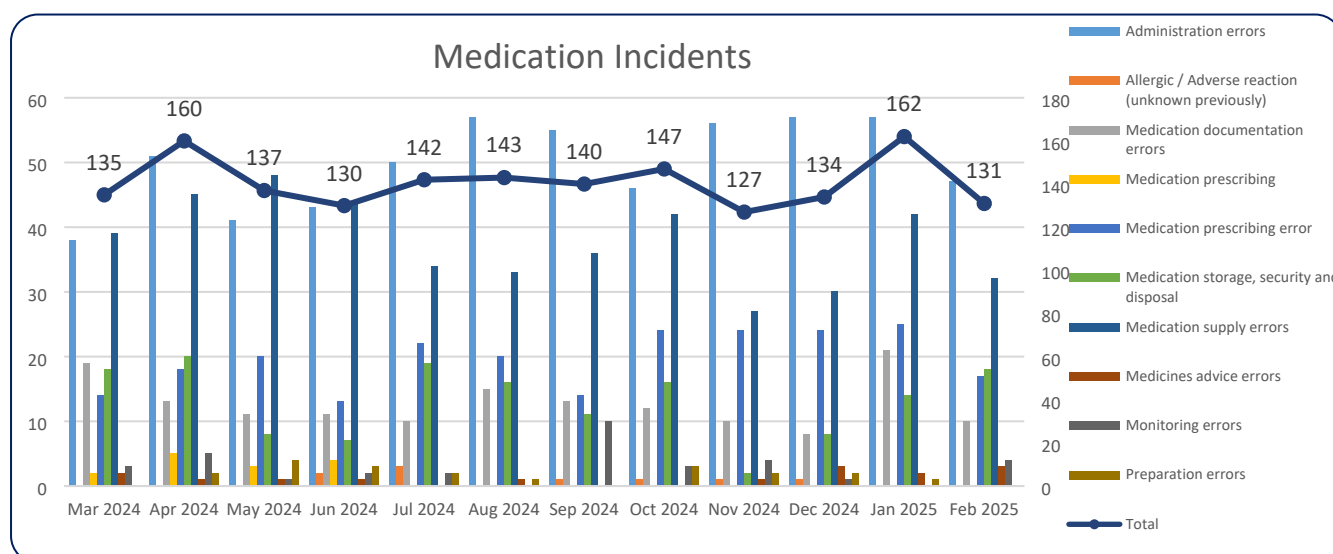
The Duty of Candour regulations were implemented from the 01.04.23. To enable monitoring of requirements, a number of metrics have been devised, which are summarised in the table below. To support the implementation of the Duty of Candour processes, dashboards have developed to provide 'live' data at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

Number of Incidents	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2024	Feb 2024
Where Duty of Candour Triggered	9	5	17	9	11	11	13	7	15	11	9	5
Where In-person notification completed	7	4	13	8	8	8	12	4	14	8	8	4
Where letter of notification sent	3	2	6	4	6	6	12	4	14	8	7	4

2.3 Specific Quality & Safety Metrics

2.3.1 Medication Safety

A total of 293 medication incidents were reported as occurring between 01.01.25 to 28.02.25. This is an increase of 32 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 (104), supply errors (74), and medication prescribing errors (42).

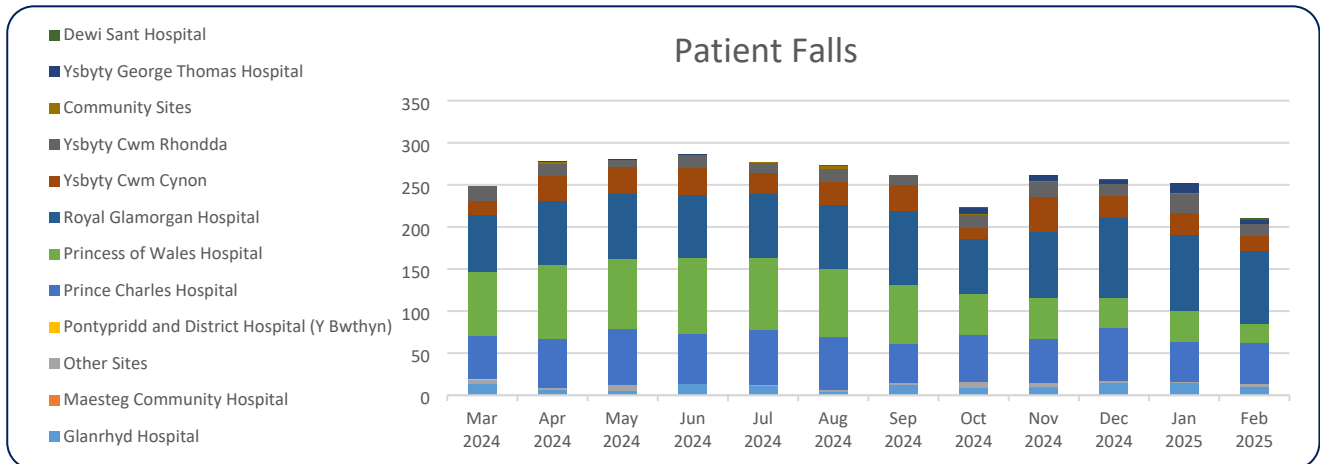


91% of the medication incidents were reported as resulting in no (140) or low (128) harm, with the remaining reported as resulting in moderate harm (22), severe harm (3) harm and catastrophic harm / death (1). It should be noted that this is the reporter's view of the level of harm and is subject to change following investigation.

2.3.2 Patient Falls Incidents

A total number of 462 falls, where the person affected was a patient, were reported during January and February 2025. This represents a decrease of 56 compared with the previous two months.

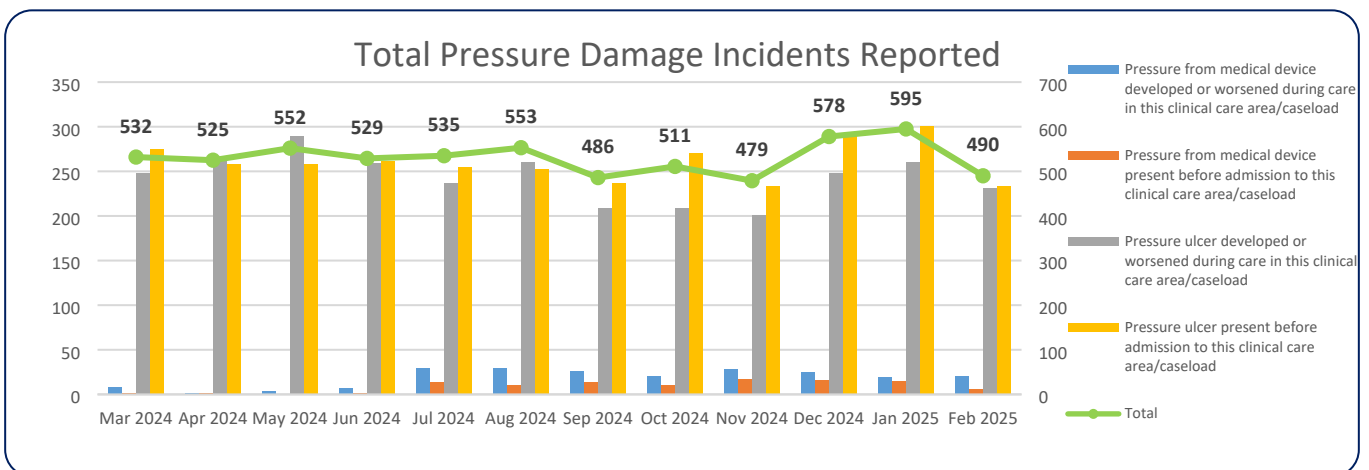
Of the falls incidents within the time period, 95% were reported as no (145) or low (295) harm. The remaining incidents were reported as moderate (22). No incidents relating to patient falls were reported as resulting in severe harm or catastrophic harm / death. Once again, it should be noted that this 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.

2.3.3 Pressure Damage

Between the 01.01.25 and 28.02.25, a total of 1085 pressure damage incidents were reported, of which 530 were reported as developing or worsening during the current case load. The remaining pressure damage incidents (555) were reported as being present before admission to this clinical care area/caseload.



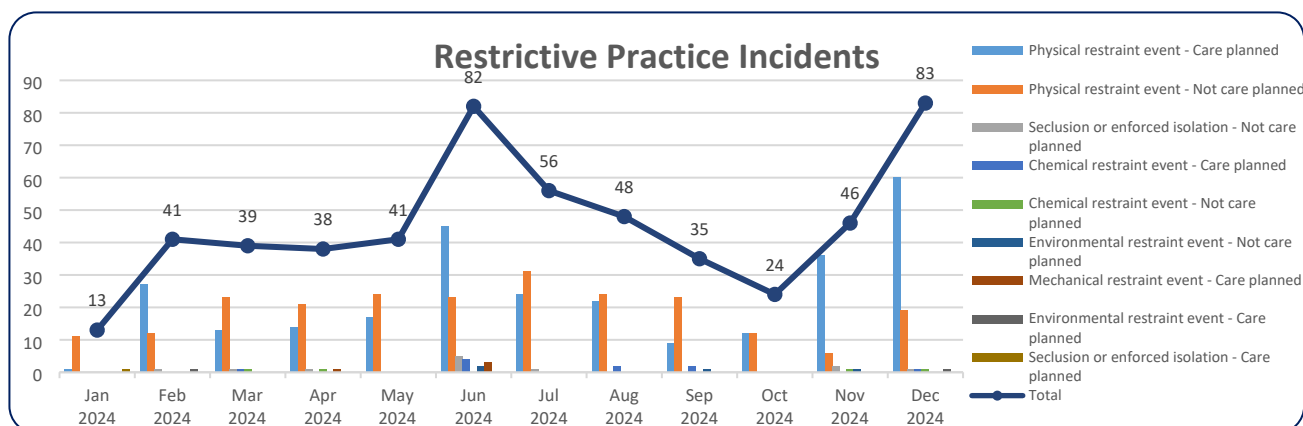
Of the 530, identified as developing or worsening during current caseload, 340 were identified as occurring within the community, which represents a continuation of the increase identified in the previous two month period.

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.

2.3.4 Mental Health Metrics

Restrictive Practices

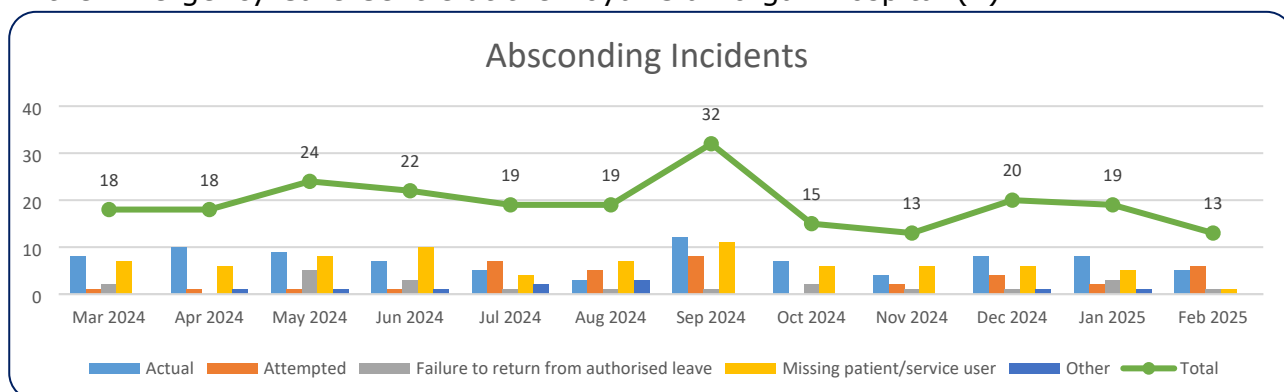
Between 01.01.25 and 28.02.25, a total of 201 incidents relating to using Restrictive Practices were reported within Mental Health. This is an increase of 63 incidents when compared to the previous two months.



Of the 201 incidents, 54 were reported as not care planned (not included in the care and treatment plan for the patient) and 98 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 (115), Seren Unit, Royal Glamorgan Hospital (124) and Adult Mental Health Acute Admissions Ward (19). It should be noted that the 136 of the incidents reported relate to 10 patients (86 relating to 2 patients).

Absconding incidents

During January and February 2025, a total of 32 incidents were reported under the category of absconding, which remains consistent with the previous 2-month period. 13 were recorded as Actual absconding, with the remaining recorded as Attempted absconding (8), Failure to return from authorised leave (4), and Missing patient/service user (6). The highest number of incidents were reported as occurring in the Emergency Care Centre at the Royal Glamorgan Hospital (7).





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

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 <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: ☒	No: ☐
	Outcome: This report outlines key areas of quality across the Health Board.	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /</i> Equality and Welsh Language <i>Have you undertaken an Equality and Welsh Language Impact Assessment Screening?</i>	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 <i>(Pobl / Ariannol) /</i> Resource Impact <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

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

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

Appendix 1

Quality & Safety Committee

People's Experience Activity Report December 2024 – January 2025

Dyddiad y Cyfarfod / Date of Meeting	25/03/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Jenny Oliver, Head of People's Experience
Cyflwynydd yr Adroddiad / Report Presenter	Nigel Downes, Assistant Director of Quality & Safety
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	
RGH	Royal Glamorgan Hospital
POW	Princess of Wales Hospital
CAMHS	Community Adolescent Mental Health Service
HB	Health Board
PALS	Patient Advice Liaison Service
CTMU HB	Cwm Taf Morgannwg University Health Board

7. Situation / Background

- 1.1 This report provides an update on the work undertaken by the People's Experience Team and related areas.

8. Specific Matters for Consideration

Population Engagement Events

Date	Event	Staff Member
3 rd December	Hope after loss event with 2wish	People's Experience Team
4 th December	Annual Christmas Concert	People's Experience Team.
19 th December	Valley Veterans Christmas event	PALS Team
30 th January 25	Dementia Friendly Group, Pontypridd	Carers Lead

NHS Wales People's Experience Framework and Toolkit

The Welsh Government/NHS Executive have advised they are aiming to release the Framework and Toolkit in early 2025.

The Health Board is currently engaging in ongoing discussions within Care Group meetings to outline the above Framework and set clear expectations for its implementation. A self-assessment tool has been developed and will be presented to the Operational Valuing People's Experience Working Group. This tool aims to provide an overview of the ongoing work and identify any gaps to support and enhance people's experience.

Ongoing Projects

Falls/Pressure Area review

Members of the PALS team are present within the review, to offer insights from the patient experience perspective, which is based on their support of patients, families, and carers in this area.

A Task and Finish group is being organised to review patient information leaflets, with the review scheduled for early 2025.

Lost Property Pilot

The ICTM team is continuing to explore the costs associated with the agreed containers, ensuring they align with sustainability processes.

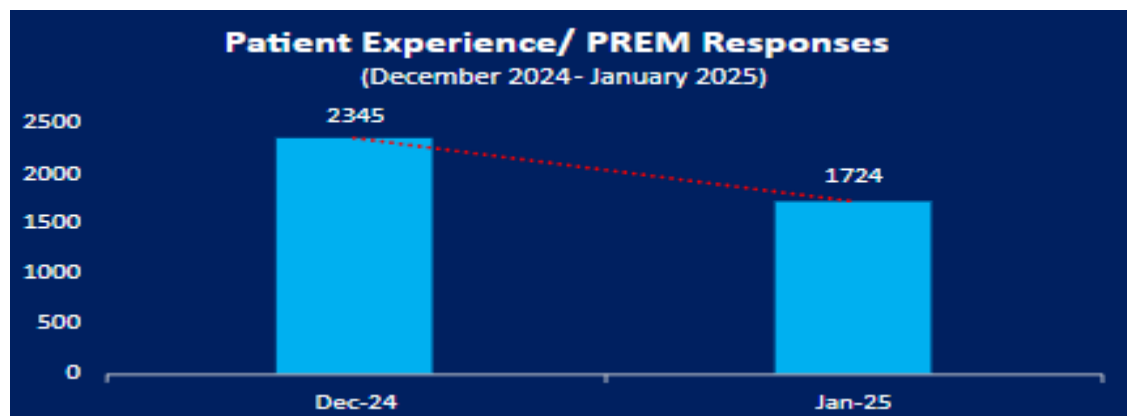
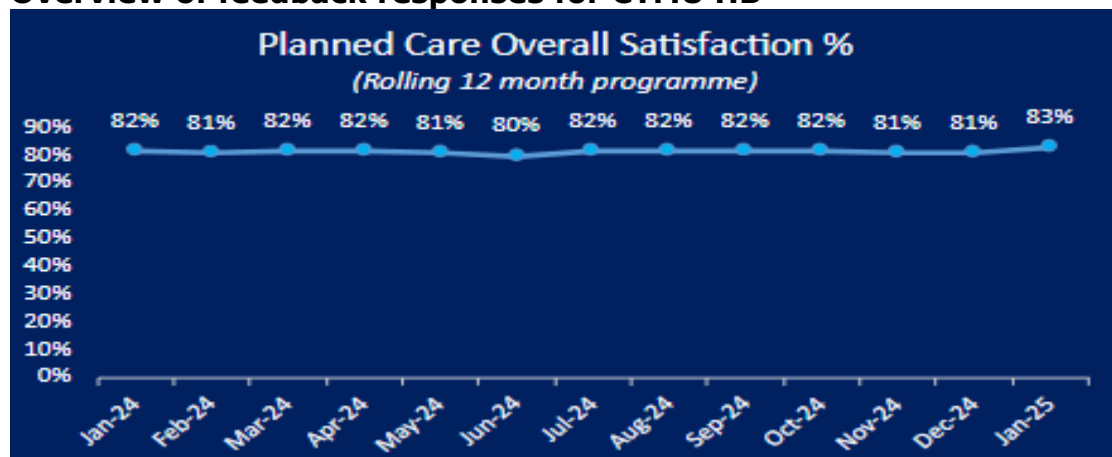


Patient Satisfaction Feedback

Progress has been made across the Care Groups, with further discussions underway to review the new All Wales Patient Experience Survey and plan its implementation in areas such as Mental Health, Trauma & Orthopaedics, and Paediatric services.

A phased approach will be adopted to understand how each service plans to collect feedback, whether through paper format, QR codes, or SMS messaging (phone text links).

Overview of feedback responses for CTMU HB





Chaplaincy

The chaplaincy team continues to explore avenues to ensure the spiritual care needs of our patients, families and staff alike are supported across CTMU HB.

Number of People Supported with Significant Spiritual and Pastoral Care	
Patients	1245
Relatives/carer's	239
Staff	284

- The team held twenty-one services during the Christmas period across the HB, with 259 patients attending. The RGH chaplains also organised a harpist, which was well received.
- The team was invited to support Ty Llidiard, POW, for a carol concert and will continue to strengthen these connections.
- The team distributed a peace light to every single patient across the HB footprint so they could light these on Christmas Eve in remembrance of their families/friends.



Bereavement

The HB continues to explore how we can support our communities following the loss of a loved one. The Clinical Bereavement Lead is actively engaging with Care Groups across the HB footprint to provide support in this area.

- The “Hope after Loss” event held in collaboration with 2wish, highlighted the support available in both the community and HB settings. The event was attended by 104 people and supported by 18 stallholders from third sector organisations.
- An Annual Christmas Carol Service was held to support the community, featuring a brass band and choir. Attendees were able to leave messages, as part of for loved ones on a Christmas Tree.
- A training session was conducted with 24 student nurses to provide insights into care after death processes.
- The lead engaged with various staff groups, including Bereavement Midwives, Health Visitors, Gynaecology department, CAMHS team, to highlight bereavement support available.

Volunteers

To support our patients and families, the volunteer team continues to actively explore opportunities to increase volunteer numbers and potentially expand their roles in supporting the HB. Over the period the team undertook the following activities:

- 24 interviews were conducted between December and January across the HB.
- A volunteer induction session in January at RGH saw 21 volunteers in attendance.
- Volunteers, leveraging their expertise from previous roles, are contributing to various projects across the HB, such as the Falls Information Leaflet Task and Finish Group.

Armed Forces/Veterans

The Head of People’s Experience has collaborated with colleagues across the HB to raise the profile of veterans and armed forces families.

- Links have been established with Primary Care to schedule a presentation at the Practise Manager Forum in 2025.
- Discussions with Local Authorities and Armed Forces Liaison officers are underway to plan events across the HB, advising of the support available from third sector organisations and HB services in 2025.
- Information to support recruitment of armed forces personnel and veterans into the HB has been provided to recruitment and retention colleagues, to inform new webpages being designed.

PALS (Patient Advice Liaison Service)

The teams are proactively supporting patients, families, carers and staff across the HB footprint.

Number of PALS contacts	Merthyr	Bridgend	Rhondda
	115	186	109

<u>Top Three Themes</u>
Communication issues
Clinical Treatment
Patient care

- The PALS teams are providing detailed reports to the Care Group Quality, Safety, Risk and Experience (QSRE) Forums, offering greater insight into the issues they help resolve for patients, families, carers and staff.
- People's Experience team met to plan engagement events for 2025-26, aligning with the Strategic Engagement Forum and expanding links with third sector and local authority plans.
- PALS have collaborated with several organisations and facilitated local groups to provide music for patients across our sites. The team also supported Father Christmas to visit the Paediatric wards across the HB.

Unpaid Carers

The Unpaid Carer's Lead has strengthened links with Care Group Leads across the HB to ensure carers' voices are heard within services, including:

- A meeting was held with the Director of Midwifery to discuss the identification and support of unpaid carers in hospital settings.
- Discussions took place around implementing the principles of John's Campaign to support carers and promote person centred care.
- Collaboration with the Head of Employee Engagement, Involvement and Employee Retention to discuss the "Time to Talk" event (Mental Health) and the launch of staff carers café.

9. Key Risks / Matters for Escalation

A member of the PALS team in RGH is still currently supporting the central concerns team so the support that can be provided here is reduced.



10. 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 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 <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:
Cydraddoldeb	Yes: ☐	No: ☒



Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? / Equality Have you undertaken an Equality Impact Assessment Screening?	Outcome:	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) To ensure that the HB has a person-centred approach and ensure the community is at the heart of service improvement and involvement patient feedback in its various forms has to be sought and fed into the HB.	
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.	

11. Recommendation

- 11.1 To note the actions that have been outlined in the above Report.

12. Next Steps

- 12.1 The People's Experience team will continue to explore avenues to broaden links within the community and the HB itself to ensure their voice is at the heart of all we do.



Agenda Item

6.2

Quality, Safety & Experience Committee

Safe Care Partnership 2 and developing a Quality Management System

Dyddiad y Cyfarfod / Date of Meeting	25/03/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Paul Gimson, Assistant director of improvement culture capability and delivery
Cyflwynydd yr Adroddiad / Report Presenter	Paul Gimson, Assistant director of improvement culture capability and delivery
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	
QMS	Quality Management System
QI	Quality Improvement

1. Situation /Background

Quality Management Systems

- 1.1 The Duty of Quality in April 2023 as part of the Health and Social Care Act 2020 requires organisations to implement a quality management system.
- 1.2 The CTM Quality Strategy 2022-2025 outlines our response to the Duty of Quality and defines our approach to QMS as embedding a culture where people listen, think, feel and act 'quality' - promoting openness and learning, continuous improvement and service transformation.
- 1.3 The CTM Quality Strategy outlines the elements required of a Quality Management System.

The Safe Care Partnership

- 1.4 The original Safe Care Partnership was between Improvement Cymru, The Institute for Healthcare Improvement and NHS Wales Health Board and Trusts.
- 1.5 CTM was a member of the partnership which focussed on improving care for deteriorating patients, ambulatory care and community settings.
- 1.6 The NHS Executive has relaunched the partnership with the following Aim:
To continuously, reliably and sustainably improve the quality, safety and outcomes of care for the people of Wales.
- 1.7 The Partnership is to be made up of 4 workstreams:
 - 1.7.1 Deconditioning
 - 1.7.2 Acute Deterioration
 - 1.7.3 Duty of Quality (delivery of QMS at an organisational level)
 - 1.7.4 Leading Quality and Safety Improvement

iCTM Improvement Strategy 2025

- 1.8 The previous iCTM Improvement Strategy focussed on three key elements;
 - 1.8.1 Building QI Capacity and Capability through training
 - 1.8.2 Staff ideation through the SimplyDo platform
 - 1.8.3 Providing QI support for services
- 1.9 In 2025 and beyond our strategy is to build on this work but shift the focus to whole system thinking and Culture Change. It will focus on:
 - 1.9.1 Building a culture of improvement capability
 - 1.9.2 Embedding QI across the organisation through a systematic approach to Quality Management Systems
 - 1.9.3 Prioritising Patient Safety



From	To
Improvement work as a series of priority projects, e.g., reducing central line infections, improving the stroke pathway.	CI as a broader, long-term strategy to drive improved delivery of care across the whole system, which involves ongoing adaptation, innovation, and learning (whilst continuing to use a project-based approach).
Improvement focused on independent initiatives, with a clear boundary around the work, supported by specific tools & information.	Improvement focused on interdependent initiatives, working across boundaries in collaboration, built on shared purpose and using multiple methods.
Improvement work is led by enthusiasts.	Improvement work is championed by the board and most senior leaders, who integrate a focus on CI into their shared work.
A small number of people have specialist improvement capability so a limited capacity for CI.	Everyone in the system has improvement skills and capability, so a wide capacity for CI.
Improvement often makes a peripheral contribution to large-scale performance delivery.	CI is at the heart of large-scale performance strategies (improvement-led delivery).
The management and measurement of improvement is piecemeal and applies to specific improvement projects only.	Operating through a Quality Management System (Healthcare Improvement Scotland, 2022): a consistent and coordinated approach to managing quality that is applied at every level from team through to board.



Source: Shah, 2020

2. Specific Matters for Consideration

- 2.1 This paper aims to provide information and assurance as to CTMs involvement in the Safe Care Partnership and its implementation of the QMS requirements under the Duty of Quality.

- 2.2 The programme will be overseen and Coordinated by iCTM. Its overall aim is to see a systematised approach to the use of Quality Management Systems across CTM.
- 2.3 The Acute Deterioration workstream will be aligned with the CTM RADAR (Recognition of Acute Deterioration and Response) group.
- 2.4 The Deconditioning workstream will be managed as part of the Six goals for urgent and emergency care programme.
- 2.5 A leadership group will oversee the establishment and implementation of a systematic approach to the implementation of QMS and our participation in the Safe Care Partnership. Our plan will be based on guidance and direction from the NHS Executive (as initially outlined in the NHS Executive publication: Developing a Quality Management System An operating system for a quality-driven learning organisation executive.nhs.wales/functions/quality-safety-and-improvement/quality-and-safety/developing-a-quality-management-system/.)
- 2.6 The QMS approach will be tested as part of existing iCTM workstreams such as the Falls and Pressure Ulcer Collaborative and the Ward Accreditation Programme.

3. Key Risks / Matters for Escalation

- 3.1 None to report at this stage

4. Assessment

- 4.1 A systematic approach to the implementation of Quality Management Systems will ensure we meet our requirements under the Duty of Quality and support an organisation cultural shift towards one of Quality and improvement.
- 4.2 Initially there are no significant resource implications. Dependent on system and implementation needs as the case for QMS develops this may change and a business case for investment may be required.

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 <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality</i> (Duty of Quality Statutory Guidance (gov.wales))	Whole-systems Perspective
	If more than one applies please list below:
Dolen i Feysydd Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality</i> (Duty of Quality Statutory Guidance (gov.wales))	Safe
	If more than one applies please list below: All
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / Quality</i> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: ☒	No: ☐
	Outcome: No full QIA needed after screening.	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? / Equality and Welsh Language</i> <i>Have you undertaken an Equality and Welsh Language Impact Assessment Screening?</i>	Yes: ☒	No: ☐
	Outcome for Equality (delete as appropriate): POSITIVE Outcome for Welsh Language (delete as appropriate): 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	Yes (Include further detail below)	



(Pobl /Ariannol) /
Resource Impact
(People / Financial)

The initial phase of this work has no financial impact other than the impact on the iCTM team. Future delivery will be subject to the approval of plan and business case.

5. Recommendation

- 5.1 The Committee is asked to **note and support** the approach outlined in this paper.

6. Next Steps

- 6.1 Establishment of a QMS leadership group and nomination of individuals to the national Duty of Quality Leaders workstream
- 6.2 Implementation of standardised early warning scores across all ages
- 6.3 Identification of projects from the Six Goals programme to submit to the acute deterioration workstream
- 6.4 Nomination of participants in the national Leading Quality and Safety Improvement Programme



Agenda Item

7.1

Quality, Safety & Experience Committee

Organisational Risk Register

Dyddiad y Cyfarfod / Date of Meeting	25 March 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	Gareth Watts, Director of Corporate Governance & Risk
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Review

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Service, Function and Executive Formal Review	February / March	RISKS REVIEWED
Operational Management Board	February 2025	ENDORSED RISKS WHERE APPLICABLE FOR ELG
Executive Leadership Group	17 March 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 7 March 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 **771** 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.

- 2.10 108 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 108 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 108 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 in June, received through evaluation, have been included below:
- *"This course was extremely useful being new to risk assessments in CTM it was the right amount of content/information and well delivered".*
 - *"yes, would like all qualified nurses be aware how to do this. ... training, well rounded, concise and very informative"*

3. Key Risks / Matters for Escalation

3.1 NEW RISKS

Digital & Data Directorate

- Datix Risk ID 6102 - Patient pathways - working in two WPAS instances. Risk score of 20.
- Datix Risk ID 5226 - Risk of damage to records and equipment due to leaking roof in the Williamstown Records Hub. New risk escalated March 2025. Risk Score of 20.

Medical Directorate

- Datix Risk ID 6111 -Medical Examiner Delays. New risk escalated March 2025 due to increase in risk score. Risk Score of 20.

Children & Family Care Group

- Datix Risk ID 5903 - Unfunded Continuing Care Packages / unfilled packages. New risk escalated March 2025 due to increase in risk score. Risk Score of 20.
- Datix Risk ID 5753 - Inadequate Special School Nurse Provision. New risk escalated March 2025 due to increase in risk score. Risk Score of 20.

Mental Health and Learning Disabilities Care Group

- Datix Risk ID 4973- Clinical Medical Cover within CTM Adult Mental Health Services. New risk escalated March 2025. Risk Score of 16.

Primary Care and Community Care Group

- Datix Risk ID 5576 - Palliative Medicine Staffing. New risk escalated March 2025. Risk Score of 16.

- Datix Risk ID 6053 - Failure to secure an alternative Clinical System for GP practices on Vision. New risk escalated March 2025. Risk Score of 20.

Unscheduled Care – Care Group

- Datix ID 5045 - Access to Neurology Inpatient and Outpatient Services for CTM Residents. New risk escalated March 2025. Risk Score of 16.

3.2 CHANGES TO RISKS

Risk Score Increased

Nil with regards to those risks currently escalated to the Organisational Risk Register.

Risk Score Decreased

Strategy and Transformation

- Datix ID 5821 - Provision of secondary care immunology services by external provider (this is a service that is not provided by CTM UHB). Risk score reduced from a 20 to a 16 as triage has commenced. Risk score will be further reviewed once a service has been commissioned for follow up appointments and CTM have converted enough urgent referrals to the 40 outpatient contacts.

Planned Care – Care Group

- Datix ID 4071 - Failure to sustain services as currently configured to meet cancer targets. Service Director for Planned Care has reviewed the risk and reduced the score from a 20 to a 12 in March 2025. The rationale for the decrease in score is that whilst not achieving SCP target there is a sustained improvement in cancer performance and backlog position. Full workforce review being conducted, process mapping of the optimal cancer pathways taking place, interviews have taken place with staff to gain insight into opportunities for improvement, meeting matrix established with a weekly cancer focus with service groups to support collaborative working. These then feed into the established weekly performance meeting with Service Director.
- Datix ID 4103 - Sustainability of a safe and effective Ophthalmology service. Service Director for Planned Care has reviewed the risk and reduced the score from a 20 to a 12 in March 2025. Continuing with above (95% macular patients meeting target date). Consultant ophthalmologist has undertaken validation exercise on Follow Ups Not Booked. Pathway now in place where every patient has their next appt agreed before leaving clinic.

Diagnostics, Therapies, Pharmacy & Specialties Care Group

- Datix ID 5590 - Radiopharmaceutical Business Interruption. Service Director for DTPS Care Group has reviewed this risk and due to a new Service Level Agreement being established with Swansea Bay University Health Board the likelihood of this risk has significantly reduced. Risk score decreased from a 20 to a 4.
- Datix ID 5462 - Adult weight management service - Insufficient capacity to meet demand. Risk reviewed by Service Director In the absence of incidents

where moderate or high level of harm is occurring then the mitigating actions are holding the risk at Care Group Level while longer term solutions and controls are put in place. The risk of target achievement is highly likely and will require further conversations through 2025. Risk score decreased from a 20 to a 12.

- Datix ID 5658 - Lack of Dietetic service provision to Princess of Wales (POW) Critical Care. Service Director reviewed. No incidents have been reported and the mitigating action of the critical care Multi-Disciplinary Team is managing the risk and is helping to manage the patients. Risk score decreased from a 16 to a 12.

3.3 CLOSED RISKS REMOVED FROM THE ORGANISATIONAL RISK REGISTER

Patient Care & Safety Directorate

- Datix ID 4907 – Failure to manage Redress cases efficiently and effectively. This risk has been closed as it has been merged with Datix Risk ID 4908 – Failure to manage Legal cases efficiently and effectively which has a risk score of 16.

Fire

- Datix Risk ID 3993 – Fire Enforcement Notice (FEN) – Princess of Wales Theatres. Fire enforcement notice has been closed as South Wales Fire and Rescue (SWFR) service are satisfied that areas of improvement will be addressed through significant work internally and externally to address fire enforcement and roof issues. FEN project board formally stood down by Linda Prosser. Ongoing assessment work will be undertaken as part of ongoing capital programme of work and theatre recommissioning.

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

Consequence	5			3337	5276 5932 6053 6102	
	4			5820	4908 4885 5576 5903 5753 5821	5646 5579 5761 5691 5961 5045 4973
						4491 3826 4632 5417 6111 5226
	3					4691
	2					
	1					
	CxL	1	2	3	4	5
Likelihood						

3.5 EMERGING RISKS

Pathology Risk - Diagnostics, Therapies, Pharmacy and Specialties (DTPS) & Digital & Data

Risk assessments are underway in terms of the sustainability of pathology services and the delivery of a digital cellular pathology solution for the Health Board. Once the assessments are complete, they will be considered for escalation to the Organisational Risk Register as appropriate. Update March 2025 – the Service Director for Diagnostics, Therapies, Specialties and Pharmacy has advised that this is an issue, rather than a risk, and is being managed as required. Therefore, at this stage no risk is being escalated.

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 (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) / 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 (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) / 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 <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	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 <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /</i> Equality and Welsh Language <i>Have you undertaken an Equality and Welsh Language Impact Assessment Screening?</i>	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	
Date 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	
6111	Executive Medical Director	Medical Directorate Function	Medical Directorate Manager	Improving Care	Patient / Staff /Public Safety	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 WIG 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 stance if required. Use of medlink sessions to manage post mortem demand.	Plan to improve timely death certification by CTNUHB specific QR code to alert wider staff and reduce delays and education videos from HES to improve accuracy. Continue to improve on communication with families around delays and estimated timescales.	Quality, Safety & Experience Committee. Operational Delivery Committee.	20	C4xL5	12 (C4xL3)		New risk escalated to the Organisational Risk Register in March 2025	05.03.2025	05.03.2025	07.04.2025
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 (EHMS). 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. Contract & 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 DHCW and other Health Boards for Business Continuity Plans - timeframe 27.3.2025. Securing a new Clinical System Provider - timeframe 30.06.2025.	Quality, Safety & Experience Committee. Operational Delivery Committee.	20	C5xL4	5 (C5xL1)		New risk escalated to the Organisational Risk Register in March 2025	15.01.2025	28.02.2025	28.03.2025
6102	Director of Digital	Central Corporate - Digital & Data	Head of Clinical Admin Transformation	Sustaining Our Future	Patient / Staff /Public Safety	Patient Pathways - Working in WIPAS 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 CTNUHB have a fully migrated PAS systems and the whole organisation is using a singular PAS system for patient pathways.	Quality, Safety & Experience Committee. Operational Delivery Committee.	20	C5xL4	5 (C5xL1)		New risk escalated to the Organisational Risk Register in March 2025	18.02.2025	7.3.2025	02.04.2025
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. 3) Redirect Take - Objective - Reduce demand for inpatient beds on the POW site and the deployment of the right staff to the right place. 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 March 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. Contractors have removed the old tiles above Main Theatres and working on Wards 7, 8, 9, 10, 11U and Endoscopy so risk of falling tiles has reduced considerably with the large area of roof where the old tiles have been removed. Remaining Wards 5 and 6 will start roof work soon. Full programme including Theatre 1 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	C5xL4	10 (C5xL2)	↔	23.09.2024	10.03.2025	10.04.2025		
4491	Chief Operating Officer	Deputy Chief Operating Officer - Acute Services.	Deputy Chief Operating Officer - Acute Services.	Improving Care	Patient / Staff /Public Safety	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: • Specialty 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 care 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 LUG 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.	Planned Care: •Progress made on >104 week •4 theatres across CTNUHB remain closed, 2 mobile endoscopy treatment rooms opened 4th March 2025, 2 Prince Charles Hospital (PCH) theatres to open end of April 2025 •Critical incident declared at Princess of Wales (POW) on 9th October 2024 due to the roof integrity issues with immediate impact on clinical pathways, bed capacity, all theatre elective capacity (inc. cardiac) and trauma capacity •There has been continuous planning on clinical pathways and diversion of emergency intakes, which again has impacted on the capacity and resilience across the full CTNUHB system. •There has been a requirement to deescalate and close 150 inpatient beds on the POW site. With re-provision of the capacity across CTNUHB acute and community. •There has also been significant reallocation of internal capacity at POW and Royal Glamorgan Hospital (RGH) to respond to the critical incident. •Planning continues on recovery phase following critical incident with the impact not yet quantified. •The risk score has been reviewed and increased on this occasion, due to the impacts of the critical incident. •There has been continuous improvement against trajectories for elective demand for a range of services including Mental Health and Learning Disabilities. •The financial and economic challenges faced by the third sector and local authority partners has an impact on the Health Boards ability to mitigate this risk, as capacity cannot be protected. •The large-scale capital programme at PCH will temporarily reduce the number of operating theatres by 2. An ongoing work programme continues to review options to mitigate this. •The current Fire enforcement notice at Princess of Wales hospital will be completed as part of the Critical incident response and reduce the number of operating theatres until early summer 2025. Plans are ongoing for the temporary location of the theatres. •Workforce recruitment continues across the care group to enable a sustainable capacity model. There continues to be a reduction of ADH and WLI activity attributed to standardisation of practice. •Regional working continues and the positive and negative impact of this will be continuously reviewed. Emergency / Unscheduled Care •Critical incident declared at Princess of Wales on 9th October 2024. Roof integrity issues with immediate impact on clinical pathways, bed capacity, all theatre elective capacity (inc cardiac) and trauma capacity •There has been a positive impact noted on performance as a result of STAMP at RGH, with plans to roll this out at PCH. •Impact of a temporary centralisation of stroke into one site. •There has been continuous planning on clinical pathways and diversion of emergency intakes that again has impacted on the capacity and resilience across the full CTNUHB system. •There has been a requirement to deescalate and close 150 inpatient beds on the POW site. With re-provision of the capacity across CTNUHB acute and community. •There has also been significant reallocation of internal capacity at POW and RGH to respond to the critical incident. •Planning continues on recovery phase following critical incident with the impact not yet quantified. •There has been some improvement against trajectories for emergency demand. Specifically, in total reduction of lost ambulance hours. •The risk score has been reviewed and despite critical incident remains unchanged, due to the following potential impacts: •There has been a reduction and re-alignment of bed capacity at POW and RGH. •There has been a diversion of emergency intakes from POW to RGH. Update March 2025 - CTM Acute Stroke services have been temporarily consolidated onto the Royal Glamorgan Hospital (RGH) across 2 wards, since January 2025. The urgent temporary changes to the Stroke service were enacted as a result of the following: •I/POW Ward 5 moved in Oct 2024, due water ingress and declaration of Critical Incident at the Princess of Wales hospital in Bridgend and the resulting necessity to decant some wards and services to alternative locations, stroke services transferred in November 2024. •If PCH Ward 10 moved to mitigate collapse of the service due to further and rapid deterioration of the Stroke Consultant workforce in January 2025 •Progress since the temporary centralisation of the Service to RGH: •Nursing teams have started to work together to review rotas across both wards to support safe staffing across the Acute Stroke Unit (ASU) •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 •Therapy teams (Physio, OT, SALT and Dietetic) have come together to work flexibly and collaboratively across the stroke unit •Stroke Consultant JAG out to advert with two candidates interested in applying •Dedicated therapy bay for Stroke patients in place •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) •Reduction in long waiting patients and on track to clear all 104+ week patients by end of March 2025 •Stroke unit improvement huddles with all professions. •CTM TIA clinics have now moved onto RGH site. •Central Monitoring has now been installed on the Stroke Unit •Consent/Risk: •Sickness/upcoming vacancies - particularly within the nursing workforce •High reliance on locum consultants to enable the service to run adequately •Unable to move POW Stroke clinics to RGH until May due to different ICT systems •WGH demand - increased diagnostic demand for doppler, echo and MRI •WGR Ltd increase in stroke beds with associated levels of workforce required •Stability with temporary nursing shift patterns / transport requests •Therapy staffing is already below national standard so increased beds numbers, patient flow issues, staffing vacancies and long term sickness have exacerbated the capacity challenges and impacted on level of care provided. •Increased pressure on WAST due to having to transfer self-presenters •The ability to report data has been disrupted by a combination of the changes in how SSNAP requires data to be recorded •Some stroke patients presenting with milder symptoms are missing the stroke pathway whilst in ED and being picked up via a different route-to be monitored •Appropriate accommodation/space across the stroke unit remains a challenge in order to provide quality interventions •Lack of psychology input across the stroke pathway remains a concern	Quality, Safety & Experience Committee. Operational Delivery Committee.	20	C4xL5	12 C4 x L3	↔	13.7.2023	07.03.2025	07.04.2025	
4632	Executive Director of Therapies and Health Sciences.	Unscheduled Care Group	Head of Strategic Planning and Commissioning	Improving Care	Patient / Staff /Public Safety	Provision of an effective and comprehensive stroke care pathways 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 the leadership of the Stroke Strategy Group • Toll 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 aligned 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 March 2025 - CTM Acute Stroke services have been temporarily consolidated onto the Royal Glamorgan Hospital (RGH) across 2 wards, since January 2025. The urgent temporary changes to the Stroke service were enacted as a result of the following: •I/POW Ward 5 moved in Oct 2024, due water ingress and declaration of Critical Incident at the Princess of Wales hospital in Bridgend and the resulting necessity to decant some wards and services to alternative locations, stroke services transferred in November 2024. •If PCH Ward 10 moved to mitigate collapse of the service due to further and rapid deterioration of the Stroke Consultant workforce in January 2025 •Progress since the temporary centralisation of the Service to RGH: •Nursing teams have started to work together to review rotas across both wards to support safe staffing across the Acute Stroke Unit (ASU) •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 •Therapy teams (Physio, OT, SALT and Dietetic) have come together to work flexibly and collaboratively across the stroke unit •Stroke Consultant JAG out to advert with two candidates interested in applying •Dedicated therapy bay for Stroke patients in place •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) •Reduction in long waiting patients and on track to clear all 104+ week patients by end of March 2025 •Stroke unit improvement huddles with all professions. •CTM TIA clinics have now moved onto RGH site. •Central Monitoring has now been installed on the Stroke Unit •Consent/Risk: •Sickness/upcoming vacancies - particularly within the nursing workforce •High reliance on locum consultants to enable the service to run adequately •Unable to move POW Stroke clinics to RGH until May due to different ICT systems •WGH demand - increased diagnostic demand for doppler, echo and MRI •WGR Ltd increase in stroke beds with associated levels of workforce required •Stability with temporary nursing shift patterns / transport requests •Therapy staffing is already below national standard so increased beds numbers, patient flow issues, staffing vacancies and long term sickness have exacerbated the capacity challenges and impacted on level of care provided. •Increased pressure on WAST due to having to transfer self-presenters •The ability to report data has been disrupted by a combination of the changes in how SSNAP requires data to be recorded •Some stroke patients presenting with milder symptoms are missing the stroke pathway whilst in ED and being picked up via a different route-to be monitored •Appropriate accommodation/space across the stroke unit remains a challenge in order to provide quality interventions •Lack of psychology input across the stroke pathway remains a concern	Quality, Safety & Experience Committee. Operational Delivery Committee.	20	C4xL5	12 (C4 x L3)	↔	11.05.2021	06.03.2025	06.04.2025	
5276	Director of Digital	Central Support Function - Digital and Data	Pathology Directorate Manager	Sustaining Our Future	Business Objectives - Operational	Failure to deliver replacement Laboratory Information Management System, LIMS 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 provision. 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 March 2025 - Delays in UAT, currently under review but due to CTRix issue still aiming for December 2025 deadline - extraordinary project planned for 03/03/2025 to discuss revision of project plan. Risk of delivery by December is increasing and concerns as to when would be an appropriate implementation date given winter pressures.	Quality, Safety & Experience Committee. Operational Delivery Committee.	20	C5xL4	5 (C5xL1)	↔	26.10.2022	20.12.2024	28.02.2025	
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	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 major 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 resus 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 Y5 to mitigate against the loss of bed capacity in the care home sector and Neasden 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 B&C 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 March 2025 - The USC SMT reviewed current ambulatory pathways and the site based clinical teams are in the process of developing an SOP relating to triage. We continue to explore the potential to expand ambulatory footprint at the Princess of Wales site. Quality statement baseline assessment has been completed, part of this work, will result in the development of an overcrowding score which should help reduce the risk of harm with overcrowding in the emergency department. 1. Currently developing a standardised approach to our huddle capture and reporting. 2. Proof of concept has been completed with engagement from operational and clinical stakeholders. 3. Have to development of software project. 4. This will support a consistent approach to recording and reporting escalation levels across all our acute sites. 5. USC Dashboard which provides daily and ongoing trend data for performance metrics 1 Emergency Care. 6. Developing data intelligence Emergency department acuity levels, including risk stratification and also clinical frailty score for all attendances in each of our Emergency Departments. 7. CTM MTP describes development of a predictive data model to enhance current systems (we already have predicted attendances) which remains an ongoing risk for all 3 sites and is reviewed regularly as implementation of targeted improvement takes place. Nurse establishments are being reviewed to ensure safe staffing. With sustained high level of escalation.	Quality, Safety & Experience Committee. Operational Delivery Committee.	20	C4xL5	12 (C4xL3)	↔	24.09.2019	6.3.2025	6.4.2025	
11																		

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
Date 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
1	5417	Chief Operating Officer	Primary Care and Community Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety	Pediatric 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 from 48% to 80%. Children can only wait 8 wks from 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 March 2025 - The service still currently only has 1 urgent GA list per month. Primary care are exploring the use of the Vanguard clinics to run the GA lists all day on a Saturday for a possible 6 month period. This would enable up to 10 children to receive treatment in this time period (approximately 240 children), this would still leave a significant number requiring care under GA. However, it may take 9 weeks from this date to arrange all the required teams to be able to deliver the lists on a weekend i.e. additional hours/availability of paediatric ward and theatre staff, paediatric anaesthetists, therefore the number of children treated is likely to be lower if the full 6 months cannot be utilised. The planning for the Saturday GA lists will form part of the weekly vanguard meetings. Slippage monies from Planned Care will be required to pay for the staffing costs. In addition to this, discussions are ongoing for regular lists to be allocated to the service in RGH and PCH.	Quality, Safety & Experience Committee Operational Delivery Committee	10	C4xL5	9 (C3xL3)	↔	20.04.2023	06.03.2025	07.04.2025
12	5903	Chief Operating Officer	Children & Family Care Group	Care Group Service Director	Improving Care	Statutory Duty, Regulation, Mandatory Requirements.	Unfunded Continuing Care Packages / unfunded 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.	1.9 wks BS currently out for advert 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 February 2025 - SBAR to be submitted to Operational Management Board for permanent recruitment to fulfil outstanding continuing care shifts, permanent recruitment of staff is required.	Quality, Safety & Experience Committee Operational Delivery Committee	20	C4xL5	6 (C2xL3)	New risk escalated to the Organisational Risk Register in March 2025	05.09.2024	19.2.2025	05.3.2025
13	5226	Director of Digital	Digital & Data Directorate	Head of Clinical Administration Transformation	Improving Care	Patient / Staff /Public Safety	Risk of damage to records and equipment due to leaking roof in the Williamstown Records Hub 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/trips 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 effected 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.	Quality, Safety & Experience Committee Operational Delivery Committee	20	C4xL5	3 (C3xL1)	New risk escalated to the Organisational Risk Register in March 2025	30.06.2022	10.02.2025	30.04.2025
14	5045	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety	Access to Neurology Inpatient and Outpatient 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, impatient 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 Liaison 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.	Significant concerns have been raised across CTM and the planning team has engaged with key stakeholders to develop a robust commissioning plan. Any development of the service will require investment. A CTM liaison service model paper has been produced and forms part of the USC Care Group IMTP plan for 2025/26. Provision of neurology services to CTM residents has been highlighted as a key risk in the Medicine CIG IMTP in previous years. The waiting lists are currently reported by C&A/HB but there has been a request for CTM to take this over. An SBAR has been drafted and tabled at OMB on 19/02/25 which identifies the resources required to take the waiting over in a reasonable position.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL4	8 (C4xL2)	New risk escalated to the Organisational Risk Register in March 2025	09.3.2022	07.03.2025	01.04.2025
15	5576	Chief Operating Officer	Primary Care and Community Care Group	New risk escalated March 2025, Risk Score of 16.	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 Ynnyr Cem 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 complement. 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.	Additional sessions offered to remaining consultant, albeit just 2 sessions. Additional middle grade doctor being sought to provide additional resilience. Timeframe April 2025.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL4	8 (C4xL2)	New risk escalated to the Organisational Risk Register in March 2025	11.10.2023	28.02.2025	28.3.2025
16	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 increased, and bridges LEA/ Education Service (SLA) do not contribute financially to the Service Level Agreement (SLA) in Special Schools Then the 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 Rhonda Cynon Taf (RCT) and Merthyr who are the only LEAs who contribute financially into the SLA Resulting in, Disatisfaction 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	Wegation - reviewing SLA at pace with LEA, 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 (13/02/2025). Engagement between senior nurse and head teachers and support for special school nurses has been given.	Update February 2025 - SBAR to be completed and escalated to directors to support funding request to invest into special school nursing services. Clarity and agree roles and responsibilities with Local Authorities - Task and Finish Group to agree roles and responsibilities with headteachers and ensure SLA's reflect this.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL4	8 (C4xL2)	New risk escalated to the Organisational Risk Register in March 2025	18.04.2024	19.2.2025	05.3.2025
17	4973	Chief Operating Officer	Mental Health Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety	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 CMH 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 needs to ensure all are aware of the cover arrangements. Two FMs 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 is the Medical Workforce Productivity in place. International recruitment drive looking to recruit two Specialty Doctors to Inpatients and Rehab in August 2025.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL4	12 (C4xL3)	New risk escalated to the Organisational Risk Register in March 2025		13.02.2025	30.04.2025
18	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 GPs have been informed of the challenges currently experienced with immunology provision and delays can be expected.	Update January 2025 - December 24 Update - Work continues to source alternative service offer. Key updates include - the provider is likely to start triaging the first batch of 40 ref's Jan/Feb. Draft agreement been produced. Referral process established with referral management team. Still need to confirm how urgent referrals seen by provider that convert to follow up. Update February 2025 - North Bristol Trust have now started to triage the first batch and we have a weekly tracker which shows the outcome e.g. referrals on to the tertiary service at Cardiff & Vale University Health Board, discharged with advice & guidance, need to be offered a first outpatient appointment. Outpatient clinics not started yet but they will be completed by 31/3/25 at the latest. In addition to the above WCG have commissioned an All Wales scoping exercise and so CTM UHB have submitted the clinical and commissioning reps and are waiting to be contacted for an initial meeting to be arranged. Risk score reviewed and slight decrease in risk score from a 20 to a 16 as triage has commenced. Risk score will be further reviewed once a service has been commissioned for follow up appointments and CTM have converted enough urgent referrals to the 40 outpatient contacts	Quality, Safety & Experience Committee Operational Delivery Committee	16 (Decreased from a 20 to a 16 in February 2025)	C4xL5	4 (C4xL3)	↓	08.07.2024	19.2.2025	30.04.2025

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
Date 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
1																	
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. In addition barriers are in place around the footpaths to keep pedestrians away from the edge of Phase 1 roofs.	Command structure established to manage the critical incident following identification of roof structure failings. Immediate mitigations to vacate 1st floor wards & depths. 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	Update March 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. Full programme including Theatre ICN works and fire compartmentation above vacated wards and depths due to be completed mid August 2025.	Quality, Safety & Experience Committee Operational Delivery Committee Health, Safety & Fire Sub Committee	16	C4xL4	8 (C4xL2)	↗	21.10.2024	10.03.2025	10.04.2025
23	4885	Director of Corporate Governance / Board Secretary	Corporate Governance	Corporate Governance	Improving Care	Quality / Complaints / Assurance / Patient Outcomes	Failure to deliver and sustain effective Policy Management System and Process 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 in place 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 March 2025 - Stage 1 of the Project Initiation Document complete and Stage 2 has commenced. Baseline position now established, however, significant work still required to improve compliance position. Timeline for completion of the project is 31.12.2025. No change to risk score at this stage.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL4	8 (C4xL2)	↗	26.10.2021	07.03.2025	30.4.2025
24	5691 Closed Session due to business sensitivities	Chief Operating Officer	Facilities Directorate	Assistant Director Facilities	Sustaining Our Future	Patient / Staff /Public Safety	Detail captured in Private Session due to business sensitivities. Impact on the safety - Physical and/or Psychological harm				16	C4xL4	C3xL4 12	↔	31.01.2024	18.02.2025	30.04.2025
25	5761	Executive Medical Director	Medical Directorate Function	Medical Directorate Manager	Improving Care	Patient / Staff /Public Safety	Cross Health Board Data Sharing 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 Anserini 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. CTM/HB 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 CMV and All 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 March 2025 - No change to risk score or current mitigations.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL4	8 C4xL2	↔	26.04.2024	30.12.2024	31.03.2025
26	5646	Chief Operating Officer	Mental Health Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety	The impact of "Right Care Right Person" (RCRP) approach. 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 S.36 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 March 2025 Risk reviewed no change Phases 3+4 implementation date 10/03/25 Stakeholder event attended by CTM leaders 07/02/25 RCRP Health Board Regional Position meetings with SBUHB and C+V UHB continue. RCRP is MHLD Care Group top investment priority in 2025/26 JMT RCRP monthly meetings continue (latest 14/02/25)	Quality, Safety & Experience Committee Mental Health Act Monitoring Committee	16	C4xL4	12 (C3xL4)	↔	08.12.2023	13.02.2025	31.05.2025
27	5579	Executive Director of Public Health Executive Director of Therapies & Health Science	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Head of Nutrition and Dietetics, Therapies, PCH	Creating Health	Patient / Staff /Public Safety	Rising childhood obesity rates resulting in an increase in obesity related conditions and poorer health outcomes. 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.	If: there is no children and young person's weight management service staff by end of 2024 (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 JMT consideration. Business case proposes a phased approach at levels 1 and 3 and was developed in collaboration with stakeholders. Finance-dependent controls: 1)Set up service if funding identified via JMT process.	Update March 2025 - control measures updated, no change to risk score. Update January 2025 - The risk has had a change in risk handler and a detailed review is scheduled for the 8 January 2025. Further update will be provided in the next iteration once the new handler has had time to review the risk.	Quality, Safety & Experience Committee Strategic Development Committee	16	C4xL4	8 C4xL2	↔	13.10.2023	13.2.2025	26.05.2025
28	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 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 WIP 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 the 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 March 2025: Regular reports not on all Legal Cases (including redress, Claims and Inquests cases), with monitoring by the Assistant Director of Concerns & Claims, with oversight by the Assistant Director of Quality & Safety. Currently, due to staffing challenges, in order to support the mitigation of this risk, the Legal Services team are applying an objective triage approach across all legal services. Agency staff are also in place, these being: • 1 legal agency admin staff, who have been in place since August 2024, and will continue in post until end of May 2025; • 1 legal agency (paralegal) commencing 10 March 2025. It is anticipated they be in post for a period of 2 months. Legal cases continue to be monitored and escalated through the weekly Q&S Assurance Meeting, led by the Executive Nurse Director, Deputy Executive Director of Nursing and Assistant Director of Quality & Safety.	Quality, Safety & Experience Committee Operational Delivery Committee	16	C4xL4	8 (C4xL2)	↔	02.11.2021	07.03.2025	07.05.2025
29	3337 Linked to RTE Risk 4803, 4795, 3273 and 3019.	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	Lack of a Single Electronic Patient Record in Mental Health Services 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 CTM/HB staff who currently use WCCIS via local authority over to CTM/HB 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. Risk reviewed no change	Quality, Safety & Experience Committee Operational Delivery Committee	15	C5xL3	6	↔	07.11.2018	13.02.2025	31.05.2025
36	4691 Linked to RTE Risk 4803, 4795, 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 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 March 2025 - Still 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	13.02.2025	31.05.2025
37																	

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
	Date 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
1	5820	Executive Director of Public Health	Public Health - Health Protection	Health Protection Team	Improving Care & Creating Health	Patient / Staff /Public Safety	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 NIP. 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 split 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.	Quality, Safety & Experience Committee Strategic Development Committee	12 Please see note in column J	C4xL3	8 (C4xL2)	↔	01.07.2024	11.02.2025	8.04.2025
38																		

Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Rating (Target)
4071	Chief Operating Officer Planned Care - Care Group	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to sustain services as currently configured to meet cancer targets.	IF: The Health Board fails to sustain services as currently configured to meet cancer targets. Then: The Health Boards ability to provide safe high quality care will be reduced. Resulting in: Compromised safety of patients, potential avoidable harm due to waiting time delays for treatment.	Tight management processes to manage individual cases on the cancer Pathway. Regular reviews of patients who are paused on the pathway as a result of diagnostics or treatment not being available. To ensure patients receive care as soon as it becomes available. Regular Quality impact assessments with the MDTs, to understand areas of challenge and risk Harm review process to identify patients with waits of over 104 days and potential pathway improvements. Initiatives to protect surgical capacity at the Vale hospital for ASA 1+2 level patients until alternatives become available. All three sites are working to maximising access to ASA level 3+4 surgery on the acute sites. HB working to ensure haematological SACT delivery capacity is maintained. Ongoing comprehensive demand and capacity analysis with directorates to maximise efficiencies. Considerable work around recommending endoscopy and other diagnostic services whilst also finding suitable alternatives for impacted diagnostics. Alternative arrangements for MDT and clinics, utilising Virtual options Cancer performance is monitored through the more rigours monthly performance review process. Each Care Group now reports actions against an agreed improvement trajectory.	Update July 2024 - risk ongoing, mitigation continues to be : ongoing increased scrutiny of pathways, focused work with urology, Gynae and colorectal, enhanced monitoring with Velindre Cancer Centre. Update November 2024 - Performance is improving, however, CTM are still not meeting the set Trajectory so the risk remains. Update January 2025 - Whilst not achieving SCP target there is a sustained improvement in cancer performance and backlog position. See update in Column L.	Quality, Safety & Experience Committee Operational Delivery Committee	12 Risk decreased from a 20 to a 12 in March 2025	12 Being considered for closure.
4103	Chief Operating Officer	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Sustainability of a safe and effective Ophthalmology service	IF: The Health Board fails to sustain a safe and effective ophthalmology service. Then: The Health Boards ability to provide safe high quality care will be reduced. Resulting in: Sustainability of a safe and effective Ophthalmology service	Measure and ODTC DU reviews nationally. . Clinical staffing structure stabilised and absence reduced (new consultant, nurse injectors, ODTC's, weekend clinics). . On going monitoring in place with regards RTT impact of Ophthalmology. . In line with other services, to meet the RTT requirement services are being outsourced - maintaining this level of performance will be challenging going forward. . Additional funding for follow up appointments provided and significant outsourcing undertaken (6,500 cases) with harm review piloting to assess all potential harms. . Additional services to be provided in Community settings through ODTC (January 2020 start date). . Intravitreal injection room x2 established with nurse injectors trained. Follow up appointments not booked being closely monitored and outsourcing enacted. Regular updates re follow up appointments not booked being monitored by Management Board / Q&SR (patient safety issues) and Finance, Performance and Workforce Committee (performance issues). Reviewing UHB Action Plan in light of more recent WAO follow up review of progress. Primary and Secondary Care working Groups in place. Ophthalmology Planned care recovery group established overseeing a number of service developments: WLI clinics, outsourcing of Cataract patients, development of an ODTC in Maesteg Hospital, implementation of Glaucoma shared care pathway, implementation of Diabetic Retinopathy shared care pathway, regional work streams, trial of new Glaucoma procedure (IMS), streamlining pathways. Quality and Performance Improvement Manager post created to provide dedicated focus, detailed demand and capacity analysis being undertaken. All patients graded according to the WG risk stratification R1, R2, R3. Additionally, several specific waiting lists are further risk stratified to ensure that the highest risk patients are prioritised.	Update August 2024 - risk ongoing, no new updates in addition to those reported in April 2024, to be reviewed in September 2024. Update January 2025 - December 2024 - 95% of macular patients are meeting their target date currently. See update in Column L.	Quality, Safety & Experience Committee Operational Delivery Committee	12 Risk decreased from a 20 to a 12 in March 2025	12 Being considered for closure.
5462	Executive Director of Public Health Executive Director of Therapies & Health Science	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Adult weight management service - Insufficient capacity to meet demand	If there is insufficient capacity within the adult weight management service to meet the demand Then patients will not be offered timely intervention in line with the All Wales Weight Management Pathway. The current waiting list is over 6 years. Resulting in missed opportunity to support activated patients who want support with their weight. Patients will live with over weight or obesity for longer and will be at high risk of a range of obesity related long term conditions such as developing or worsening type 2 diabetes, long term MSK, CVD and some cancers.	Non-finance dependant mitigation's in place and are closely monitored: 1) Move to group based delivery 2) Workforce modelling review every time there is a vacancy 3) Waiting well support via AWMS web page and onward signposting to WISE 4)SBAR to seek agreement to prescribe medications in line with prescriber capacity - currently capped due to budget. Presented to Access to Medicines committee 9/01/25 - now going to OMB 5)Pan HB steering group due 14/02/25 to explore range of complex challenges such as waiting well, equitable access to medications in line with Nice Technical appraisal, meeting chairs objectives for increased capacity at level 3 6)Pan Wales Peer support via various groups and with Executive Directors of AHPs and Health science, to share learning Finance-dependant mitigations 1)CYP Business case in final stages and includes small establishment that could support adults as part of family led interventions - this should enable meeting chairs target 24-25 of 10% Level 3 capacity.	Update March 2025 - control measures updated. Risk Score reduced to a 12. Risk reviewed by Service Director. In the absence of incidents where moderate or high level of harm is occurring then the mitigating actions are holding the risk at Care Group Level while longer term solutions and controls are put in place. The risk of target achievement is highly likely and will require further conversations through 2025.	Quality, Safety & Experience Committee Operational Delivery Committee Strategic Development Committee	12 Risk decreased from a 20 to a 12 in March 2025	C4xL2 - 8
5658	Chief Operating Officer	Creating Health Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Lack of Dietetic service provision to Princess of Wales (POW) Critical Care	If there is no dietetic service to POW critical care... Then this will impact on the safe and effective provision of nutrition and hydration to critically ill patients... Resulting in poorer nutrition provision and increased rated of malnutrition, which in turn lead to increased risk of infection, dependency on mechanical ventilation, poorer patient outcomes, increased length of stay and longer rehabilitation and recovery times following critical care. In addition to increased health utilisation costs, inequity of service provision across CTM critical care units, and non compliance with national standards and guidance as highlighted in critical care peer review.	At present there is no dietetic provision to POW critical care unit due to lack of specialist critical care dietitian on the POW site and lack of funding. Therefore the nutritional needs of critical care patients on the POW site are managed by the critical care Multi Disciplinary Team.	Update March 2025 - Service Director reviewed. No incidents have been reported and the mitigating action of the critical care Multi Disciplinary Team is managing the risk and is helping to manage the patients.	Quality, Safety & Experience Committee Operational Delivery Committee	12 Risk decreased from a 16 to a 12 in March 2025	C4xL2 - 8

Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Rating (Target)
5590	Chief Operating Officer	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Radiopharmaceutical Business Interruption	IF: CTMUHB Radiology Department are unable to procure radiopharmaceuticals as per Service Level Agreement with CAV. THEN patients will not receive the necessary imaging RESULTING IN delayed diagnosis/treatment/intervention and poor outcomes for patients and potential litigation .	Weekly Business Contingency meetings with all Health Boards. WG directive is to share capacity regionally. Clinical stratification of patient priority - USC i.e. imaging at Princess Of Wales. Use of Mag Trace or alternative for SNLB - Breast Services	Update November 2024 - 07/11/24 Further shortage of Technescan HDP until 11/11/24 impacting Isotope provision, particularly bone scans. The Reactor in Poland restarted 31/10/24. Confirmation received that the usual levels of supply will reinstated by 11/11/24. No change to risk score. Update January 2025 - 16.12.24 update - ongoing nationally . No change to risk score. See Column L.	Quality, Safety & Experience Committee Operational Delivery Committee	4 Risk decreased from a 20 to a 4 in March 2025	C4xL1 Being considered for closure.

De-escalation Rationale
Service Director for Planned Care has reviewed the risk and reduced the score from a 20 to a 12 in March 2025. The rationale for the decrease in score is that whilst not achieving SCP target there is a sustained improvement in cancer performance and backlog position. Full workforce review being conducted, process mapping of the optimal cancer pathways taking place, interviews have taken place with staff to gain insight into opportunities for improvement, meeting matrix established with a weekly cancer focus with service groups to support collaborative working. These then feed into the established weekly performance meeting with Service Director. This risk has been de-escalated from the Organisational Risk Register but will continue to be monitored via the Care Group.
Service Director for Planned Care has reviewed the risk and reduced the score from a 20 to a 12 in March 2025. Continuing with above (95% macular patients meeting target date). Consultant ophthalmologist has undertaken validation exercise on Follow Ups Not Booked. Pathway now in place where every patient has their next appt agreed before leaving clinic. This risk has been de-escalated from the Organisational Risk Register but will continue to be monitored via the Care Group.
Risk reviewed by Service Director. In the absence of incidents where moderate or high level of harm is occurring then the mitigating actions are holding the risk at Care Group Level while longer term solutions and controls are put in place. The risk of target achievement is highly likely and will require further conversations through 2025. This risk has been de-escalated from the Organisational Risk Register but will continue to be monitored via the Care Group.
Risk Reviewed by Service Director. No incidents have been reported and the mitigating action of the critical care Multi Disciplinary Team is managing the risk and is helping to manage the patients. This risk has been de-escalated from the Organisational Risk Register but will continue to be monitored via the Care Group.

De-escalation Rationale
Service Director for DTPS Care Group has reviewed this risk and due to a new Service Level Agreement being established with Swansea Bay University Health Board the likelihood of this risk has significantly reduced. This risk has been de-escalated from the Organisational Risk Register but will continue to be monitored via the Care Group.

	A	B	C	D	E	F	G	H	I	J	K
	Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Month Closed on Org RR	Closure Rationale
1	4907	Executive Nurse Director / Deputy Chief Executive	Improving Care	Statutory Duty, Regulation, Mandatory Requirements	Failure to manage Redress cases efficiently and effectively	If: The Health Board is unable to meet the demand for the predicted influx of Covid19 related, FUNB Ophthalmology Redress/Claim cases 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 poor management of cases. Financial impact to the Health Board from Redress cases which have been poorly managed and consequently proceed to claim.	Controls are in place and include: * Regular reports run on all Redress cases, with monitoring by the Head of Legal Services & Legal Services Manager 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 October 2024: Over the summer, all Redress cases have been reviewed by the senior staff member allocated overtime; with priorities identified for each case. The Legal Services team is currently depleted of staff, by 4 Claims Investigation Officers and 2 Legal Administrative Staff, which is due to sickness levels and members of staff leaving the organisation. This is having an effect on the workload of the Legal Services team. Staff members are being managed and supported appropriately through the Managing Attendance at Work Policy. The recruitment process of staff is also underway and the team are/have temporarily recruited agency staff to address the issues identified above, relating to management of legal cases. The agency staff recruited/to be recruited are: • 2 legal agency admin staff, who have been in place since August 2024, and will continue in post until end of February 2025; • 2 legal agency (solicitors) are being recruited, to cover the immediate gap in case management of Redress and Inquest cases. It is anticipated they will commence in November 2024 – for an initial period of 2 months. Legal cases continue to be monitored and escalated through the weekly Q&S Assurance Meeting, led by the Executive Nurse Director, Deputy Executive Director of Nursing and Assistant Director of Quality & Safety. It is proposed that both Datix ID 4907 & 4908 are amalgamated as one for the next ARC meeting as both the risks relate to Legal Services/Concerns and are of the same nature of risk. Update January 2025 - A full and robust review of both risks 4907 & 4908 will be undertaken in readiness for the next iteration of the risk register. No change to current risk score of 16.	Quality, Safety & Experience Committee Operational Delivery Committee	March 2025	Risk closed as now merged with Risk ID 4908, reducing duplication.
3	3993	Executive Director of Strategy & Transformation	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Fire Enforcement Notice - POW Theatres.	If: The Health Board fails to meet fire standards required in this area. Then: the safety of patients, staff, contractors/visitors etc. and the protection of the buildings could be compromised. Resulting in: potential harm, risk of fire. Possible further enforcement in the form of prosecution.	Storage room obtained on ward 16 to store theatre equipment to ensure evacuation corridor is kept free for evacuation. Staff training on lift evacuation. Closed storage cupboards purchased for safe storage of equipment. "safe" areas identified with Senior Fire officer for storage of equipment in corridors. Weekly meetings to discuss and plan building work necessary to meet requirements of the enforcement notice. Enforcement notice has been extended to December 2023. A meeting has been arranged with FRS in November with plans with a view to gaining a further extension. Need to plan for drop in theatres to mitigate work commencing	Update January 2025: Following the identification of risks with the hospital roof in Princess Of Wales Hospital, the first floor of the Hospital has had to be vacated to allow the remedial roofing works to take place. As a result, this has emptied the Theatre template and will therefore make the current FEN invalid. Discussions with South Wales Fire & Rescue Service have led to them withdrawing the Fire Enforcement Works in this area due to the area now being unoccupied and the ongoing programme of work to satisfy the issues in the FEN. The Fire Service will continue to monitor the Health Board's progress with these works to ensure the Main Theatres are fully fire safety compliant prior to the Health Board taking back occupancy of this area.	Quality, Safety & Experience Committee Health, Safety & Fire Committee	March 2025	04/03/2025 - Fire enforcement notice has been closed as SWFR service are satisfied that areas of improvement will be addressed through significant work internally and externally to address fire enforcement and roof issues. FEN project board formally stood down by Linda Prosser. Ongoing assessment work will be undertaken as part of ongoing capital programme of work and theatre recommissioning.
4											



Agenda Item

7.2

Quality, Safety & Experience Committee

Coroner's Inquest – Case Activity and Lessons Learned

Dyddiad y Cyfarfod / Date of Meeting	25/03/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Kellie Jenkins-Forrester, Head of Concerns & Business Intelligence
Cyflwynydd yr Adroddiad / Report Presenter	Nigel Downes, Assistant Director of Quality & Safety
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Dom Hurford, Executive Medical Director
	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

WAST	Welsh Ambulance Services Trust
UHB	University Health Board

1. Situation /Background

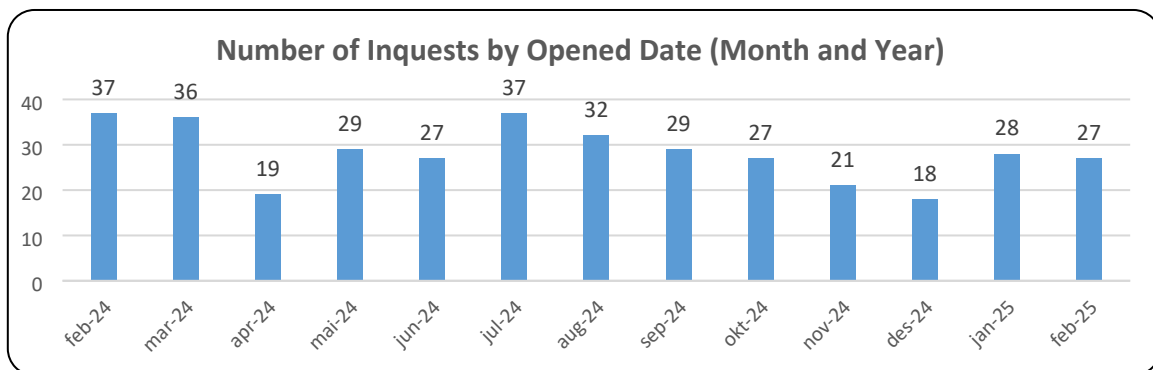
An inquest is a formal investigation by the Coroner to determine how a person died. They are held in certain circumstances, for example if the death was sudden or unexpected.

The purpose of this report is to provide an overview of inquest activity within the Health Board. In addition, the report will outline arrangements for future reporting in relation to themes and trends.

2. Specific Matters for Consideration

New Inquests Received

In the time period **01.11.24 to 28.02.25**, the Health Board received notification of **94** inquests. A trend graph of the inquests opened during period is provided below.

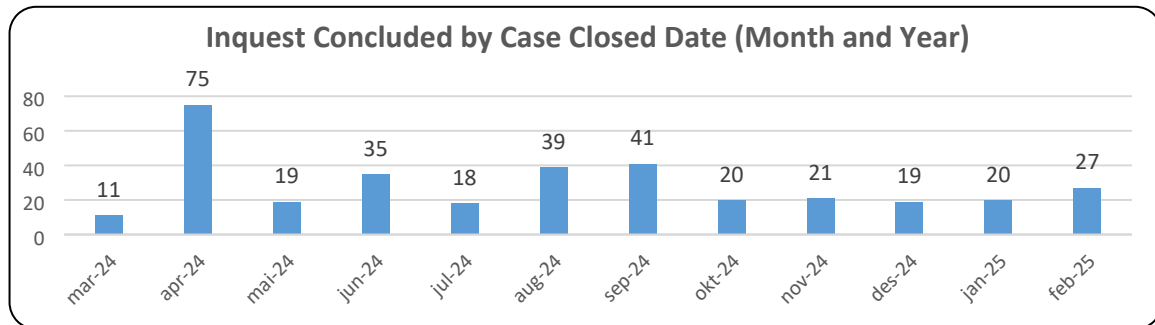


Of the 94, the highest number of inquests were received for the **Unscheduled Care Group**. A breakdown of inquests received by Care Group is provided below.

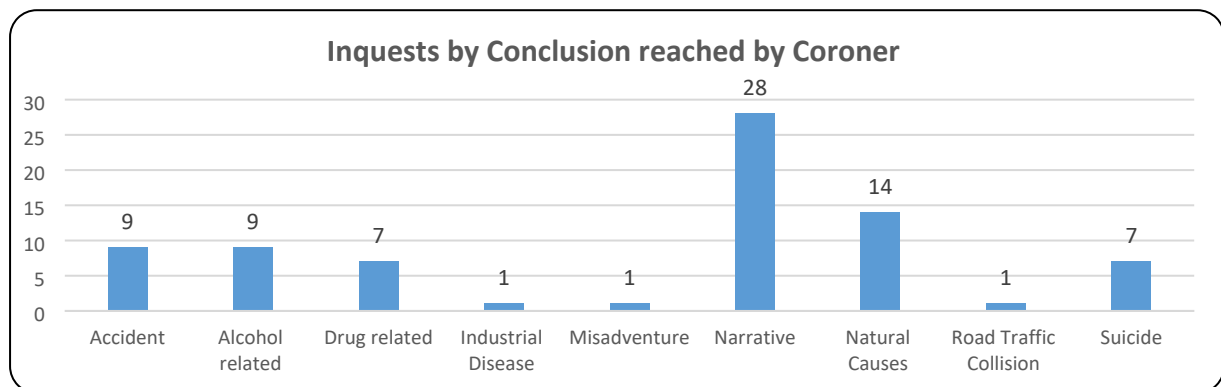
Care Group	Number Received
Community	3
Diagnostics, Therapies & Specialist Care	0
Families & Children	2
Mental Health	20
Planned Care (Surgery)	16
Primary Care	1
Unscheduled Care (Medicine)	50
Total	94

Inquests Concluded

During the same 4 month period, 87 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 87 inquests cases closed on Datix, 9 were discontinued by the Coroner prior to hearing. Of the remaining cases, 55% were concluded with a narrative conclusion (29) or with an outcome of natural causes (14). A further breakdown of the outcome of inquests concluded between the 01.11.24 and 28.02.25 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 01.11.22 and 28.05.25 the Coroner issued 1 regulation 28 reports to the Health Board. On a further case whilst the Coroner did not issue a regulation 28 report, a letter identifying opportunity for improvement was issued to the Health Board during the same time period.

A summary of the matters concerned raised with the regulation report and the letter is provided below:

1. Regulation 28 Report – care for patients non-clinical spaces
 - Care for patients in the emergency department is frequently provided in the corridor and other non-clinical spaces, which:



- Impedes efficient clinical assessment, causing clinicians to take longer performing tasks and rendering clinical care more difficult;
- Impedes the ability of staff to recognize a patient's deteriorating condition;
- Increases patient morbidity through environmental factors compromising a patient's ability to sleep, hygiene and nutrition.
- May slow the process of ambulance handovers.
- Care in corridors and other non-clinical spaces has been normalized, which in the opinion of the consultant who gave evidence is unsafe.
- When conducted routinely, care in corridors and other non-clinical spaces reduces the capacity of the Emergency Department so that should acuity escalate, it is likely to cause delays to the release of ambulances.
- The underlying obstacle to improving flow through the hospital and relieving pressure on the Emergency Department is the significant number of patients who are medically fit to be discharged but whose discharge is delayed due to non-medical reasons.

2. Letter Issued - Transfer of patients between Health Board sites

- Following a fall at Ysbyty Cwm Rhondda, a patient showing signs of a hip fracture with rotated foot and pain required transferred to the Royal Glamorgan Hospital. The inquest identified a 15½ hour delay in the arrival of the ambulance.
- The Coroner determined that it is highly unsatisfactory for Healthcare Professionals to be unable to secure a vehicle to transport a patient to a clinical setting that they need to go. The Coroner further highlighted evidence by WAST, that Aneurin Bevan UHB has commissioned vehicles and at least 1 paramedic whose whole purpose is to assist in the transfer of non-emergency patients between outlying sites or home and the general hospitals.
- The accuracy of information provided to WAST by staff is critical. When a nurse is not sure, but suspects e.g. a hip fracture, they should say so explicitly as this additional information can impact the grading of the call. The Coroner suggested additional training could be provided in relation to this issue.

3. **Key Risks / Matters for Escalation**

The Health Board utilises the Datix Cymru system to record its inquest case management. Significant developments have been undertaken on an All Wales basis to improve the information that is captured within the Datix Cymru system, specifically in relation to lessons learned.

Work continues to be undertaken internally to improve the data accuracy and consistency. This will enable the Health Board to enhance the reporting arrangements for themes and trends arising from inquests.



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 (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) / Link to Enablers of Quality (<i>Duty of Quality Statutory Guidance (gov.wales)</i>)	Learning, Improvement & Research
	If more than one applies please list below:
Dolen i Feysydd Ansawdd (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) / Link to Domains of Quality (<i>Duty of Quality Statutory Guidance (gov.wales)</i>)	Safe
	If more than one applies please list below:
	Effective Timely
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / Quality</i>	Yes: ☒	No: ☐
	Outcome: This report outlines Inquest Activity one of the key areas of quality across the Health Board.	If no, please include rationale below:



<i>Have you undertaken a Quality Impact Assessment Screening?</i>		
Cydraddoldeb a'r Gymraeg <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /</i> Equality and Welsh Language <i>Have you undertaken an Equality and Welsh Language Impact Assessment Screening?</i>	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	Yes (Include further detail below)	
	The Report relates to the Coroner's process.	
Enw da / Reputational	Yes (Include further detail below)	
	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. This includes regulation 28 reports.	
Effaith Adnoddau <i>(Pobl / Ariannol) /</i> Resource Impact <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

The Quality, Safety & Experience Committee is asked to **NOTE** the information outlined in this report.

6. Next Steps

- Continue to develop capturing and reporting of lesson learned in relation to Inquest Activity
- Further iterations of the Patient Safety and Quality Reports to include inquest related information.



Agenda Item

7.3

Quality, Safety & Experience Committee

Highlight Report from the Health, Safety & Fire Sub Committee

Dyddiad y Cyfarfod / Date of Meeting	25/03/2025
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	Dilys Jouvenat, Independent Member
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 24 January 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 /	Fire Safety: • <i>Storage of Equipment in Corridors presenting a Fire Risk</i> - The Committee expressed concerns in relation to any potential disregard of fire safety procedures as a result of equipment being stored in fire exit routes or fire doors being inappropriately propped open. The Committee sought assurance that similar to the action taken to address this in Prince Charles Hospital, with the introduction of environmental walkarounds by Senior Team Members, that other Care Groups had similar interventions and that future assurance on this matter be captured in Care Group update reports following consideration at the Operational Management Board. • <i>Risk of onboarding in Corridors blocking Fire Escape Routes</i> - The Committee sought urgent assurance that this risk continues to be mitigated. The Executive Director for People advised that such risks should be escalated through operational escalation routes and stressed that he would explore this further immediately after the meeting with a visit to site, in order to seek assurance that this risk is being



	managed and that appropriate escalation processes are being followed. Suitable Training Environments – the Committee were concerned to note that compliance in manual handling training is being impacted by the availability of suitable, safe and available training environments across the CTM estate. Listening and Learning Story – Violence and Aggression Incident – The Committee welcomed the learning from the response to incidents at the Intensive Care Unit in Prince Charles Hospital and the collaborative work in the clinical areas which has resulted in a number of actions which will reduce the severity and likelihood and future incidents. It was noted that training in acute delirium and clinical holding will effectively reduce violent incidents within Critical care. In response, to the positive work of the team, the Committee were concerned that medical workforce engagement could be further improved and suggested that this is brought to the attention of the Clinical/Medical Executive colleagues. Visibility of Estates Risks – The Committee requested that the Estates Directorate revisit their local Estates Risk Register to consider if any risks held locally require escalation to the Organisational Risk Register, attention was drawn to the risk in relation to backlog maintenance and it was suggested whether this risk should be considered for escalation due to its wider organisational impact. Positive Escalation: in response to the roof replacement works at Princess of Wales Hospital, and its delivery against the project timescales, the Fire Enforcement Notice for the hospital was lifted by South Wales Fire and Rescue Service on the 31 December 2024.
Advise	Extreme Fire Risks – to fully understand the context of the extreme fire risks presented to the Committee, under the Fire Safety Report, further assurance was sought as to the mitigation that was being taken, the process of escalation through operational routes and their consideration for further escalation as required e.g. to the organisational risk register. Organisational Risk Register – the Committee noted the updates contained within the report and a wider action was agreed in terms of considering whether all Estates and Fire risks have been escalated as appropriate to ensure Board visibility.

	Chief Operating Officer – Overarching Report – the following key updates were noted: • Progress on the works in response to the critical incident at Princess of Wales hospital. • Facilities update in terms of the Adverse Weather Plan, changes to the Car Parking at the Royal Glamorgan Hospital, Pest Control Interventions, Security Management and Systems upgrades to CCTV and Estate Tree management. Health and Safety Report from the Primary Care and Community Care Group – the key highlights brought to the Committees attention related to the following: • Drainage Problem in Ysbyty Cwm Cynon – with works underway to remedy areas requiring immediate attention. • Alternative accommodation is being sourced for the Vaccination and Immunisation Service delivering from Ysbyty George Thomas Hospital since the additional 2 wards (Fernhill and Dinas) have been opened to support the decant from Princess of Wales Hospital. An option has been identified and will be finalised by the end of January 2025 in order to facilitate the reinstatement of the dining room on site. Health and Safety Report from the Mental Health & Learning Disabilities Care Group - the key highlights were brought to the Committees attention: • Ongoing challenges with internal door security at Ty Llidiard which are being managed by the operational management team with support from the Estates Directorate to ensure appropriate mitigations are in place. • Smoking Policy Implementation – It was noted that despite the policy shift, incidents of patients smoking, or vaping have continued, particularly during adverse weather when patients gather in sheltered areas, however, the Committee noted that the Care Group are positively and actively supporting adherence and seeing improvements with the improvement actions being implemented, such as the tannoy system outside the main entrance to the Mental Health Unit at the Royal Glamorgan Hospital.
Assure	Health and Safety Executive (HSE) Involvement – the Committee were informed that there are currently no active HSE investigations in place in the Health Board. It was noted that the HSE are planning to inspect 30 NHS bodies annually, with this year having a focus on compliance with manual handling and violence and aggression risks. CTMUHB have not received confirmation as to whether they will be subject to inspection in these areas yet.



	CTM Face-Fit Team – the Committee were delighted to note the work of the “Face-Fit” team who were now operational and have to date “Face fit tested” more than 1200 staff. For future reports Members sought further information as to the level of compliance across the Health Board and the remaining number of staff still requiring this service. Training Format – the Committee commended the Health, Safety and Fire Team for their innovative approaches to health and safety updates, utilising a “7-minute briefing” approach and introducing Podcasts. Manual Handling Training – the Committee were pleased to note that compliance had improved now there is a full establishment of manual handling training provision across the Health Board.
Inform	The following items were approved/noted via the consent agenda: Unconfirmed Minutes of the meeting held on 5 September 2024 – Approved.
Appendices	Not applicable

3. 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)) /	Not Applicable
	If more than one applies please list below:



Link to Domains of Quality (Duty of Quality Statutory Guidance (gov.wales))	
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
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
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 2 of this report.

Agenda Item	8.1.1

Unapproved Minutes of the Quality, Safety & Experience Committee

Date and Time of Meeting	Tuesday 21 January 2025 at 09:30am
Venue	Virtually via Microsoft Teams

Members Present	Carolyn Donoghue	Independent Member (Committee Chair)
	Kath Palmer	Vice Chair (Committee Vice Chair)
	Hayley Proctor	Independent Member
	Patsy Roseblade	Independent Member
In Attendance	Dom Hurford	Executive Medical Director (In part)
	Gethin Hughes	Chief Operating Officer (In part)
	Lauren Edwards	Executive Director of Allied Health Professionals & Health Sciences (In part)
	Philip Daniels	Executive Director of Public Health (In part)
	Richard Hughes	Deputy Director of Nursing (In part)
	Nigel Downes	Assistant Director of Quality & Safety (In part)
	Sallie Davies	Deputy Medical Director
	Becky Gammon	Assistant Director of Nursing and Peoples Experience, Corporate Nursing (In part)
	Ceri Bear	Llais Cymru Representative
	Emma James	Care Group Nurse Director, Unscheduled Care
	Gaynor Jones	Staff Side Representative
	Lucie Owen	Care Group Nurse Director, Primary & Community Care (In part)
	Ana Llewellyn	Care Group Nurse Director (In part)
	Sharon O'Brien	Care Group Nurse Director, Planned Care

	Lisa Jenkins	Clinical Lead, Serious Incidents and Complex Concerns (In part)
	Leah Panniers	Head of Nursing Children & Young People
	Carl Verrecchia	Care Group Service Director, Children & Young People
	Susan Reed	Tissue Viability Specialist Nurse (In part)
	Claire O Keefe	Head of Safeguarding (In part)
	Cally Hamblyn	Assistant Director of Governance & Risk
	Emma Walters	Head of Corporate Governance & Board Business (Secretariat)
Meeting Observers	Janet Gilbertson	Assistant Director of Clinical Education
	Rhiannon Dubberley	Graduate Trainee Manager
	Andrea Davies	Head of Mental Health Psychology

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. The Committee Chair advised that as a result of pressures in the system resulting in Executive Directors having to attend a Gold Command meeting at 11.30am, there would be some changes to the running order of the agenda today to enable Clinical Executives to be available to present on their items.
1.2	Apologies for Absence
	Apologies for absence were received from: • Greg Dix, Executive Director of Nursing/Deputy CEO; • Suzanne Hardacre, Director of Midwifery; • Mary Self, Care Group Clinical Director.
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 – Adult Mental Health Services
	Members noted that the Listening & Learning story item was shared at the In Committee session held prior to this meeting. Members noted that this was as a result of the patient requesting that their story was not published in the public domain.
5.	SETTING THE SCENE – SERVICE DELIVERY
5.1	Thematic Spotlight Presentation – Welsh Ambulance Services NHS Trust (WAST) joint investigation framework thematic review
	L Jenkins shared a presentation and highlighted the key matters for Members attention. The Committee Chair extended her thanks to L Jenkins for sharing the comprehensive presentation which showed the complexity of the issues and the number of actions being undertaken to address the issues. R Hughes extended his thanks to the Team for the work undertaken in this area and added that he had seen positive collaboration between WAST and CTMUHB, which involved discussing difficult and complex stories in regard to cases which had experienced significant delays and identifying the lessons learnt in regard to how cases could have been handled better. Members noted that tangible learning had been gained from undertaking the thematic review. E James advised that she was part of the Multi-Professional Team that undertakes the joint investigations and also extended her thanks to L Jenkins and the Team for their support in this area. E James recognised the importance of learning lessons from this activity, such as reflecting on a significant amount of patients that may not need to have been conveyed to hospital. As a result of this, part of the feedback included the need to ensure that advanced care planning was in place alongside engagement with primary care, with feedback being shared with the End of Care Life Board in regard to specific cases. Members noted that WAST had also refined some of their processes as a result of this review. K Palmer reinforced the importance of this activity, commenting how it was also an area of focus for the Vice Chairs, particularly in relation to sharing of good practice. Members noted that the Vice Chairs had received a presentation from the Health Board and had welcomed the work undertaken, which included the development of the Navigation Hub. K Palmer referred to a walk round she had undertaken of the Emergency Department at the University Hospital of Wales in



	Cardiff and added that she was impressed with the pilot they were undertaking of the e-triage system and encouraged colleagues to visit the department to look at the system in operation. K Palmer further expressed the importance of ensuring a whole system approach was being taken and added that this should not be an issue solely for the staff within the Emergency Department to resolve. P Roseblade made reference to a report that had previously been received by the Committee in relation to a WAST produced quality report, which enabled Independent Members to triangulate information between both organisations. P Roseblade advised that she would find it helpful if this report could be provided to Committee Members moving forwards. P Roseblade commented on the important role that Paramedics undertake in terms of the appropriate conveyance of patients into hospital, which appears to have been further strengthened with the requirement to have more medical experience. She queried whether there was an understanding as to the level of acuity, which would be helpful to understand compared to previous years. P Roseblade drew attention to the area of the presentation which suggested that there were no targets for Amber, Amber one and Green and clarified that whilst there were targets for these areas, they were not nationally reportable, which is important for the Committee to note. A Llewellyn advised that given that this item had generated a significant discussion, she queried whether this item needed to regularly report to future meetings of the Committee. The Committee Chair advised that she would give further consideration to the frequency of reporting on this matter outside the meeting. P Roseblade supported this suggestion on the basis that reports were being received at the Hosted Bodies Audit, Risk & Assurance Committee that ambulance response times were at the highest critical risk of 25, which the Health Board needed to recognise was a very high risk to the Health Board's patient population. R Hughes advised that he would welcome further discussion on this with the Committee Chair to determine what level of information needed to be presented to the Committee moving forwards.
Resolution:	The presentation was NOTED .
Action:	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 Analysis to be undertaken as to whether the newer more medicalised paramedics were conveying more appropriate patients into hospitals. Understanding required on the level of acuity, in comparison to previous years. 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
5.2	Report from the Clinical Executives



This item was taken after the Stroke Services Update Report.

R Hughes and colleagues presented the report and highlighted the key matters for Members attention.

P Roseblade referred to visiting times review and queried whether the patients' visitors impacted on the ability of nurses to provide patient care, and she sought clarity on the intended outcome measures. R Hughes advised that in relation to the impact visiting has on patient care, a review was being undertaken of the busiest times on the wards when direct patient care was required, and added that there was evidence in place that showed that introducing longer visiting times within a ward setting, which was specialty dependent, may enhance care and improve the emotional wellbeing of patients. R Hughes advised that the driver behind this review was the significant variation across the sites in relation to visiting times which has resulted in the need for a review to be undertaken.

P Roseblade referred to the Professional Head of Radiography appointment and queried whether this was an additional post or a rearrangement of the existing team to create this position. L Edwards advised that the creation of this post was a repurposing of existing resource which would allow for a single oversight to be in place across all three sites.

P Roseblade referred to the Winter IPC Pressures section of the report and in particular flu and sought clarity as to whether many of the patients who had been hospitalised or treated for flu had been vaccinated. P Daniels confirmed that the Health Board were seeing some vaccinated individuals contracting flu, which was expected in older individuals and individuals who had a poor immune response to the vaccine. Members noted that the position was being audited, and data was being collected, which would be analysed by the UK Health Security Agency, with an interim report being shared early Summer and the full report being shared during the Autumn.

P Roseblade referred to the Handover guidance that had been updated by the Welsh Ambulance Services NHS Trust and queried whether the Health Board had any input into the development of this. G Hughes confirmed that the Health Board had engaged in the development of this guidance.

H Proctor referred to the staff survey undertaken this year which had received a positive response and added that she would welcome increased visibility as to the actions taken in response to the survey outcomes and feedback from previous years. L Edwards advised that a Board Development session was held on this matter where it was agreed that some key priorities would be identified that could be focussed on by every team and added that she would be happy to obtain an update on the current status of this activity. L Edwards also acknowledged that it would be helpful to ensure there is clear communication that could be shared with staff on progress being made on the key priority areas.

	B Gammon advised that in relation to the staff survey, a regular monthly meeting was being held, which was being led by the Employee Experience Lead and attended by service leads and staff side representatives, to discuss the outcome of last year's staff survey, identifying themes and developing an action plan in order to help influence some of the changes required. The Committee Chair advised that it was important for the Committee to be aware of what the outcomes were of key pieces of work. The Committee Chair drew attention to the positive work highlighted within the report in regard to medical staff productivity and questioned whether the learning was being shared with other Care Groups. D Hurford advised that learning was being shared via the Performance and Escalation Group which sits within the Medical Workforce Productivity Programme. The Committee Chair also noted the positive updates shared in relation to the nurse of the year awards and the improvements that had been made in the Physiotherapy Rehabilitation service.
Resolution:	The report was NOTED .
Action:	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.
5.3a	Children & Families Care Group Highlight Report
	C Verrecchia presented the report and highlighted the key matters for Members attention. D Hurford advised that Dr Deekollu was stepping down as the Clinical Director for Paediatrics and advised that it would be important for the Committee to acknowledge the difference he made and all that he achieved, particularly in relation to the development of the Neonatal programme. The Committee Chair advised there appeared to be a recurring theme identified within the reports which highlighted the impact to the health and wellbeing of staff involved in moves to other areas and sought assurance as to how this is being managed. D Hurford advised that the impact the changes had on all staff professions could not be underestimated and added that whilst most staff appreciated the reasons why the moves were required, further consideration needed to be given as to how Teams were supported to help manage the impact of the changes.
Resolution:	The report was NOTED.
5.3b	Unscheduled Care Group Highlight Report
	E James presented the report and highlighted the key matters for Members attention.



	The Committee Chair welcomed the positive areas that had been highlighted within the report, which included the positive response to audits.
Resolution:	The report was NOTED.
5.3c	Planned Care Group Highlight Report
	S O'Brien presented the report and highlighted the key matters for Members attention. The Committee Chair recognised the pressure that staff were working under, particularly within areas of critical care. The Committee Chair referred to the Cancer Harm Reviews and the statement made within the report that additional support was required, which she would welcome some further detail on. S O'Brien advised that this had been an ongoing challenge for the Cancer Board in relation to harm reviews. Members noted that there were very few harm reviews from the delays in treatment and due to the timeframes that were put into place nationally, there was a subsequent increase in the number of harm reviews that needed to be undertaken. S O'Brien advised that now the timeframe had reduced, this had reduced the workload, and the Cancer Lead was now reviewing the backlog of incidents which was taking some time to address. Members were provided with assurance that the level of harm and risk of harm was minimal.
Resolution:	The report was NOTED.
5.3d	Mental Health & Learning Disabilities Care Group Highlight Report
	A Llewellyn presented the report and highlighted the key matters for Members attention. P Roseblade sought clarity on the nature of Ministry of Justice involvement in Mental Health Services, how medical staffing challenges were impacting on this and steps taken to address this issue. A Llewellyn advised that patients who were detained under some sections of the Mental Health Act are subject to Ministry of Justice restrictions to protect the public. Members noted that the Ministry of Justice periodically write to individual Consultant Psychiatrists to ask for updates on their patients and it had come to the attention of the Care Group leadership team that there had been a delay in submitting these reports in a small number of cases. A Llewellyn advised that the Care Group is in the process of implementing a new monitoring system so that the oversight of updates is no longer solely dependent on individual Consultant Psychiatrists. P Roseblade referred to the reported issue of transportation of patients who currently required police support and questioned whether staff were at risk because of this issue. A Llewellyn advised that this related to Phase Three of Right Care, Right Person and added that it was understood that the Police service would no longer be conveying patients from their homes to a place of safety within a Mental Health establishment. Members noted that the Joint Commissioning Committee were responsible for commissioning Emergency and Non-Emergency patient transport and noted that further clarity was still required

	on the national arrangements for Phase Three conveyance. A Llewellyn advised that the Health Board was working with all relevant bodies, including the Welsh Ambulance Services NHS Trust to explore options. K Palmer referred to the workforce issues which had previously been highlighted, recognising the increased urgency and expressed the need for a review to be undertaken regionally as to how this could be addressed. She also drew attention to Right Care, Right Person, and advised that whilst implementation of Phase Three had been extended to March 2025, this still presented a risk in relation to the ability to address any issues prior to implementation. A Llewellyn advised that whilst this was an area of risk, the Health Board was engaging with all relevant parties and added that there was a national Police workshop taking place on 7 February 2025 where concerns would be escalated. Members noted that the Police would be unable to refuse to convey patients to hospital until revised conveyance arrangements were put into place. The Committee Chair thanked A Llewellyn for the update and suggested that this matter was included as an area of concern within the Highlight Report to Board.
Resolution:	The report was NOTED.
Action:	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
5.3e	Primary & Community Care Group Highlight Report
	L Owen presented the report and highlighted the key matters for Members attention. K Palmer welcomed the fantastic progress that was being made within a number of areas within Primary Care and Community, particularly in relation to Parc Prison and the wound clinic bus which was supporting homeless people. K Palmer also referred to dental services and advised that she would welcome an update on the work being undertaken on Dental Services to a future meeting of the Committee. L Owen advised that she would be happy to provide an update report on this matter. The Committee Chair advised that this would be discussed further at the next agenda planning meeting. The Committee Chair referred to the Outpatients service at Maesteg Hospital and the delays in regard to the confirmation date of the move and sought clarity as to what the latest position was. L Owen advised that this would be discussed further with the Planned Care Group Nurse Director in the next week and advised that an update on the position would be included in the March Highlight Report.
Resolution:	The report was NOTED.
Action:	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 regard to scheduling the item for discussion



5.3f	Diagnostics, Therapies, Pharmacy & Sciences Care Group Highlight Report
	S Bolt presented the report and highlighted the key matters for Members attention. The Committee Chair welcomed the update provided in relation to the success of the Snowdrop Centre and added that this was a positive example of a good model of care moving forwards.
Resolution:	The report was NOTED.
5.4	Stroke Services Update
	This item was taken immediately following the Quality dashboard report G Hughes presented the report and highlighted the key matters for Members attention. G Hughes extended his thanks to staff for their flexibility during these temporary service moves. The Committee Chair advised that she felt this was a helpful report and added that it was evident that this was a significant issue for everyone, particularly this Committee which had discussed issues in regard to stroke at several meetings. G Jones queried whether the Health Board had experienced a sudden loss of Stroke Physicians, given that prior to the issues experienced with the roof at the Princess of Wales Hospital, a stroke service was being run at Princess of Wales and Prince Charles Hospitals, and added that the Health Board could now only run one service at the Royal Glamorgan Hospital site. G Hughes confirmed that some Consultant resource had been lost recently at both the Prince Charles and Princess of Wales Hospitals, which had resulted in the Consultant body advising that they could not sustain the service at that point on 2.8 WTE over two sites. G Jones expressed concern on behalf of the Trade Unions in the way in which staff were informed, which she considered was not acceptable and caused a significant amount of upset and anxiety for staff. G Jones added that she was also concerned that there was now an empty ward (Ward 10) at Prince Charles Hospital, and an increase in beds from 12 to 18, with no substantive staff to staff the ward, which she felt would result in an increase in anxiety for staff. G Hughes recognised that this was unfortunate and added that the fundamental challenge for the Health Board was that it was already running at 75 beds less because of the roof issues at the Princess of Wales Hospital and it was evident that the Health Board could not sustain a further 20 bed reduction. G Hughes advised that the Health Board needed to ensure it had the right plan in place to ensure that the right skills of staff were with the right patients. E James advised that the Care Group had been working with Trade Union colleagues on this matter and added that the Care Group were responsive to the



	patients that were left behind after the move that did not need to move along with the Stroke Service. E James added that there was a need for the Care Group to continue to run the ward area that was now un-commissioned at Prince Charles Hospital and advised that the Head of Nursing and the Site based Unscheduled Care Team were working through how the position could be stabilised with some workforce and designing a service that was appropriate and safe for patients and staff in order to limit the further loss of beds. G Jones expressed concern that given that Prince Charles Hospital already had the highest number of vacancies, she did not want staff feeling so unhappy that they were looking to move to jobs in neighbouring organisations. G Jones added that the Health Board needed to be mindful as to how staff were feeling and to provide them with as much support as possible. K Palmer advised that whilst she fully appreciated that this was a challenging time, she sought clarity as to where the patient experience element was being considered given that some patients would have been moved further away from their home. G Hughes advised that a process had been put into place to capture patient experience. E James advised that the Care Group had received support from the Patient Advice Liaison Service (PALS) and Chaplaincy Service who had multiple conversations with patients and their relatives before the moves took place which helped to mitigate any early concerns. Members noted that the PALS service would also be supporting the Care Group with capturing the patient experience following the move. Members noted that further updates on this matter would be included in future Care Group Highlight Reports within the Stroke Services section. G Jones advised that the Health Board had been supportive of staff that had moved from Prince Charles to Royal Glamorgan Hospital, with transport provided for the first six weeks along with the allocation of travel time, which was positive. The Committee Chair referred to the status of the outpatient service and sought clarity as to the timescales for the regional piece of work being undertaken around Stroke Services. G Hughes confirmed the Southeast Wales Stroke Programme Board was not currently working at a desired pace. Members noted that the Health Board were working closely with Cardiff & Vale University Health Board to expedite decisions linked to the programme, which would be subject to an engagement process. In relation to the outpatient service, G Hughes advised that the Health Board was continuing to provide as much access as locally as possible, which was dependent on the number of sessions of doctor time available, with support being sought from Cardiff & Vale University Health Board to provide this.
Resolution:	The report was NOTED.
6.	DELIVERING OUR PLAN
6.1	Patient Safety, Quality and Experience Dashboard
	This item was taken as the first item after the Action Log and Matters Arising items.



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

G Jones referred to medication errors and sought clarity as to whether any trends had been identified in relation to the types of medication errors being recorded and if so, what was being undertaken to mitigate the circumstances. D Hurford advised that he had undertaken a review of the position with the Chief Pharmacist and advised that no pattern or trend was identified from that review. Members noted that most of the errors related to poor handwriting being misunderstood and misinterpreted and was not limited to one particular type of medication. D Hurford added that work would continue to be undertaken to review the position and advised that the numbers of errors was small compared to the volume of medication that was being prescribed across the Health Board daily.

R Hughes reminded Members that they had previously supported the new process in regard to the Harm Free Care agenda and advised that this would be the first month that a report on Harm Free Care would be submitted to the Improving Care Board, with a bi-annual update on the work being undertaken to be presented to a future Committee meeting. The Committee Chair advised that Committee Members would welcome this report given that falls and pressure sores had been a cause for concern and Members would wish to see the impact of the work that was being undertaken.

K Palmer referred to Duty of Candour and queried whether the data could be separated out into Primary and Secondary Care. N Downes advised that he would explore outside the meeting whether it would be possible to split the data.

K Palmer also referred to the Patient Experience Report at Appendix A and recognised the value of listening to case studies and added that it would be helpful to hear how and if the Patient Experience Team picked up on any case studies. R Hughes advised that the Patient Care & Safety Team were currently engaging with Internal Audit who were undertaking a review on Patient Experience, which was focussing on the services provided and processes in place in relation to data and assurance. Members noted this report would be presented to a future meeting of the Committee once finalised.

H Proctor made reference to medication errors, pressure sores and falls and queried whether some of these issues could be equated to staff stress and burnout and queried whether there would be any data available to determine whether there was any correlation, which may become more evident in the staff survey results once available. D Hurford advised that he would hope that the staff survey results would identify if there were any issues of this nature and added that there had not been a spike in the number of incidents reported and there had been more of a gradual trend. N Downes confirmed that the trend was quite stagnant, with some peaks and troughs at certain points in the year, particularly post the summer period.



	G Hughes advised that it may be helpful to undertake a review of staff fill rate on certain shifts and number of incidents to determine if there was a correlation. R Hughes confirmed that this data would be presented to the Improving Care Board from a quality improvement approach perspective and added that this would then feed into the Quality, Safety & Experience Committee through usual reporting processes. S O Brien advised that as part of the Nurse Staffing Act on the 25a and 25b wards key quality metrics were being captured on Safe Care in regard to falls, pressure ulcers and medication errors. Members noted that when this information is recorded on Datix, nursing staff can indicate whether they deemed that the incident was because of the reduced funded establishment. Members noted that the same process was being followed for Complaints and that this information was being reported to Welsh Government on an annual basis. S O'Brien added that themes and trends were being monitored, with actions being taken forward if any issues were being identified. The Committee Chair advised that she found this encouraging that appropriate action was being taken once themes had been identified. The Committee Chair referred to page 6 of the report where it had been reported that an incident had been open for 160 days. N Downes advised that incidents were being reviewed regularly to determine whether incidents can be closed.
Resolution:	The report was NOTED .
Actions:	Bi-Annual update on the work being undertaken by the Harm Free Care Board to be presented to a future meeting. Internal Audit Review of Patient Experience to be presented to a future meeting of the Committee Exploration to be given as to whether the Duty of Candour data can be split into Primary and Secondary Care
7.	GOVERNANCE, RISK AND ASSURANCE
7.1	Organisational Risk Register – Risks Assigned to the Quality & Safety Committee
	C Hamblyn presented the report and highlighted the key matters for Members attention. The Committee Chair recognised the gaps in updates against some risk areas and noted that this was because of staff dealing with unprecedented pressures at present, but that there was commitment to ensure risks were reviewed as soon as possible where review dates had passed
Resolution:	The report was REVIEWED and CONSIDERED.
7.2	Mortality Indicators and Mortality Reviews

	S Davies presented the report and highlighted key updates for Members attention. P Roseblade referred to the 18 cases that were awaiting review by the Stage 3 Mortality Review Panel and questioned whether families were having to wait until these reviews were completed before funerals could be arranged for family members. S Davies confirmed that families were only required to wait until the Medical Examiner had undertaken their review and did not have to wait for a review to be undertaken by the Mortality Review Panel. P Roseblade sought clarity as to whether the process between the Medical Examiner and the Hospital was duplicating the work and queried whether there were ever any differences of opinion on cause of death between the Health Board and the Medical Examiner. S Davies advised that there were not often any serious disagreements given that cases were presented to the Medical Examiner prior to being shared with the Health Board and added that if there were disagreements these were resolved by discussions between both services.
Resolution:	The report was NOTED.
7.3	Safeguarding Strategy 2024 - 2027
	C O Keefe presented the report and highlighted the key matters for Members attention. P Roseblade referred to a previous safeguarding incident that occurred in Bridgend where there had been missed opportunities to identify safeguarding issues with a child given that staff felt they were unable to speak out against the Paediatric Consultant at the time. P Roseblade sought clarity as to whether if this Strategy had been in place at the time, would it have helped to prevent the issues that were there at the time. C O'Keefe advised that having a full Cwm Taf Morgannwg approach to safeguarding would help to minimise the differences in practices that were being seen at that time. Members noted that the arrangements within Bridgend had been strengthened from a partnership perspective and within the Health Board. S Davies added that excellent work had been undertaken by the Safeguarding Team to ensure that issues experienced previously do not re-occur. P Roseblade referred to page four of the policy and the long paragraph relating to 'Embedding a Robust Safeguarding Culture to Prevent Abuse and Harassment' and advised that it was not clear as to whether this was referring to protecting members of staff or patients and members of the community from abuse or harassment. C O'Keefe confirmed that this was in relation to protecting staff and all patients, both adults and children.
Resolution:	The Strategy was ENDORSED for BOARD APPROVAL.
7.4	Pressure Ulcer Prevalence Audit 2024

	S Reed presented the report and highlighted the key matters for Members attention. H Proctor extended her thanks to S Reed for sharing the presentation and advised that this was something that was really needed within the Health Board and expressed the importance of ensuring funding was in place for appropriate equipment, particularly slide sheets, to be provided to staff to assist them in caring for patients and to limit the development of pressure ulcers. K Palmer also extended her thanks to S Reed for presenting a comprehensive update on an important and serious area. K Palmer advised that she was surprised to see the number of patients who were admitted into the Health Board with a pressure sore and queried whether a wider campaign needed to be undertaken on this. She also sought clarity as to whether there was awareness as to what settings patients were developing pressures sores in, care homes for example. She further added that in relation to patients sitting in chairs, she was aware that given the recent pressures, more patients were being placed in chairs whilst awaiting treatment. S Reed provided assurance that the Tissue Viability Team within the Health Board had positive relationships in place with Care Homes and added that whilst Care Homes did not currently have a mechanism in place for recording incidences of pressure sores, they did have good governance and assurance arrangements in place regarding this. S Reed added that it was often difficult to track back to the origin of the setting in which patients had developed pressure sores. The Committee Chair suggested that the issues highlighted in relation to equipment and data were included in the Committee Highlight report to Board, given its significance to patient harm, cost and staff time. B Gammon referred to the Primary Care collaborative that was underway? with the Improvement Team around pressure ulcer care which was being dovetailed with the work being undertaken by the Pressure Ulcer Annual Audit Steering Committee. B Gammon advised that the reason a decision had been made to undertake an audit of the Emergency Department, was to determine whether patients were coming into hospitals with pressure sores and from what environments they were being admitted from, to direct training into the most appropriate areas. B Gammon advised that in relation to finances, a review was being undertaken as to how much was being paid out on claims and redress. The Committee Chair extended her thanks to S Reed for sharing the presentation on this fantastic piece of work.
Resolution:	The report was NOTED.
Action:	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.
8.	CONSENT AGENDA
8.1	FOR APPROVAL
8.1.1	Unconfirmed Minutes of the meeting held on 19 November 2024

Resolution:	The Minutes were APPROVED
8.1.2	Unconfirmed Minutes of the In Committee meeting held on 19 November 2024
Resolution:	The Minutes were APPROVED
8.1.3	CTM Learning Academy
Resolution:	The report was APPROVED
8.1.4	Estates Policies This item has been deferred to the meeting taking place on 25 March 2025 (to include the Asbestos Management Plan, Water Safety Plan, Medical Gases Policy and Ventilation Policy)
8.2	FOR NOTING
8.2.1	Non-Routine Committee Business (Forward Plan)
Resolution:	The Forward Plan was NOTED
8.2.2	Committee Annual Cycle of Business 2025
Resolution:	The Annual Cycle of Business was NOTED
8.2.3	Report from the Medicines Safety Group
Resolution:	The report was NOTED
8.2.4	Human Tissue Act (2004) Compliance and Progress Report
Resolution:	The report was NOTED
8.2.5	Joint Commissioning Committee Quality & Patient Safety Committee Chairs Report
Resolution:	The Report was NOTED
8.2.6	Healthcare Inspectorate Wales Improvement Plan Tracker Report
Resolution:	The report was NOTED
8.2.7	Cwm Taf Morgannwg University Health Board Infant Feeding Strategy 2025-2030
Resolution:	The report was NOTED
9.	CLOSE OUT BUSINESS
9.1	Committee Highlight Report to Board - Verbal
	C Hamblyn advised that she had been populating the Highlight Report throughout the meeting and added that she would share the report with Members immediately following the meeting for approval. C Hamblyn sought confirmation as to whether Members were content to include the concerns raised in relation to pressure ulcers and equipment issues in the assure section and the concerns raised in regard to the delays in the implementation of Phase three Right Care, Right Person had been noted in the



	assure section also. The Committee Chair and Vice Chair requested that the concerns raised in relation to pressure ulcers and equipment were included in the alert/escalate section.
9.2	Meeting Feedback
	The Committee Chair extended her apologies for the meeting disruption in regard to the order agenda items were taken and added that she would be happy to receive further feedback outside the meeting.
10.	Private / Closed Session Business
	The following item was discussed at the In Committee session held prior to this meeting: Listening & Learning Story – Adult Mental Health Services.
11.	DATE AND TIME OF NEXT MEETING
	The next meeting take place on Tuesday 25 March 2025 at 9:00am.



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

Date and Time of Meeting	Tuesday 21 January 2025 at 08:45am
Venue	Virtually via Microsoft Teams

Members Present	Carolyn Donoghue	Independent Member (Committee Chair)
	Kath Palmer	Vice Chair (Committee Vice Chair)
	Hayley Proctor	Independent Member
	Patsy Roseblade	Independent Member
In Attendance	Dom Hurford	Executive Medical Director
	Gethin Hughes	Chief Operating Officer
	Lauren Edwards	Executive Director of Allied Health Professionals and Health Sciences
	Philip Daniels	Executive Director of Public Health
	Richard Hughes	Deputy Director of Nursing
	Sallie Davies	Deputy Medical Director
	Clare Yates	Lead Nurse, Adult Unscheduled Care, Mental Health
	Ana Llewellyn	Care Group Nurse Director
	Cally Hamblyn	Assistant Director of Governance & Risk
	Emma Walters	Head of Corporate Governance & Board Business
Meeting Observers	There were no meeting observers.	

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 for absence were received from: Greg Dix, Executive Director of Nursing/Deputy CEO
1.3	Declarations of Interest



	There were no interests declared.
2.	MAIN AGENDA
2.1	Listening & Learning Story – Experience of Care received from the Adult Mental Health Service A Llewellyn shared a video and presentation which related to a patient's experience of care received from Adult Mental Health Services. Members welcomed the story and expressed the importance of recognising lessons learned. Members noted that work had been undertaken in regard to training people with lived experience which had made a significant impact. Members noted that whilst there was confidence in place that the right clinical decisions were being made in regard to diagnosis and treatment within inpatient settings, further work needed to be undertaken on ensuring the right clinical decisions were being made within Emergency Department settings. The Committee Chair extended her thanks to A Llewellyn and C Yates for sharing the story and added that she would welcome a further update at a future meeting which demonstrated the impact of the lessons that had been learnt.
Resolution:	The presentation was NOTED.
Action:	Update to be presented at a future meeting which demonstrated the impact of the lessons that had been learnt.
3.	ANY OTHER BUSINESS
3.1	Regulation 28 Report D Hurford provided Members with a verbal update in relation to a Regulation 28 report that had been shared with Board Members by email. Members noted that a review of the case had been undertaken by the Deputy Director of Nursing and Assistant Director of Quality & Safety. D Hurford agreed to keep Committee Members updated on this matter.
4.	DATE AND TIME OF NEXT IN COMMITTEE SESSION - TO BE CONFIRMED



Agenda Item

8.1.3

Quality, Safety & Experience Committee

Policy for the Asbestos Management Plan

Dyddiad y Cyfarfod / Date of Meeting	25/03/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Christopher Lewis, Assistant Head of Assets, Governance & Technical Services
Cyflwynydd yr Adroddiad / Report Presenter	Sally May, Executive Director of Finance
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Sally May, Executive Director of Finance

Pwrpas yr Adroddiad / Report Purpose	For Approval

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Asbestos Advisory Group - Approved	10/10/2024	ENDORSED FOR APPROVAL
Health, Safety & Risk Group	26/09/2024	ENDORSED FOR APPROVAL
Capital and Estates Governance Board	18/11/2024	ENDORSED FOR APPROVAL
Sharepoint Consultation	14/02/2025	ENDORSED FOR APPROVAL

Acronyms / Glossary of Terms

ACM	Asbestos Containing Material
AMP	Asbestos Management Plan
CAR	Control of Asbestos Regulations

1. Situation / Background

- 1.1 Under the Control of Asbestos Regulations (CAR) 2012 Cwm Taf Morgannwg University Health Board has a legal duty to manage asbestos in its non-domestic premises.
- 1.2 This Asbestos Management Plan (AMP) sets out the responsibilities and procedures to ensure the safe management of asbestos present in any of the buildings owned, leased or otherwise used by the organisation and its staff, patients and visitors.

2. Specific Matters for Consideration

- 2.1 Engagement on this Policy and Procedure has taken place with:

Name Title	Date Consulted/Completed
Equality Impact Assessment	04/11/2024
Informal Consultation with interested parties	Through the groups listed on page 1
Formal Consultation	Through the groups listed on page 1
Committee – For approval	This stage

- 2.2 The policy has been reviewed and is consistent with the approach across NHS Wales / legislation.
- 2.3 The Chief Executive has overall accountability for health and safety including asbestos within the Health Board. They shall ensure that sufficient resources are allocated to meet the objectives of the Asbestos Management Plan in order to minimise the risk of exposure to asbestos, of staff, patients, visitors and anyone engaged to carry out work in the Health Board's premises.
- 2.4 The Health Board's Asbestos Compliance Officer / Manager is accountable for the implementation and updating of the Asbestos Management Plan. In conjunction with an appointed Asbestos Consultant, they are responsible for the continued management, identification and removal of ACMs to meet the requirements of the Asbestos Management Plan, CAR 2012 and all other relevant legislation.
- 2.5 Organisational values and behaviours have been reflected within the policy.



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board



3. Key Risks / Matters for Escalation

No key risks or matters for escalation to be reported or recorded at this time.

Only minor typographical amendments were made as a result of the various consultation stages.

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 (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) / Link to Enablers of Quality (<i>Duty of Quality Statutory Guidance (gov.wales)</i>)	Whole-systems Perspective
	If more than one applies please list below:
Dolen i Feysydd Ansawdd (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) / Link to Domains of Quality (<i>Duty of Quality Statutory Guidance (gov.wales)</i>)	Safe
	If more than one applies please list below:
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:
Assessment completed,
has identified no
indicators for a full QIA.

If no, please include
rationale below:

Cydraddoldeb a'r Gymraeg

*Ydych chi wedi ymgymryd â
Sgrinio Asesiad o'r Effaith ar
Cydraddoldeb 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

If no, please include
rationale below:

Outcome for Welsh
Language (delete as
appropriate): NEUTRAL

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 **approve** the Policy for the Asbestos Management Plan.

6. Next Steps

- 6.1 Once approval is sought the author will share the document with the Corporate Governance Team for publication on SharePoint and the Health Board Internet Site.

POLICY FOR THE ASBESTOS MANAGEMENT PLAN

Document Type:	Non Clinical Organisational Wide Policy
Ref:	EST03
Author:	Paul Lewis - 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:	6.0

Target Audience:

People who need to know this document in detail	All Capital and Estates management and staff, ICT management and any other managers who might employ staff or contractors working on UHB building fabric or infrastructure.
People who need to have a broad understanding of this document	Head of Health Safety and Fire, Health and Safety Co-ordinators, All Capital, Estates Primary Care, ICT, Facilities managers and any other property managers.
People who need to know that this document exists	Board Members, Management Board. Senior Leaders. Board Committees.

Integrated Impact Assessment:

Equality Impact Assessment Date & Outcome	Date: 04/11/24 Outcome: No impacts
Welsh Language Standard	
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

Disclaimer:

If the review date of this document has passed please ensure that the version you are using is the most up to date version either by contacting the author or CTM_Corporate_Governance@wales.nhs.uk



CONTENTS

	Introduction	3
1	Policy Statement	4
2	Scope of Policy and Duty holder principles	4
3	General principles	5
4	Responsibilities	6
5	Key themes	16
6	Procedure	18
7	Review, Monitoring and Audit Arrangements	22
8	Related documents	23
9	None conformance	23
10	Equality impact assessment statement	23
11	References	24
12	Types of Survey	24
Appendices		
Appendix A	Permit to Work for Asbestos Removal or Encapsulation	27
Appendix B	Organisational Structure	28
Appendix C	Key Contacts	29
Appendix D	Authority to Proceed	30
Appendix E	Risk Management Index	31
Appendix F	Accidentally Disturbed / Possibly Disturbed ACM's	32
Appendix G	Emergency Procedure Using Toolkit	33
Appendix H	Flowchart for Project Work	34
Appendix I	Flowchart for Reactive / Maintenance Work	35
Appendix J	Work with Asbestos	36
Appendix K	Approved Labels	37
Appendix L	Socotec Organisational Contacts	38
Appendix M	List of CTMUHB Duty Holder Properties	39

INTRODUCTION

Under the Control of Asbestos Regulations (CAR) 2012 Cwm Taf Morgannwg University Health Board (Health Board) has a legal duty to manage asbestos in its non-domestic premises.

This Asbestos Management Plan (AMP) sets out the responsibilities and procedures to ensure the safe management of asbestos present in any of the buildings owned, leased or otherwise used by the organisation and its staff, patients and visitors.

If asbestos has been identified in any of the premises, an Asbestos Inspection Programme will be undertaken.

It is the responsibility of the Chief Executive to ensure that all the procedures and arrangements detailed in the AMP are implemented. All relevant documentation related to these procedures and arrangements will be recorded on the MICAD web database.

This AMP must at all times be available for inspection by anyone who is liable to disturb the fabric of the building. The AMP will be hosted on the Estates Policies page in SharePoint and copied to the MICAD web database for access by contracted staff.

If there are any queries or concerns regarding the management of asbestos, the Cwm Taf Morgannwg **Estates Helpdesk** must be contacted via **01443 443210**, **internal** direct dial Rhondda & Merthyr Properties: **73210**, Bridgend Properties: **54000**.

Outside the normal working hours of 8am to 4pm Monday to Friday—contact Duty Estates Officer On-Call via the relevant Switchboard.

PCH Switchboard 01685 721721

RGH Switchboard 01443 443443

POW Switchboard 01656 752752

All CTMUHB policies must be drafted in line with and incorporating the Health Board's organisational values and behaviours available via the following link:
<http://ctuhb-intranet/dir/AtOurBest/SitePages/Home.aspx>



1. POLICY STATEMENT

- 1.1 This Asbestos Management Plan (AMP) sets out the responsibilities and procedures to ensure the safe management of asbestos present in any of the buildings owned, leased or otherwise used by the organisation and its staff, patients and visitors.

2. SCOPE OF POLICY

- 2.1 Asbestos has been used commercially for over 130 years in over 2000 different products. Cwm Taf Morgannwg, in common with other Health Boards, has asbestos incorporated into premises under its control in building materials, the majority of which were installed before 1980.
- 2.2 The presence of asbestos in these areas is taken into account in all building and services maintenance, refurbishment and demolitions.
- 2.3 The HSE expects non-domestic premises built prior to the year 2000 to have Management Survey information already; this data is essential for the **Duty holder** to effectively manage Asbestos Containing Materials (ACMs) and thus comply with the 'Duty to Manage' requirement stated in Regulation 4 of the Control of Asbestos Regulations 2012. CTMUHB Duty holder properties are listed in Appendix M.

DUTY HOLDER PRINCIPLES

- 2.4 **Sites and properties owned by CTMUHB.** The University Health Board holds the **Duty holder** responsibilities for properties owned by CTMUHB. See Appendix M.
- 2.5 **Sites and properties managed but not owned by CTMHUB,** such as head lease rented properties. The University Health Board will hold the **Duty holder** responsibilities for properties rented outright by CTMUHB, unless otherwise stated in the lease agreement. See Appendix M.
- 2.6 **Sites and properties partly occupied by, but not owned by CTMUHB.** The University Health Board will **NOT** hold the **Duty holder** responsibilities for these properties, unless otherwise stated in the lease/rental agreement.
- 2.7 **Installation of NHS Services into properties not owned or managed by CTMUHB.** For example ICT installations in opticians or privately owned GP surgeries. The University Health Board will **NOT** hold the **Duty holder** responsibilities for these properties.
- 2.8 **Private Domestic Properties.** For example ICT installations in private residences. CTM ICT will order appropriate PSBA circuits for home working, on the assumption that the resident is permitted to undertake such work at

Ref: EST03

Policy Title: Policy for the Asbestos Management Plan

Page Number: 4

the property. Any internal cabling is a matter for the resident. CTM ICT staff will not enter private residences to undertake work and/or support.

3. GENERAL PRINCIPLES

- 3.1 The majority of asbestos removal from within Health Board premises will only be undertaken using the services of Licensed Asbestos Removal Contractors.
- 3.2 Identification of asbestos will be confirmed by survey, reference to laboratory test results and/or site record drawings / specifications. In the absence of immediate information each potential occurrence will be assumed to be asbestos based until confirmed otherwise.
- 3.3 For information on types of survey available refer to **Section 12** of this AMP.
- 3.4 Asbestos building surveys, removal air monitoring, four stage clearance and analytical testing, will only be undertaken by UKAS Accredited Analytical Companies, (to ISO/IEC 17020 17025) covered by an adequate level of Public Liability and Professional Indemnity Insurance.
- 3.5 The Asbestos Management Plan will act as The Policy and Procedures, and will be reviewed annually by The Asbestos Advisory Group or in the event of changes in procedure or the issue of further guidance or legislative changes. The live version will be available on the Health Board's Intranet SharePoint site, and MICAD database.
- 3.6 Asbestos products and materials will not be specified for future build or refurbishment schemes. In line with the current guidance, asbestos is left undisturbed providing it is in good condition and the risk of exposure during normal activities is minimal. It is removed or encapsulated when there is a need to do so, either due to deterioration, building or services repair, maintenance or demolition, or when the Management Plan dictates.
- 3.7 Systems and procedures are developed in order to minimise the risk to health arising from asbestos of all personnel having requirements for whatever reason to access any of the properties under Health Board control.
- 3.8 For the Emergency Services, information on the location and condition of asbestos containing materials (ACM's) will be located in

the Fire Department boxes situated at the entrance to each pre 2000 building.

- 3.9 The Health Board's Fire Officer will be consulted prior to commencement of asbestos removal works where the integrity of fire compartmentation may be affected or means of escape obstructed.
- 3.10 A Permit to Work will be issued by the Asbestos Manager or his team for any ACM removal or encapsulation undertaken in the Health Board's premises. (**"Appendix A refers"**)

4. RESPONSIBILITIES

4.1 Key Contact List ("Appendix C refers")

4.2 Key Personnel

4.2.1 The Chief Executive

The Chief Executive has overall accountability for health and safety within the Health Board. They shall ensure that sufficient resources are allocated to meet the objectives of the Asbestos Management Plan in order to minimise the risk of exposure to asbestos, of staff, patients, visitors and anyone engaged to carry out work in the Health Board's premises.

4.2.2 The Board Secretary / Corporate Director

The Board Secretary / Corporate Director has overall responsibility for implementing the Organisation's Workplace Safety and Health Policy, associated policies and procedures and ensuring compliance with all relevant regulations and guidance.

4.2.3 The Assistant Director of Capital and Estates

The Assistant Director of Capital and Estates has responsibility for ensuring suitable arrangements are in place for the implementation of the AMP. This includes appointing a responsible person to undertake local management of ACM's on their behalf, if the duty is not to be personally undertaken.

4.2.4 Head (And Assistant Head) of Assets, Governance and Technical Services

The Head (and Assistant Head) of Assets, Governance and Technical Services is responsible for ensuring the ongoing management arrangements of the Asbestos Management Plan. These duties include:

- Setting policies for ACM management and developing procedures for effective implementation.
- Informing and/or seeking advice from the Asbestos Manager on any amendments considered necessary to the Asbestos Register.
- Implementing and updating this Plan.

- Ensuring compliance with CAR 2012.
- Arranging and acting upon internal and or external audits on the management of the Asbestos Management Team and ensure that audit recommendations are actioned through the Asbestos Advisory Group.

4.2.5 **The Asbestos Manager – Compliance Officer**

The Compliance Officer accountable for Asbestos Management, also referred to as the Asbestos Manager is accountable for the implementation and updating of the Asbestos Management Plan. In conjunction with the appointed Asbestos Consultant, they are responsible for the continued management, identification and removal of ACMs to meet the requirements of the Asbestos Management Plan, CAR 2012 and all other relevant legislation. The duties include the following:

- Facilitate asbestos surveys for all the premises and other buildings in which the organisation's employees work and providing this information to the Operational Estates Managers.
- Maintaining a Central Asbestos Register, which is a collection of all the premises Asbestos Survey Information.
- Providing advice and information on ACMs to persons who have an appropriate interest or connection. This shall include the undertaking of project specific inspections on site.
- Ensuring regular and routine inspections of ACMs, as identified in the Asbestos Register, are undertaken at regular intervals.
- Seeking advice from experts in situations where the Asbestos Register is not sufficiently detailed or further advice / reassurance is required.
- Identifying the training needs of Estates staff who may be exposed to asbestos and arrange for that training to be delivered.
- Review of training being delivered and requirements for refresher training.
- Arrange for risk assessments associated with potential exposure to asbestos for in-house activities and to review such assessments regularly.
- To assess, in conjunction with Estates and Project Managers and the accredited Asbestos Consultant, the competence of contractors working on site when asbestos is present or may be disturbed.
- To evaluate, in conjunction with an accredited Asbestos Consultant, the Risk Assessments and Plans of Work of Licenced Contractors involved with work on or with asbestos.
- To ensure appropriate monitoring of the Licenced Asbestos Removal Contractor and Asbestos Consultant on site during the course of, or on completion of their work to ensure compliance with CAR 2012.

Ref: EST03

Policy Title: Policy for the Asbestos Management Plan

Page Number: 7

- To liaise with the Licenced Asbestos Removal Contractor and Asbestos Consultant with respect to air monitoring and clearance testing.
- To assist with the emergency arrangements in the event of an uncontrolled release of asbestos fibres, **Appendix G**.
- When informed, to provide information about the location and condition of asbestos to every person liable to disturb it, and to the emergency services.
- Isolating any area adjacent to an ACM or suspected ACM if they are disturbed or damaged in conjunction with support from the Estates Dept.
- Where applicable, to produce in conjunction with the accredited Asbestos Consultant, a Specification of Works with respect to any asbestos removal to enable Licenced Contractors to submit tender proposals.
- To generate and issue the Permit to Work (PTW) to Licensed Contractors for any asbestos removal works ensuring that.
 - ❖ Licenced Contractors operate in accordance with the Specification and Method Statement.
 - ❖ The enforcing authority is notified by any Licensed Contractor engaged to carry out removals or abatement.
 - ❖ All requirements of CAR 2012 and any associated legislation/guidance are complied with.
- Arranging for remaining ACMs to be appropriately labelled.

4.2.6 **The Asbestos Manager and Asbestos Consultancy**

The Asbestos Consultancy listed in Appendix C and Appendix L, will undertake the duties and responsibilities of the Asbestos Manager both during periods of absence and when delegated.

They will also be the point of contact for any queries or emergency works in periods of absence or when delegated.

4.2.7 **Head of and Assistant Head of Operational Estates**

Head of, and Assistant Head of Operational Estates shall be responsible for ensuring adequate delegated resource is available for prioritising the management of asbestos for Operational Estates.

4.2.8 **Head of Capital**

The Head of Capital shall be responsible for ensuring adequate delegated resource is available for prioritising the management of asbestos for capital projects, including survey works detailed in section 11.

4.2.9 **Senior Projects Manager, Capital Project Managers, Capital Officers, Operational Estates Managers, Estates Officers and Supervisors**

Ref: EST03

Policy Title: Policy for the Asbestos Management Plan

Page Number: 8

(N.B. No work which requires Asbestos removal or encapsulation can be undertaken without the approval and signed Permit to Work (see Appendix A) from the Asbestos Manager or his team. For all work on the fabric of the building where there is asbestos present but removal or encapsulation is not required, an "Authority to Proceed" form (see Appendix D) must be obtained from the Asbestos Manager or his team.

Consider the age of the premises when assessing if Asbestos is present. Any premises whose construction was completed before 2000 should always be presumed to contain Asbestos unless there is strong evidence to suggest they do not. Any premises constructed after 2000 can be presumed to be Asbestos free. However exercise caution in circumstances where new premises are built on existing basements or linked to adjoining structures. Noting any asbestos related Health Building Notices (HBN) or Estates and Facilities Alerts (EFA).

Members of the Health Board's Capital and Estates Directorate are generally responsible for any work undertaken on the fabric of the buildings which are owned or leased by the Health Board. They shall:

- Assist the Asbestos Manager in the day to day operation of the Asbestos Policy and Procedures, and in particular, contact Estates Help Desk and log a formal request for the Asbestos Management Team to confirm or arrange the appropriate survey or safe procedure if the work to be undertaken may require asbestos removal, encapsulation, or potential exposure to asbestos fibres.
- Ensure that all work under their control involving or potentially involving asbestos materials is brought to the attention of the Asbestos Manager.
- Assist the Asbestos Manager and Consultant in maintaining the integrity of the asbestos register by ensuring they are advised of any changes.
- To assess, in conjunction with the Asbestos Manager and the accredited Asbestos Consultant, the competence of contractors working on site when asbestos is present or may be disturbed.
- Ensure ready accessibility to the Asbestos Register for themselves and all staff under their control / direction and make use of the Asbestos Register and to ensure its ongoing use in any appropriate work instruction.
- Must ensure that all staff under their control undertake regular asbestos refresher training.
- Encourage / promote asbestos awareness through the provision of information and explanation where relevant.
- Ensure that new members of the department receive guidance as to the danger of asbestos, its location, the AMP and the use of the Asbestos Register.

- Ensure that any contractors working under their direction are made aware of the presence of asbestos in their proposed area of work and all relevant safe working procedures which apply.
- ensure that contractors supply adequate risk assessments and method statements before undertaking any work;
- Ensure that all Estates staff and contractors working in pre 2000 buildings and in the vicinity of ACMs have had "Asbestos Awareness Training", and where applicable have appropriate "PPE and are Face Fit certified".
- Shall ensure that all recommendations are being adopted in the working practices of staff working under their control or direction.
- Ensure appropriate escalation to senior estates management & the Asbestos Manager if problems, issues, emergencies or when uncontrolled asbestos fibre release occurs, such as noticeable damaged to ACMs.

4.2.10 IT Project Managers

(N.B. No work which requires Asbestos removal, encapsulation or work in locations where there is a potential for air borne asbestos fibres to be present can be undertaken without the approval of the Asbestos Manager or his Team. For works on/in Post 2000 Buildings it can be presumed that no asbestos will be present and work can proceed without reference to the Asbestos Management Team or Asbestos Register.) IT Project Managers:

- Shall ensure that all work under their control involving or potentially involving asbestos materials is brought to the attention of the Asbestos Manager.
- Shall encourage / promote asbestos awareness through the provision of information and explanation where relevant.
- Shall ensure that any contractors working under their direction are made aware of the presence of asbestos in their proposed area of work and all relevant safe working procedures which apply.
- Ensure that contractors supply adequate risk assessments and method statements before undertaking any work.
- Ensure that all contractors working in pre 2000 buildings and in the vicinity of ACMs have had "Asbestos Awareness Training", and where applicable have appropriate "PPE and are Face Fit certified".
- Must be in possession of an "Authority to Proceed" ("**Appendix D Refers**") form prior to commencement of any works deemed by the Asbestos Management Team to require their assistance.

When ICT network services are provisioned, for example supply and installation of PSBA circuits, cabinets, and network cabling, IT must refer to section 2.1

- **CTM owned/managed sites:** CTM ICT will order and manage network services.
- **Sites and properties partly occupied by, but not owned by CTMUHB.** The University Health Board will **NOT** hold the **Dutyholder** responsibilities for these properties. IT to contact the property owner, and request that installations are managed and installed by the property owner.
- **Sites not owned or managed by CTM:** the owner or tenant of the site will order network services directly, and will recharge CTM if appropriate. These sites are responsible for the provision and possession of their own appropriate asbestos register, which will need to be made available to CTM as required. Examples include primary care, unitary authorities, opticians, and the voluntary sector.
- **Private residences:** CTM ICT will order appropriate PSBA circuits for home working, on the assumption that the resident is permitted to undertake such work at the property. Any internal cabling is a matter for the resident. CTM ICT staff will not enter private residences to undertake work and/or support.

4.2.11 Estates Maintenance staff

Estates Staff are responsible for:

- Reporting to the Help Desk, any known asbestos containing materials which are damaged or disturbed. Also any suspect ACMs (in any condition) and any defects or concerns they may have related to asbestos issues or remedial works.
- Attending asbestos awareness training when so requested.
- Awareness of the potential risks related to ACMs with appropriate knowledge required for identification of suspect materials. Staff are to be suitably skilled to identify suspected ACMs and stop work prior to testing.
- Ensuring that they do not disturb any known ACMs whilst carrying out their duties.
- Ensuring that personal protective equipment including RPE is used when entering potentially contaminated areas (for example, above ceilings in Merthyr Block PCH) and only when agreed and supported by one of the Asbestos Management Team.
- To follow the procedures set out in this AMP for emergency situations or accidental exposure to asbestos fibres.

4.2.12 Primary Care Manager or any other Contractor employing Health Board Manager

The Employing Health Board Manager, is any manager who employs the direct services of a contractor on Health Board owned or leased premises that is not specifically listed in the above sections. A duty of care must be exercised to ensure the contractor is informed of any asbestos related risks.

(N.B. No work which requires Asbestos removal, encapsulation or work in locations where there is a potential for air borne asbestos fibres to be present can be undertaken without the approval of the Asbestos Manager or his Team. For works on/in Post 2000 Buildings it can be presumed that no asbestos will be present and work can proceed without reference to the Asbestos Management Team or Asbestos Register.) Managers:

- Shall ensure that all work under their control involving or potentially involving asbestos materials is brought to the attention of the Asbestos Manager.
- Shall encourage / promote asbestos awareness through the provision of information and explanation where relevant.
- Shall ensure that any contractors working under their direction are made aware of the presence of asbestos in their proposed area of work and all relevant safe working procedures which apply.
- Ensure that contractors supply adequate risk assessments and method statements before undertaking any work.
- Ensure that all contractors working in pre 2000 buildings and in the vicinity of ACMs have had "Asbestos Awareness Training", and where applicable have appropriate "PPE and are Face Fit certified".
- Must be in possession of an "Authority to Proceed" ("**Appendix D Refers**") form prior to commencement of any works deemed by the Asbestos Management Team to require their assistance.

4.2.13 Contractors

All contractors will be managed under the Health Board's Control of Contractors' Procedure. Those who will be working on or in the vicinity of any ACMs will be made fully aware of the locations and condition as detailed in the Asbestos Register by the employing Health Board Manager consulting with the Health Board's Asbestos Manager – Compliance Officer.

All contractors undertaking work for the Health Board must:

- Maintain an awareness of the dangers of asbestos and a high degree of vigilance for suspecting its presence in the particular areas of their work.

Ref: EST03

Policy Title: Policy for the Asbestos Management Plan

Page Number: 12

- Ensure that their work does not cause an exposure to asbestos, either for themselves or others and must use the HB Asbestos Register to confirm or otherwise the presence of asbestos in any workplace.
- Contact the relevant Health Board Manager in the event that asbestos is suspected in their work area.
- Ensure that in the event of doubt or the inability to confirm a non-asbestos presence, confirmation must be obtained from the employing Health Board Manager before proceeding.
- Ensure that they respond to, and maintain, all communications with their Health Board Project Manager.
- Ensure that they comply with the AMP and relevant procedures, and where acting as sole, main or principal contractor have a thorough understanding of these procedures.
- Ensure that all employees and sub-contractors have received asbestos awareness training and subsequent refresher training in accordance with CAR 2012.
- Ensure that all sub-contractors are informed of the AMP and relevant procedures, and are aware of the location of ACMs within the project area.
- Cooperate with any Licensed Asbestos Removal Contractors or associated contractors working within or adjacent the known or intended project area.
- Ensure that emergency measures are in place for any suspected or known exposure to ACMs and that these are in line with Health Board procedures.
- Ensure sub contracted licensed asbestos works are carried out by a licensed asbestos removal contractor only. The appointment of a licensed asbestos removal contractor is subject to approval and agreement of the Health Board's Asbestos Manager.
- Non Asbestos Contractors are not allowed to carry out Non Licensed/ Non Notifiable asbestos work unless they have received the appropriate training.

4.2.14 LICENCED ASBESTOS REMOVAL CONTRACTORS

Licensed Asbestos Removal Contractor's employed by the Health Board are responsible for:

- Complying with current legislation, associated Approved Codes of Practice and Guidance and also the Health Board AMP and Project Procedures.

- Attending site to assess and prepare quotations against asbestos remedial work specifications, the Licenced Contractor shall raise any issues relating to the health and safety aspects or potential costs of a project.
- Providing a Plan of Work to the Project Manager and the Statutory Authority. This shall include details of project resources and timetable and an emergency procedure discussed and agreed with the Project Manager.
- Providing Statutory Notice to the Statutory Authority prior to commencing asbestos works, or, by agreement and at the request of the Project Manager, applying for a waiver from the minimum notice.
- Attend the asbestos contract pre-Start meeting, Progress Meetings, and handover Meeting as required.
- Carrying out regular inspections of the work environment, any defects found by or reported to the Project Manager or Analyst being rectified by the Licenced Contractor immediately.
- Complying with all reasonable requests from the Project Manager.
- Complying with all Permits to Work.
- Liaising with the appointed Analyst to ensure the satisfactory progress of the works.
- Providing copies of notification and consignment notes and other relevant documentation with final account to the Project Manager.

4.2.15 ASBESTOS CONSULTANTS/ANALYSTS

Asbestos Consultant's employed by the Health Board are responsible for:

- Maintaining UKAS accreditation relevant to instructed tasks.
- Providing pro-active support to the Health Board.
- Reviewing and commenting on asbestos works specifications and, prior to start of the works, on the Licenced Contractors Plan of Work.
- Providing quotations which reflect the anticipated project site and analytical requirements.
- Attending meetings, including but not restricted to, Pre-start and Project, Progress and Handover Meetings.
- Completing check lists, warning and advisory signs etc.
- Assisting with the application and completion of Health Board project, including hot works permits etc.

Ref: EST03

Policy Title: Policy for the Asbestos Management Plan

Page Number: 14

- Carrying out analytical works and inspections as agreed with the Health Board.
- Where site conditions alter, and the Asbestos Management Team is not immediately available, the Analyst shall adjust the level of testing and inspection to ensure that all information relevant to the continued health and safety of the Licenced Contractor and building occupants is obtained.
- Reporting to the Asbestos Management Team any defects or non-compliances relating to the Licenced Contractors performance, including suitability of the work areas, adherence to the Plan of Work, Statutory Instruments and AMP.
- Where the Asbestos Management Team is not immediately available the Analyst shall take any measures necessary to ensure the health and safety of the Licenced Contractor and building occupants.
- Checking areas on completion of asbestos remedial works to ensure that the Licenced Contractor has completed the scope of works and all affected areas have been left in a satisfactory condition.
- Maintaining regular contact, as minimum at start and at end of each site day, with the Project Manager, regarding progress of site works.
- Reporting to the Project Manager any aspects of asbestos management encountered on site which could give rise to health risks.
- Providing daily / weekly written reports on project progress to the Asbestos Management Team; the reports to include such information, in excess of accreditation requirements, as requested by the Asbestos Management Team.
- Issuing formal Reports, including 4 Stage Clearance and Certificate of Re-Occupation, to the Asbestos Management Team on completion of site works.
- Asbestos consultant will deputise for the Asbestos Manager in their absence or when delegated and will assume the role of the asbestos manager.

4.2.16 HOTEL SERVICES STAFF AND WARD/DEPARTMENT STAFF

Given the nature of work conducted by the Hotel Services Section staff it is possible they may encounter areas containing asbestos materials and therefore they shall:

- Be responsible for maintaining an awareness of the dangers of asbestos and a high degree of vigilance for its presence in their areas of work, particularly regarding floor and ceiling tiles, wall cladding and linings etc.

- Be responsible for ensuring that their work does not cause an exposure to Asbestos Containing Materials, either for themselves **or** others, and shall, via their supervisor, contact the Asbestos Management Team for advice.
- Immediately report any suspected asbestos containing material or damage to identified asbestos containing materials, to their supervisor who will contact the Asbestos Management Team for advice.

4.2.17 ASBESTOS ADVISORY GROUP

This group shall consist of:

Compliance Officer/Asbestos Manager
 Estates Administrator
 Facilities and Estates Compliance Officer
 Head of Assets, Governance and Technical Services
 Head of Data Networking
 Head of IT
 Head of Operational Health/Safety & Fire
 Head of Operational Estates
 Assistant Head of Operational Estates
 Operational Estates Manager (Merthyr & Cynon Group)
 Operational Estates Manager (Bridgend & Ogmore Group)
 Operational Estates Manager (Rhondda, Taff Ely Group)
 Primary Care & Community Estates Development Manager (Or Deputy)
 Senior Projects Manager (Capital Asbestos Lead)
 Facilities/Housekeeping Manager
 Staff Side Representatives

The Asbestos Advisory Group has been constituted to manage and monitor asbestos issues within the Health Board's premises in order to comply with the Control of Asbestos Regulations 2012. The main role shall be to:

- Review policies and procedures.
- Develop and review the Asbestos Management Plan including the implementation of safe systems of work and permit to work systems.
- Keep up to date with statutory and mandatory legislation.
- Ensure that the risk assessments are current.
- Develop systems for emergency work.
- Ensure that all asbestos containing materials are inspected by a competent person at intervals determined by the risk assessment.
- Ensure that staff are informed of the hazards associated with asbestos.

- Ensure that there is an adequate flow of information throughout the Health Board.
- Ensure that staff receive appropriate training.

5 KEY THEMES

5.1 Training

All Project Managers including relevant ICT staff / Supervisors and Estates Maintenance staff shall undergo formal training in asbestos awareness. For newly appointed personnel this training will be carried out at induction. All Project Managers / Supervisors and Estates Officers will also undergo training on the MICAD Asbestos Management Database.

In compliance with CAR 2012 the relevant Estates staff, Capital staff and IT staff will have annual asbestos awareness/refresher sessions.

Asbestos management plan toolbox talks will be delivered to Estates (Capital officers, Estates Supervisors, Estates Officers and Trades Staff) and ICT staff on an annual basis.

Best use will also be made of the knowledge of Engineering and Building Supervisors and Estates Officers who are particularly aware of the site and the staff they supervise.

All other staff should have a basic awareness of ACMs the associated risk levels and where they may be found.

5.2 Ongoing Risk Assessment of Asbestos

This Plan states that new buildings shall be designed to be asbestos free. Older buildings will be inspected for the presence of asbestos and risk assessments undertaken by an independent consultant accredited by UKAS for inspection (asbestos survey) and testing (sample analysis and air monitoring).

"Appendix E" illustrates the Health Board Risk Management Index for monitoring and programmed removal based upon the results of the risk assessment process.

All ACMs will be risk assessed in accordance with the guidance in HSG 227. Any Extreme Risks (with a score of 17+) will be programmed for removal within one year. (**"See Appendix E"**)

High Risks (10-16) will be programmed to be removed as soon as reasonably practicable.

Any slippage on this program will be reported on the Health Board's Risk Register.

Until the programmed work has been completed suitable control mechanisms will be introduced in order to manage the risk appropriately.

All asbestos materials will be risk assessed on an ongoing basis in order to check for deterioration or change in circumstances. This will generally be undertaken on an annual basis.

All asbestos data and risk assessments will be formally recorded in the asbestos register.

5.3 Maintenance of the Asbestos Register

The Asbestos Register serves as the basis for the development of site-specific action plans. The Action Plan will be implemented by the application of Control Actions in the first instance, followed by Management Actions.

The options available as Control Actions are:

- Restrict access or isolate area.
- Urgent decontamination under controlled conditions.
- Remove under controlled conditions.
- Repair damaged material.
- Seal exposed faces / edges (encapsulation).
- box in or barrier (enclose);
- Environmental clean of debris.

The options available as Management Actions are:

- Restrict access or isolate area.
- Monitor and re-inspect at suitable frequency.
- Label with appropriate stickers.
- Operate a Permit-to-Work system.
- Provide information, instruction or training to staff and Contractors.
- Conduct air monitoring.

Programmed re-inspections will be carried out on a frequency dictated by the potential for damage as identified by a risk assessment in accordance with Appendix E. These inspections also check the integrity and location of any labels that may have been installed.

The findings of the re-inspections are used to update the Asbestos Register and are an important mechanism by which programs of abatement work are initiated in response to unacceptable deterioration.

The Organisation will maintain its Asbestos Register online via the MICAD database. The Asbestos Management Team will have administrator rights to the database and all other Estates Managers, Supervisors and where applicable staff representatives will have "read only" access to the entire data.

The Asbestos Management Team will be responsible for maintaining the register. This register shall be used to develop the Asbestos Management Plan to enable

Ref: EST03

Policy Title: Policy for the Asbestos Management Plan

Page Number: 18

the Health Board to demonstrate its ongoing commitment to the management of its asbestos issues.

The Asbestos Database will contain the following:

- Copies of all ongoing risk assessments.
- Current copy of the Asbestos Survey.
- Archived data of removed materials.
- Copies of all test results.
- Copies of any drawings showing asbestos location.
- Copies of all photographs etc. showing current condition of asbestos.

6. PROCEDURE

6.1 General Procedure for the Removal or Remedial works of Asbestos Containing Materials

The Asbestos Management Team will oversee / supervise all asbestos removal / encapsulation undertaken in premises owned or leased by the Health Board.

All asbestos removal and remedial works will only be carried out by a specialist contractor who is licensed by the Health and Safety Executive and monitored on behalf of the Health Board by an independently appointed UKAS accredited Analytical Company.

Prior to any removal or remedial work being carried out, the Asbestos Management Team will ensure that a full risk assessment of the work is carried out by the licensed asbestos removal contractor. This risk assessment will reflect:

- Type of asbestos.
- Likely disturbance / spread of dust.
- Possible exposure to this dust of any person (patient, visitor or staff).
- Amount of asbestos containing material, material type and location.
- Control methods to be used.

The Asbestos Management Team will ensure the Licensed Contractor produces a full Method Statement for the work in conjunction with the Analytical Consultant which will include notification to the HSE in addition to approved work methods, controls and technical detail.

A "Permit to Work" ("**Appendix A Refers**") will then be issued by the Asbestos Management Team before the work can commence.

A detailed four stage certificate of re-occupation for licenced works, including clearance air monitoring will be undertaken to each work area following a detailed visual inspection and active air disturbance, prior to returning the area to normal occupation.

The Analytical Consultant will arrange for the testing of adjacent areas which may have been evacuated during the asbestos removal process to ensure it is safe to re-occupy.

During the abatement process, the whole area will be clearly marked with appropriate asbestos warning signs / barriers to prevent unauthorised access to the area.

All stripped asbestos and debris from the enclosure will be double bagged and sealed for disposal as asbestos waste at a properly licensed landfill site by the licensed contractor.

In addition to having control over the removal process, the Asbestos Management Team will liaise with all appropriate Fire Officer, Department Managers, and recognised Health and Safety Staff Representatives. (For major upgrades this duty will be the responsibility of the relevant Project Manager in consultation with the Asbestos Management Team).

The work will be recorded in the Asbestos Database together with all supporting information and test results.

6.2 Procedure for Handling an Exposure (or Possible Exposure) to Asbestos (Refer also to Appendices F and G)

In the event of an uncontrolled release of asbestos fibres or discovery of new damage to asbestos materials the following procedure shall be followed.

If individuals have been exposed assess the extent and implement safety measures. Take immediate steps to make the site and persons safe by either barring access or making arrangements necessary to vacate an area.

6.3 Emergency Tool Kit (PCH Only) will be located at a strategic location (Old ITU Plant Room, Merthyr Block, First Floor), to be readily available for any person(s) who are contaminated with asbestos fibres ("Appendix G Refers").

The kit(s) will comprise of:

- Disposable hooded overalls.
- Masks.
- Overshoes.
- Wet wipes.
- Towels.
- Asbestos disposal bags.
- Valuables bags.
- Tool Kit Procedure document.

Procedure for the use of Emergency Toolkit(s) can be viewed in "**Appendix G**".

6.4 Procedure for Accidentally disturbed ACMs

The procedure for instances where asbestos is accidentally disturbed can be seen in the Flow Chart in **Appendix F**. Contact and appraise the following staff: (See key contacts in **Appendix C** of this AMP):

- Asbestos Management Team.
- Site Operational Maintenance Manager or Deputy.
- Estates Helpdesk
- Operational Head of Health, Safety and Fire
- Occupational Health

Incidents involving accidentally disturbed ACMs will be referred to the Head of Operational Health, Safety and Fire for Investigation. Incidents will also be considered for notification to RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013)

- Asbestos Management to contact Analytical Company.
- Consultant to assist with assessments and take air/bulk samples to ascertain exposure level.
- Analytical Company evaluates problem and defines work methods to be adopted with Asbestos Manager.
- If necessary, a Licensed Contractor will be appointed and undertakes work, which will be monitored by the Independent Analytical Consultant.
- Analytical Consultant undertakes all necessary testing, during and upon completion of the work, prior to allowing reoccupation of area.
- Copies of air test, certificate of reoccupation made available to staff affected.
- Relevant Operational Estates Manager to record the incident in the Datix incident reporting database which is located on the Health Boards intranet.

6.5 Procedure for Project and Maintenance Work.

When requesting works / assistance relating to asbestos or work in close proximity of ACMs such as:

- An asbestos survey.
- Refurbishments / upgrades via the departments Capital team.
- Maintenance / repairs
- In house alterations / upgrades.

The procedure which must be followed is:

- Relevant Manager, Estates Officer or Supervisor must contact the Estates Help Desk on 01443 443210 or 54000 in Bridgend. The Help Desk is to be informed that the call is to go to the Asbestos Management Team.
- A brief description of the works to be undertaken must be provided along with the location and date of intended works.
- The Asbestos Compliance Officer/Team will be contacted to determine if an ATP form is required.
- The Team will confirm with the originator of the call what assistance will be necessary and when it can be provided.

Ref: EST03

Policy Title: Policy for the Asbestos Management Plan

Page Number: 21

- If considered necessary the Team will appoint relevant contractors i.e. Licenced Asbestos Removal Contractor, Consultant or Analyst who will be required to assist with the works.
- For emergency works where response time is important the Asbestos Management Team can be contacted directly via the Estates Help Desk. For out of hours emergencies the Duty Estates Manager will be contactable via the relevant Switch board. A Key Contacts List is available in Appendix C of the AMP.

The procedure to be followed when considering or undertaking project work is detailed in "**Appendix H**".

The procedure to be followed for the maintenance and reactive work is detailed in "**Appendix I**".

6.6 Work with Asbestos ("Appendix J refers")

A flow chart outlining the procedure for working with Asbestos is detailed in **Appendix J**.

6.7 Safe Systems of Work

The Health Board operates the following safe systems of work with regard to Asbestos:

- SWP01: PCH-Inspection above ceiling;
- SWP02: PCH-Replacement of suspended ceiling tiles;
- SWP03: PCH-Drilling partition walls;
- SWP04: PCH Merthyr Block: Work above ceilings, ground and 1st floor;
- SWP05: PCH only: Drilling holes through all concrete surfaces in Phase 1 Merthyr Block.
- SWP06: All Sites, management of gaskets in pipework, Re: NHS Wales Estates and Facilities alert WG EFA 2017 006. Supply of CNA 2000 pipeline gaskets: presence of Asbestos.

This list is continually under review and can be added to as situations develop.

6.8 Labelling

The Health Board believes labelling ACMs, where identified, should only form part of a comprehensive management system. Labelling alone is not sufficient to warn persons of the presence of an ACM and this complies with current HSE guidance. The Organisation is aware that labelling systems may fail due to abuse, wear and tear etc.

Labelling will be applied where asbestos has been assessed as satisfactory to leave intact i.e. it does not require removal. This will enable people working in the vicinity to identify asbestos sources, and to stop working if their work could cause fibre release. Labelling will not be applied to floor tiles because of potential loss or damage to the labels. Labels, where fitted will be inspected together with the associated ACMs as dictated by Appendix E.

Different labels are deployed as follows:

- ACMs in public areas;
- ACMs in staff, plant or service areas.

The label designs approved by the Health Board are included in **Appendix K**.

7. REVIEW, MONITORING AND AUDIT ARRANGEMENTS

7.1 Monitoring

The Organisation will monitor the level of compliance in respect of the management of asbestos through a scorecard management system. The scorecard will report the level of compliance based on the core requirements of the Control of Asbestos Regulations 2012.

The scorecard will be completed by the Estates and Facilities Compliance Manager and their Team together with all other areas of Statutory Compliance for the Directorate. It is overseen by the Head of Assets, Governance and Technical Services and updated / amended in discussion with the Asbestos Manager.

The scorecard will be presented to:

- Asbestos Advisory Group;
- Estates Health Safety and Risk Group;

7.2 Audit

The Capital and Estates Governance Team will review the effectiveness of the AMP by undertaking an independent audit every 2 years as part of the ISO14000 Environmental Management System (EMS) audit. A report based on the results of the audit will be sent to the Assistant Director of Capital and Estates and the Asbestos Manager.

The Asbestos Manager will present the report to the following Groups:-

Asbestos Advisory Group
Capital and Estates Health Safety and Risk Committee
Capital and Estates Governance Board

The Assistant Director of Capital and Estates will in turn report actions and audit outcomes to the Corporate Risk Committee and Board as part of the Compliance Report.

7.3 Review

In line with the requirements of The CAR 2012 the AMP, including records and drawings will be reviewed on an annual basis by the Asbestos Manager. It will also be reviewed if there is reason to believe that circumstances have changed (e.g. there is a change of use of building, work being undertaken, ACMs removed or repaired etc.).

8. RELATED DOCUMENTS

- The Health and Safety at Work etc. Act 1974;

Ref: EST03

Policy Title: Policy for the Asbestos Management Plan

Page Number: 23

- The Control of Asbestos Regulations 2012 and Supporting Documents;
- The Health Board's Workplace Safety and Health Policy.

9. NON CONFORMANCE

There is a requirement of all staff to comply with the provisions of the Asbestos Management Plan and associated Procedures and, where requested, to demonstrate such compliance. Failure to comply with these requirements will be dealt with in accordance with the appropriate Health Board Workforce and Organisational Development policy.

10. EQUALITY IMPACT ASSESSMENT STATEMENT

This Plan has been subject to a full equality assessment and no impact has been identified.

11. REFERENCES

- Managing risks and risk assessment at work' available on HSE website
- The Control of Asbestos Regulations 2012 – ISBN 0 110751914
- Work with Materials Containing Asbestos – Control of Asbestos Regulations 2012 – Approve Code of Practice and Guidance – ISBN 0 7176 62063 – amalgamated into the ACoP L143: Managing and working with asbestos 2013 ISBN 978 0 7176 6618 8
- The management of asbestos in non-domestic premises Regulation 4 of the Control of Asbestos at Work Regulations 2012. Approved Code of Practice and Guidance L127 (Second Edition) HSE Books 2006 ISBN 0 7176 6209 8 – amalgamated into the ACoP L143: Managing and working with asbestos 2013 ISBN 978 0 7176 6618 8
- Asbestos: The analysts' guide for sampling, analysis and clearance procedures HSG248 Asbestos: the analysts guide 2021 ISBN 978 0 7176 6707 9
- Asbestos essentials task manual: Task guidance sheets for the building maintenance and allied trades HSG210 HSE Books 4th Edition 2017 ISBN 0 7176 18870 – now only available online as asbestos essentials
- The Survey Guide HSG264 HSE Books 2012 2nd Edition ISBN 0 7176 2076 X Web version: www.hse.gov.uk/pubns/mdhs/index.htm - published in 2010 (updated 2012)
- Asbestos: The licensed contractors' guide HSG247 HSE Books 2006 ISBN 0 7176 2874 4
- Managing Asbestos in Premises (INDG 223(rev2) – this is the welsh version. HSG 227: A comprehensive guide to managing asbestos in premises
- Asbestos Alert for Building Maintenance, Repair and Refurbishment Workers. Leaflet INDG 188 2/02 C700 - HSE. – welsh version

12. TYPES OF SURVEY

Management Surveys

Ref: EST03

Policy Title: Policy for the Asbestos Management Plan

Page Number: 24

- Management surveys are intended to identify ACMs that could affect the normal occupation of a building.
- This includes ACMs that might be disturbed not only by regular maintenance activities, but also those affected by reasonably foreseeable activities such as cabling works in risers.
- The 2010 HSG 264 guidance emphasises the benefit of thorough surveys, with attempts to be made to open up areas where maintenance or similar can be anticipated. Samples of suspect materials should be taken, although some level of 'presumption' and reduced sampling regimes are acceptable so long as the consequent management of identified or suspected ACMs is appropriate.
- 'Management surveys' fell under Type 1 and 2 survey descriptions in earlier HSE guidance (MDHS 100).
- The current knowledge of Health Board ACMs is at a level comparable with this 'Management Survey' definition.
- The HSE expects all non-domestic premises built prior to the year 2000 to have Management Survey information already; this data is essential for the **Dutyholder** to effectively manage ACMs and thus comply with the 'Duty to Manage' requirement stated in Regulation 4 of the Control of Asbestos Regulations 2012.

Refurbishment surveys and demolition surveys

These surveys attempt to locate and describe all ACMs in a project area and are required well before any refurbishment or demolition is due. This type of survey is also required for what may appear, initially, as relatively minor work, for example, formation of a riser, or dismantling of heating plant. Prior to January 2010, these surveys were termed 'Type 3' in the HSE MDHS 100 guidance.

To enable this level of identification the area must be fully accessible to the surveyor and appropriate investigation techniques and equipment be employed. Survey planning is essential, to allow the Surveyor to understand the scope of the intended works, for any exclusions to the survey to be agreed with the Client, and for arrangements to be made for the area to be unoccupied. HSG 264 emphasises the need for the survey area to be isolated from building occupants and that; ideally, reoccupation after survey is not planned. However, it recognises that this is not always achievable. Where the survey area is to be reoccupied, assurance that it is acceptable for re use should be obtained from the Surveyor.

Intrusive investigation works can be significant – making good after survey works is minimal unless requested otherwise. Suspect materials are sampled during the

survey, and the extent of ACMs estimated. The condition of the ACM is generally not reported except where materials are damaged, if areas of asbestos debris may be expected, or if there will be a time delay between the survey and the intended refurbishment or demolition.

For a refurbishment / demolition survey to be successfully completed at least the following criteria must be met:

- Area is unoccupied, with no intention to reoccupy after survey.
- Area is fully accessible – with fixings, furnishings, and heavy equipment removed, or at least easily movable.
- Area is fully accessible in terms of decontamination sign-offs and other relevant authorisations.
- Suitable survey techniques are employed – breaking through of partitions, opening up of floor voids, use of access platforms for high level areas etc.

If the conditions above are not met the survey will not be considered comprehensive; limitations will be noted in the Survey Report and arrangements will need to be made to undertake further survey work when the site conditions are appropriate.

The HSE recognise that unidentified ACMs may still remain in the survey area, thus appropriate controls need to be in place for the actual refurbishment period, and most certainly for any demolition works.



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Appendix A - Permit to Work for Asbestos Removal or Encapsulation



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Asbestos Permit to Work

Permit No: _____

PART 1 - to be completed by Maintenance Manager or Asbestos Team Management

This permit is only valid for the work indicated below. Persons carrying out the work must have appropriate certified training under the current Control of Asbestos Regulations. The person in charge is responsible for issuing site safety information to other parties working on site.

- a) Location of Work: _____
- b) Work to be carried out: _____
- c) This permit is valid: From _____ am/pm to _____ am/pm On _____ To _____

d) Precautions check list (Circle as required)

Air Monitoring	Yes/No/N/A	4 Stage Clearance	Yes/No/N/A
ASB 5 Present	Yes/No/N/A	NNLW	Yes/No/N/A
Waste Note (Post Works)	Yes/No/N/A	Plan of Work/Risk Assessment	Yes/No
Other Requirements		Related permit required (specify below)	
_____		_____	
_____		_____	

e) I certify that I am satisfied that it is safe for the work detailed above to proceed in accordance with the Health Board's Asbestos Safe Working Procedures.

Signed _____ (Maintenance Officer/ Asbestos Team Management)

Name _____ Time and Date _____ Tel No _____

PART 2 - To be completed by Asbestos Removal Contractor

I confirm that I fully understand the work to be carried out and the requirements of this permit as given in Part 1. I accept responsibility for carrying out the work in accordance with the current Control of Asbestos Regulations and the Licensed Contractors Guide HSG247.

Signed _____ (person in charge) Company _____

Name _____ Time and Date _____ Tel No/Ext No _____

THIS PERMIT IS NOT VALID UNTIL PARTS 1 AND 2 HAVE BEEN SIGNED

PART 3 - To be completed by the appointed analyst on completion or suspension of the work. Permit must be returned to the Maintenance Manager or Asbestos Team Management on completion or suspension of work.

I confirm that the work described in Part 1 has been satisfactorily completed/suspended. All personnel and equipment have been withdrawn and the area made safe.

Signed _____ (person in charge)

Name _____ Time and Date _____

PART 4 - To be completed by the Maintenance Manager or Asbestos Team Management

I confirm that the work detailed in Part 1 has been satisfactorily completed/suspended and that this permit is cancelled.

Signed _____ (Maintenance Officer/ Asbestos Team Management)

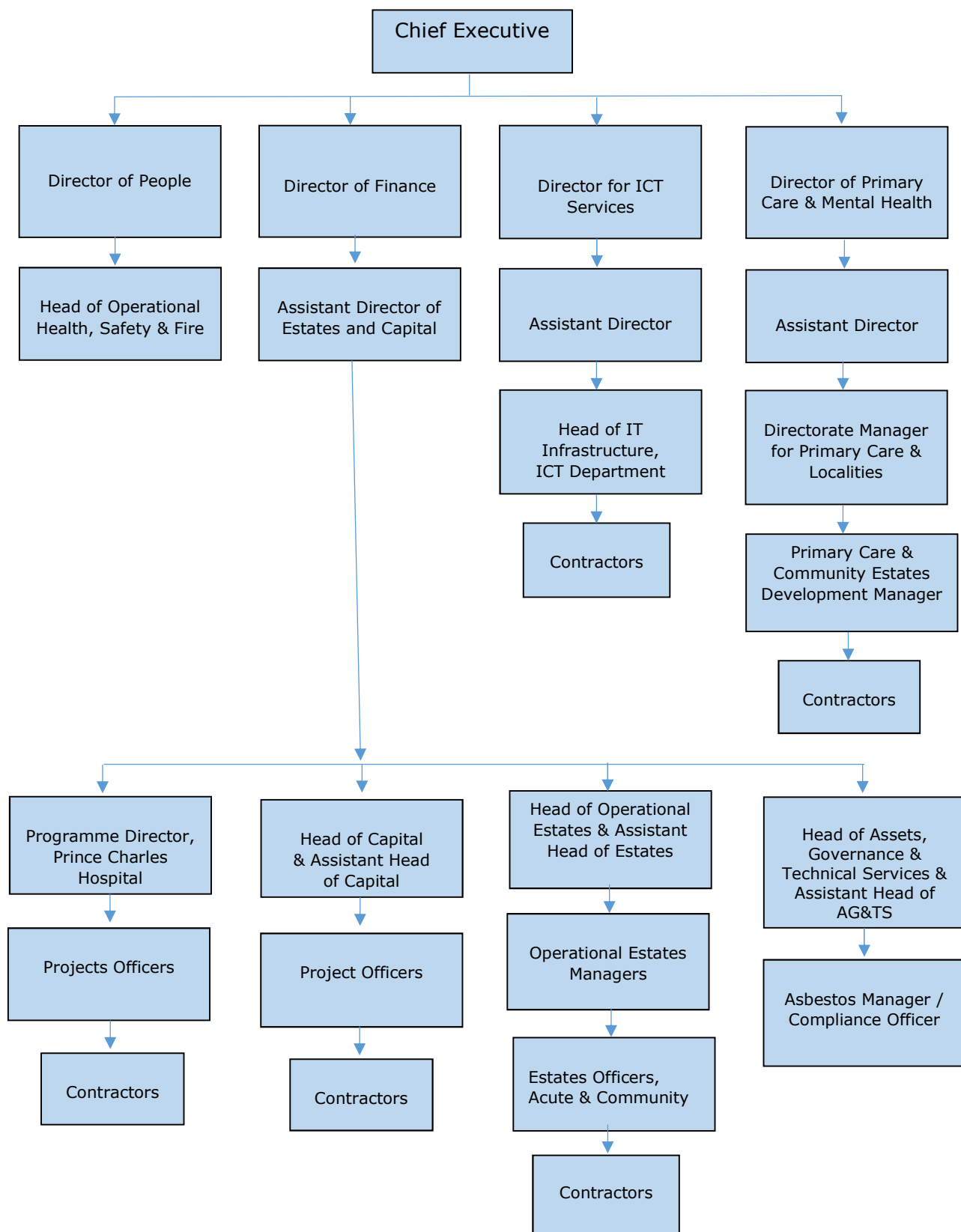
Name _____ Time and Date _____

Ref: EST03

Policy Title: Policy for the Asbestos Management Plan

Page Number: 27

Organisational Structure and Key Contacts



Ref: EST03
Policy Title: Policy for the Asbestos Management Plan
Page Number: 28

Appendix C - Key Contacts

Title and address

Name phone and email

Asbestos Manager –Compliance Officer
Major Projects Office
Prince Charles Hospital

Head of Assets, Governance & Technical Services
The Bungalow
Dewi Sant Hospital

Head of Operational Estates
Estates Department
Dewi Sant Hospital

Assistant Head of Operational Estates
Estates Department
Dewi Sant Hospital

PCH MPU Responsible Officer
Major Projects Office
Prince Charles Hospital

PCH Programme Director
Major Projects Office
Prince Charles Hospital

Head of ICT Infrastructure
ICT Department
Prince Charles Hospital

Head of Operational Health Safety and Fire
The Bungalow
Dewi Sant Hospital

Primary Care and Community Estates
Development Manager,
Primary and Community Care
Keir Hardie University Health Park

Senior Capital Project Manager
Estates Building
Royal Glamorgan Hospital

See also Appendix L: External Asbestos Consultants' Contact Details

Appendix D - Authority to Proceed

If using a contractor, the survey and ATP shall be undertaken at the same time as obtaining a quote. This must be completed and signed off by a member of the Asbestos Management Team before placing an order and proceeding with any work. For IT projects, the IT Project Manager will issue a copy of the completed form to the contractor.

Once the ATP has been issued for a project the document only applies to the works detailed in the plan associated with that ATP. In any situation where plans are changed, works must halt, the ATP process and associated plan must be re-reviewed by the asbestos manager/consultant, signed by relevant parties and re-submitted.

PART 1 – To be completed by Project Manager

Project manager	Signed/Date
Site	Location
The following work is to be undertaken	
On:	At:
Customer	SOUR/SON
Estates helpdesk reference number	
ICT ServicePoint reference number	

PART 2 – To be completed by Asbestos Manager/Deputy

Asbestos Register Checked	Y/N	Asbestos RAMS Reviewed	Y/N/NA
Asbestos Present	Y/N	Cable Route Agreed (if applicable)	Y/N/NA
Site Meeting with all Parties	Y/N/NA	Work can proceed	Y/N

Comments/Agreed Method for Avoiding Disturbance of Asbestos:-

(Continue on the back or a separate sheet if necessary)

	Asbestos Manager	Works Manager	Contractor*
Signed			
Print			
Date			

*This ATP must be brought to the attention of any/all subcontractors, by the contractor.

Appendix E - Risk Management Index

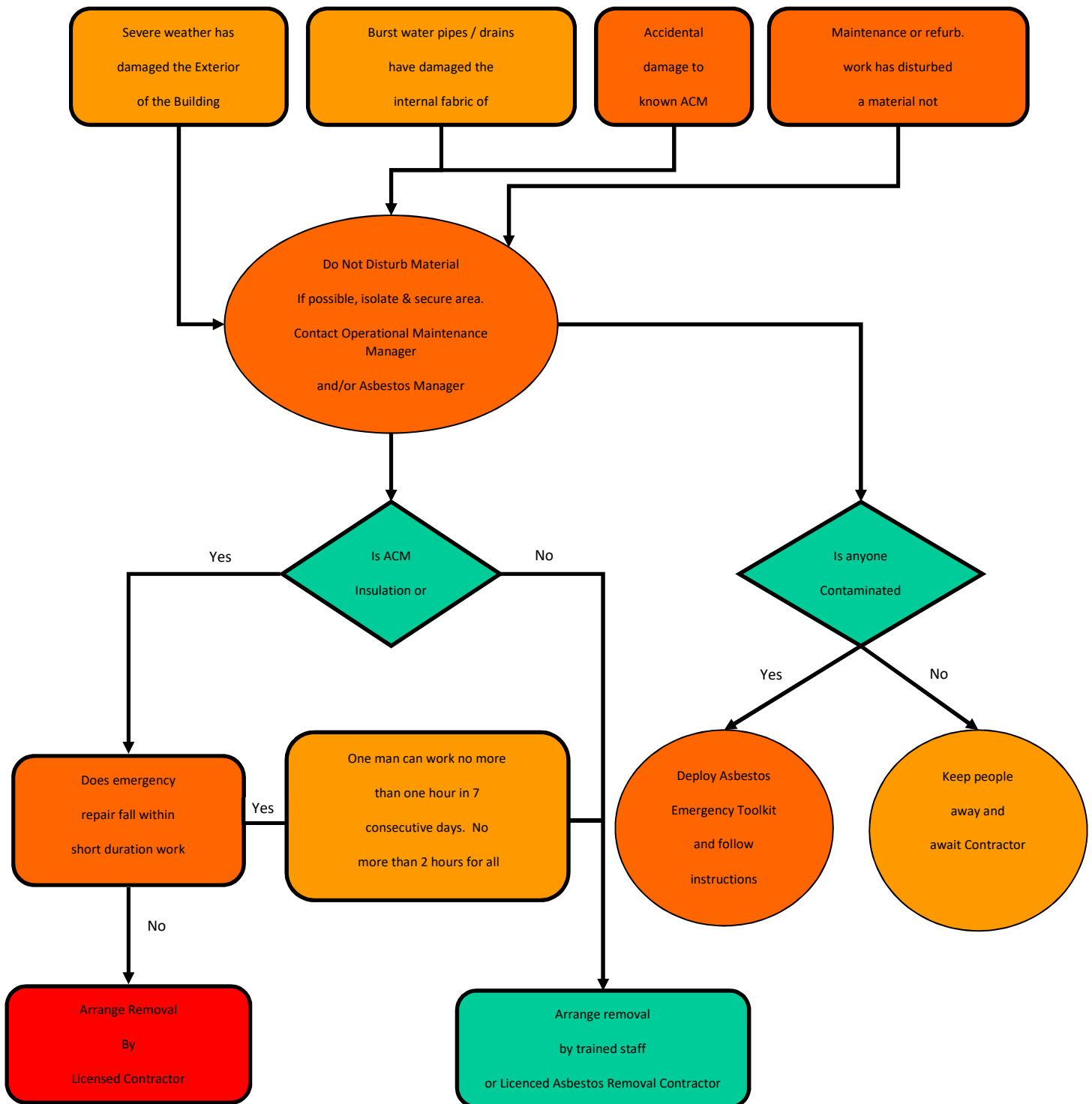
Risk	Score	Monitor	Removal
		(Months)	(Months)
Low	1-3	60	Manage / monitor
Moderate	4-9	36	Manage / monitor
High	10-16	12	Condition monitor and review if removal/abatement is necessary
Extreme	17-24	6	Manage / Monitor Remove within 12 months

1 – 3	Low risk -	10 – 16	High risk -
4 – 9	Moderate risk	17 – 24	Extreme risk

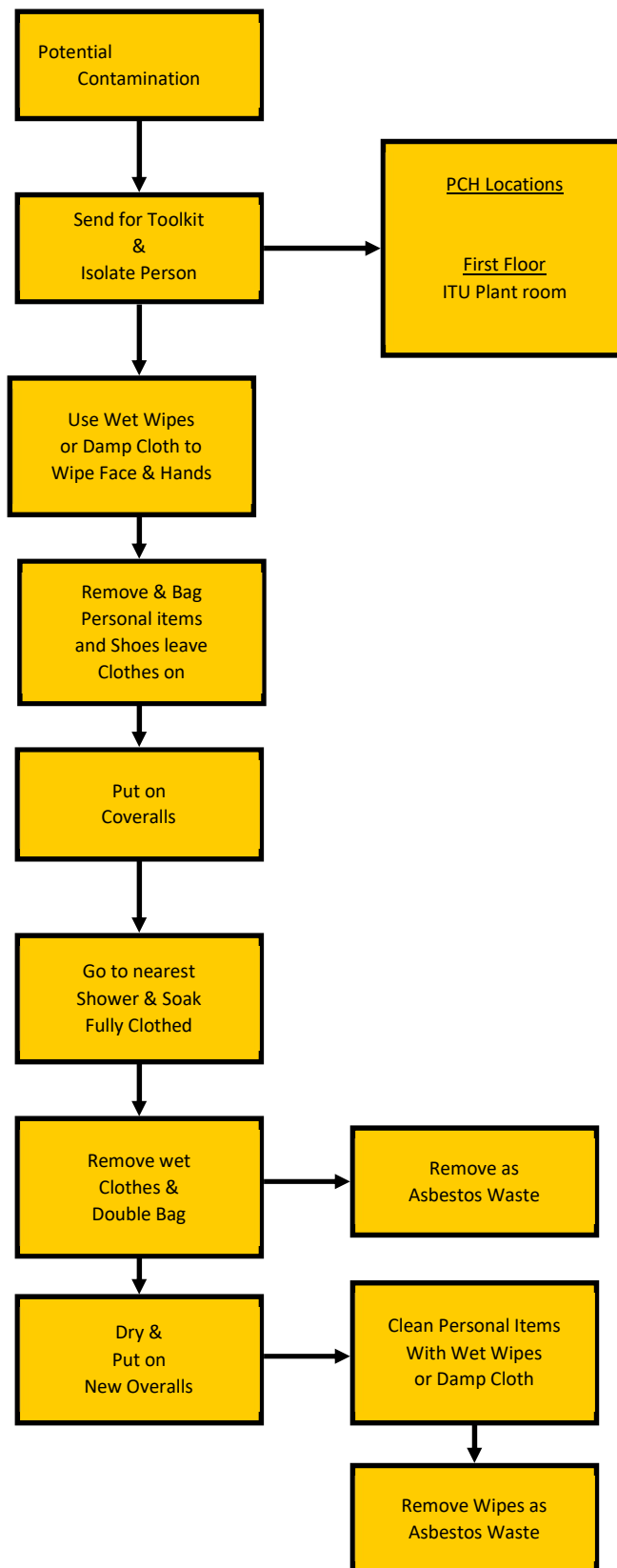
Appendix F - Accidentally Disturbed / Possibly Disturbed ACM's

Refer to section 5.3 of this AMP for more details on this procedure.

FLOW CHART-ACCIDENTALLY DISTURBED/POSSIBLY DISTURBED ACM's

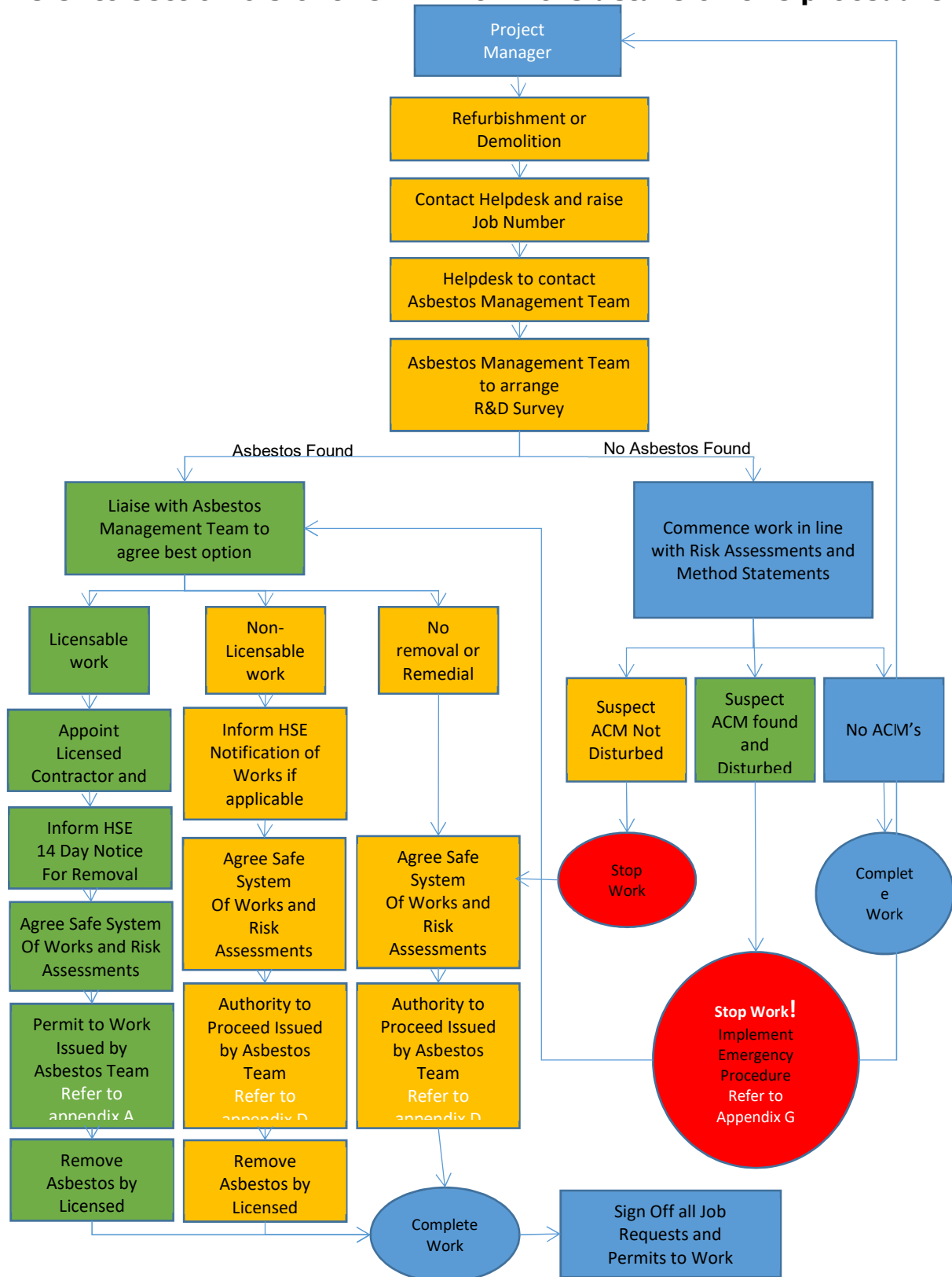


Appendix G - Emergency Procedure Using Toolkit



Appendix H - Flowchart for Project Work

Refer to section 6.5 of this AMP for more details on this procedure.



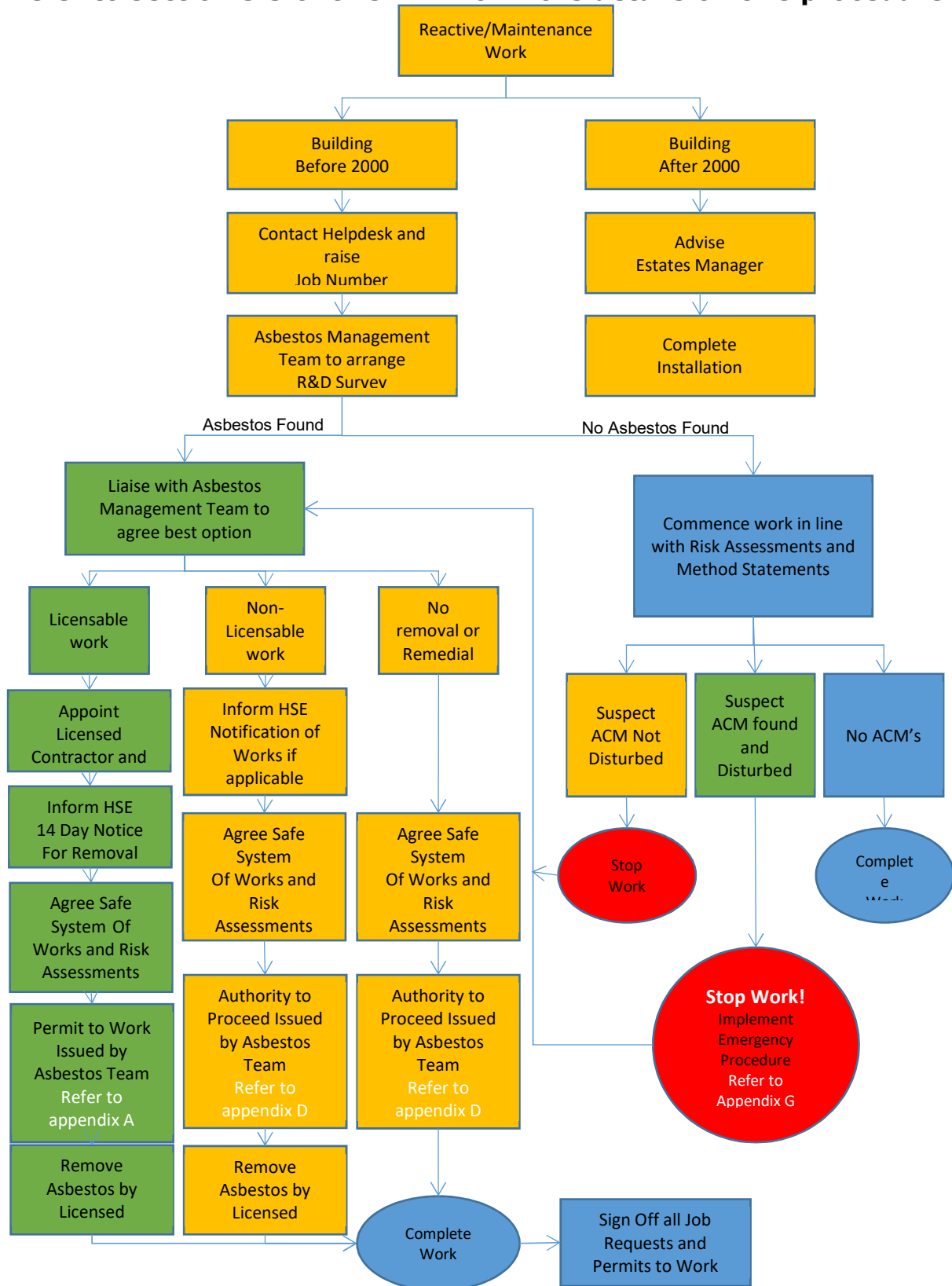
Ref: EST03

Policy Title: Policy for the Asbestos Management Plan

Page Number: 34

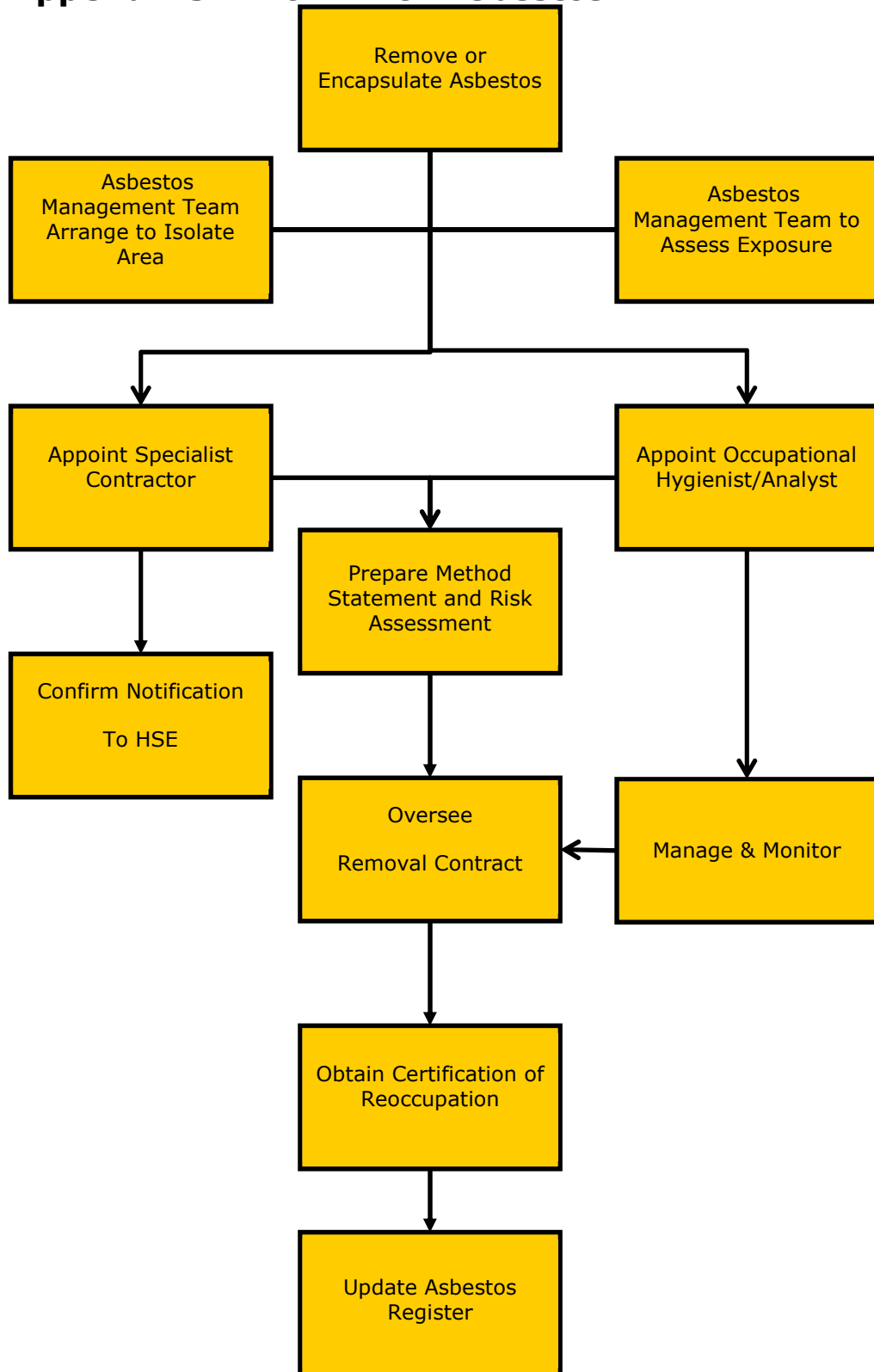
Appendix I - Flowchart for Reactive / Maintenance Work

Refer to section 5.5 of this AMP for more details on this procedure.





Appendix J - Work with Asbestos

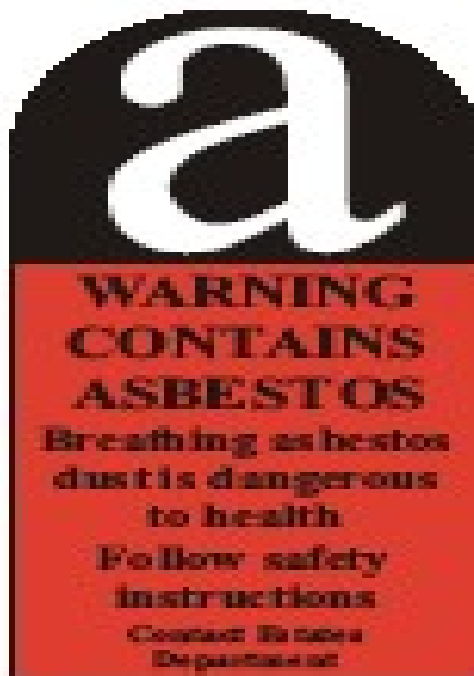


Appendix K - Approved Labels

Asbestos-containing materials in public areas:



Asbestos-containing materials in staff plant or service areas:



Appendix L - External Asbestos Consultant Contacts

Socotec

Socotec Head Office
Tel: 01656 646588



Appendix M - List of CTMUHB Duty Holder Properties

Hospital Properties	Facility Type	Building Owned By	Asbestos Duty Holder	Asbestos Present Yes/No
Prince Charles Hospital	Hospital	Cwm Taf Morgannwg UHB	CTM-Estates	Yes
Royal Glamorgan Hospital	Hospital	Cwm Taf Morgannwg UHB	CTM-Estates	Yes
Ysbyty Cwm Rhondda	Hospital	Cwm Taf Morgannwg UHB	CTM-Estates	Post 2000
Pontypridd Cottage Hospital - Y Bwthyn	Hospital	Cwm Taf Morgannwg UHB	CTM-Estates	Yes
Pinewood House	Mental Health Unit	Cwm Taf Morgannwg UHB	CTM-Estates	Presumed
Ysbyty George Thomas	Hospital	Cwm Taf Morgannwg UHB	CTM-Estates	No
Ysbyty Cwm Cynon	Hospital	Cwm Taf Morgannwg UHB	CTM-Estates	Post 2000
Princess Of Wales Hospital	Hospital	Cwm Taf Morgannwg UHB	CTM-Estates	Yes
Glanrhyd Hospital	Hospital	Cwm Taf Morgannwg UHB	CTM-Estates	Yes
Glanrhyd Hospital Angelton	Hospital	Cwm Taf Morgannwg UHB	CTM-Estates	Post 2000
Glanrhyd Hospital Blocks	Hospital	Cwm Taf Morgannwg UHB	CTM-Estates	Yes
Glanrhyd Hospital MSU Caswell	Hospital	Cwm Taf Morgannwg UHB	CTM-Estates	Post 2000
Glanrhyd Hospital Taith Newydd	Hospital	Cwm Taf Morgannwg UHB	CTM-Estates	Post 2000
Maesteg Community Hospital	Hospital	Cwm Taf Morgannwg UHB	CTM-Estates	Yes
Llantrisant Health Park	Specialist Unit	Cwm Taf Morgannwg UHB	CTM-Estates	Presumed

Other Properties	Facility Type	Building Owned By	Asbestos Duty Holder	Asbestos Present Yes/No
Aberdare Health Centre	Health Centre	Cwm Taf Morgannwg UHB	CTM-Estates	Yes
Aberfan Clinic	Clinic	Cwm Taf Morgannwg UHB	CTM-Estates	No
ARC Mental Health Clinic (Quarella Road)	Mental Health	Leased	CTM-Estates	Post 2000
Bryncethin Clinic	Health Centres/Clinics	Cwm Taf Morgannwg UHB	CTM-Estates	Yes
Bryntirion Clinic (Due for closure)	Clinic	Cwm Taf Morgannwg UHB	CTM-Estates	Yes
Carnergie Clinic	Clinic	Cwm Taf Morgannwg UHB	CTM-Estates	Yes
Cefn Yr Afon Mental Health Unit	Mental Health Unit	Cwm Taf Morgannwg UHB	CTM-Estates	Post 2000
Cefyn Yr Afon Rehabilitation Unit (Quarella Road)	Office Space	Cwm Taf Morgannwg UHB	CTM-Estates	Post 2000
Central Production Unit	Food production Facility	Leased	CTM-Estates	Yes
Central Stores POW	Stores	Cwm Taf Morgannwg UHB	NWSSP	Yes
Dewi Sant Hospital	Treatment Centre	Cwm Taf Morgannwg UHB	CTM-Estates	Yes
Dewinton Field Practice (Tonypanyd Health Centre)	Field Practice	Cwm Taf Morgannwg UHB	CTM-Estates	Yes
East Glamorgan Unit Community Offices	Office Space	Cwm Taf Morgannwg UHB	CTM-Estates	Yes
East Glamorgan Unit Laundry & Boilerhouse	Laundry Facility	Cwm Taf Morgannwg UHB	CTM-Estates	Yes
Keir Hardie Undergraduate Centre	Training Centre	Cwm Taf Morgannwg UHB	CTM-Estates	Post 2000
Kier Hardie Health Park	Health Park	Cwm Taf Morgannwg UHB	CTM-Estates	Post 2000
NHS Wales Shared Services Partnership (Charmwood)	Office Space	Leased	CTM-Estates	Post 2000
NIAW Building Pencoed	Training Centre	Cwm Taf Morgannwg UHB	CTM-Estates	Post 2000
North Cornelly Clinic	Clinic	Cwm Taf Morgannwg UHB	CTM-Estates	Yes
North Road Stores	Warehouse	Leased	CTM-Estates	No
Ogmore Vale Clinic	Clinic	Cwm Taf Morgannwg UHB	CTM-Estates	Post 2000
Old Trust HQ 71 Quarella Road	Office Space	Cwm Taf Morgannwg UHB	CTM-Estates	Yes
Pencoed Primary Care Centre	Health Centre	Cwm Taf Morgannwg UHB	CTM-Estates	Post 2000
Pontypridd Health Centre	Health Centre	Cwm Taf Morgannwg UHB	CTM-Estates	Yes
Pontypridd Resource Centre (Maritime)	Mental Health Unit	Cwm Taf Morgannwg UHB	CTM-Estates	Post 2000
Porth Dental Teaching Unit, Leith House	Dental Teaching Unit	Leased	CTM-Estates	No
Quarella Road Clinic (Due for closure)	Clinic	Cwm Taf Morgannwg UHB	CTM-Estates	Yes
Talbot Green Health Centre	Health Centre	Cwm Taf Morgannwg UHB	CTM-Estates	Yes
Tonteg Hospital, (Training & Child & Family Unit)	Training & Child & Family Unit	Cwm Taf Morgannwg UHB	CTM-Estates	Yes
Trealaw Resource Centre	Mental Health Unit	Cwm Taf Morgannwg UHB	CTM-Estates	Post 2000
Tylorstown Clinic	Clinic	Cwm Taf Morgannwg UHB	CTM-Estates	No
Unit 1 Viaduct House, Merthyr	Warehouse	Leased	CTM-Estates	No
Unit 2 Gwaun Elai, The Hub.	Office Space	Cwm Taf Morgannwg UHB	CTM-Estates	Post 2000
Unit 3 Gwaun Elai, The Hummingbird	Treatment Centre	Cwm Taf Morgannwg UHB	CTM-Estates	Post 2000
Unit 4 Gwaun Elai, Snowdrop Breast Centre	Treatment Centre	Cwm Taf Morgannwg UHB	CTM-Estates	Post 2000
Unit G1 Welsh Health Specialist Services Committee	Office Space	Leased	CTM-Estates	Yes
Williamstown Medical Records	Warehouse	Cwm Taf Morgannwg UHB	CTM-Estates	Yes
Ynysmeurig House	Office Space	Cwm Taf Morgannwg UHB	CTM-Estates	Post 2000
Ynyswen Clinic	Clinic	Cwm Taf Morgannwg UHB	CTM-Estates	No

Primary Care Properties	Facility Type	Building Owned By	Asbestos Duty Holder	Asbestos Present Yes/No
Cwm Gwyrdd Medical Centre GilfachGoch	Medical Centre	Head Lease (Primary Care)	CTM-Estates	Post 2000
Ferndale Medical Centre	Medical Centre	Head Lease (Primary Care)	CTM-Estates	No
Hirwaun Primary Resource Centre	Medical Centre	Head Lease (Primary Care)	CTM-Estates	Post 2000
Maerdy GP Surgery (Branch of Ferndale)	Primary Care Centre	Head Lease (Primary Care)	CTM-Estates	Yes
New Tynewydd Surgery, Base (William Street, Treherbert)	Primary Care Centre	Head Lease (Primary Care)	Primary Care	No
New Tynewydd Surgery, Branch (128 High Street, Treorik)	Primary Care Centre	Head Lease (Primary Care)	Primary Care	Yes
Porthcawl Primary Care Centre	Medical Centre	Head Lease (Primary Care)	Primary Care	Post 2000
Treharris Primary Care Centre	Primary Care Centre	Head Lease (Primary Care)	CTM-Estates	Post 2000
Tylorstown Surgery	GP Surgery	Head Lease (Primary Care)	Primary Care	No
Ty Calon Lan	Primary Care Centre	Head Lease (Primary Care)	Primary Care	Post 2000
Ynyshir Surgery	Primary Care Centre	Head Lease (Primary Care)	CTM-Estates	Post 2000

Ref: EST03

Policy Title: Policy for the Asbestos Management Plan

Page Number: 39



Agenda Item

8.1.4

Quality, Safety & Experience Committee

Medical Gases Management Policy

Dyddiad y Cyfarfod / Date of Meeting	25/03/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Christopher Lewis, Assistant Head of Assets, Governance & Technical Services
Cyflwynydd yr Adroddiad / Report Presenter	Sally May, Executive Director of Finance
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Sally May, Executive Director of Finance
Pwrpas yr Adroddiad / Report Purpose	For Approval

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Medical Gases Advisory Group - Approved	23/09/2024	ENDORSED FOR APPROVAL
Capital and Estates Governance Board	18/11/2024	ENDORSED FOR APPROVAL
Sharepoint Consultation	14/02/2025	ENDORSED FOR APPROVAL

Acronyms / Glossary of Terms	
WHTM	Welsh Health Technical Memorandum



1. Situation /Background

- 1.1 This Policy has been developed to introduce a structured procedure for the Management and Control of Medical Gases in compliance with current guidelines contained in Welsh Health Technical Memorandum (WHTM 02-01).
- 1.2 The Policy specifies the management responsibilities for ensuring compliance with 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 CTMUHB.
- 1.3 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.

2. Specific Matters for Consideration

- 2.1 Engagement on this Policy and Procedure has taken place with:

Name Title	Date Consulted/Completed
Equality Impact Assessment	05/07/2024
Informal Consultation with interested parties	Through the groups listed on page 1
Formal Consultation	Through the groups listed on page 1
Committee – For approval	This stage

- 2.2 The policy has been reviewed and is consistent with the approach across NHS Wales / legislation. It is the responsibility of the Board to ensure that the organisation meets its legal obligations under the current WHTM standards. The Board must ensure adequate funds and resources are available to meet the organisation's medical gas requirements and responsibilities.
- 2.3 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.
- 2.4 Organisational values and behaviours have been reflected within the policy.



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board



3. Key Risks / Matters for Escalation

No key risks or matters for escalation to be reported or recorded at this time.

In addition to minor typographical amendments, amendments to the following areas were made as a result of the various consultation stages:

- Training responsibilities and requirements were clarified to reflect current organisational set up (Section 5 & 6)
- Instructions / procedures with in the appendices were amended to clarify and improve the information (Appendices A-D)

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 (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) / Link to Enablers of Quality (<i>Duty of Quality Statutory Guidance (gov.wales)</i>)	Whole-systems Perspective
	If more than one applies please list below:
Dolen i Feysydd Ansawdd	Safe



(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality (Duty of Quality Statutory Guidance (gov.wales))	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: Assessment completed, has identified no indicators for a full QIA.	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Cydraddoldeb 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	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.	

5. Recommendation

- 5.1 The Quality, Safety & Experience Committee are asked to **approve** the Medical Gases Management Policy.

6. Next Steps

- 6.1 Once approval is sought the author will share the Policy with the Corporate Governance Team for publication on SharePoint and the Health Board Internet Site.

Medical Gases Management Policy

Document Type:	Non Clinical Organisational Wide Policy
Ref:	EST 005
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:	2.0

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	3
1. POLICY STATEMENT.....	3
2. SCOPE OF POLICY	3
3. DEFINITIONS.....	4
4. AIMS AND OBJECTIVES.....	5
5. RESPONSIBILITIES.....	5
6. INFORMATION, INSTRUCTION AND TRAINING	13
7. PROCEDURE	15
8. REVIEW, MONITORING AND AUDIT ARRANGEMENTS	15
9. IMPLEMENTATION/POLICY COMPLIANCE	15
10. RETENTION OR ARCHIVING	16
11. NON CONFORMANCE.....	16
12. EQUALITY IMPACT ASSESSMENT STATEMENT	16
13. MAIN RELEVANT LEGISLATION / STANDARDS	16
APPENDICES.....	17

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.

Ref: EST005

Policy Title: Medical Gas Management Policy V2.0

Page Number: 3

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

Ref: EST005

Policy Title: Medical Gas Management Policy V2.0

Page Number: 4

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

Ref: EST005

Policy Title: Medical Gas Management Policy V2.0

Page Number: 5

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)

Ref: EST005

Policy Title: Medical Gas Management Policy V2.0

Page Number: 6

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

Ref: EST005

Policy Title: Medical Gas Management Policy V2.0

Page Number: 7

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.

Ref: EST005

Policy Title: Medical Gas Management Policy V2.0

Page Number: 8

- 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

Ref: EST005

Policy Title: Medical Gas Management Policy V2.0

Page Number: 9

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 Nursing Directorate. The DNO training risk sits under the Nursing 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 Nursing

Ref: EST005

Policy Title: Medical Gas Management Policy V2.0

Page Number: 10

Directorate. The DMO training risk sits under the Nursing 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 Nursing Directorate and the Nursing 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.

Ref: EST005

Policy Title: Medical Gas Management Policy V2.0

Page Number: 11

- 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 – Nursing 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)

Ref: EST005

Policy Title: Medical Gas Management Policy V2.0

Page Number: 12

- 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 Nursing Directorate. The DNO/DMO training risk sits under the Nursing Directorate who are responsible for their compliance and reporting of compliance.

Medical Gas Safety - General Nursing Staff

Ref: EST005

Policy Title: Medical Gas Management Policy V2.0

Page Number: 13

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 Nursing Directorate and the Nursing 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.

Ref: EST005

Policy Title: Medical Gas Management Policy V2.0

Page Number: 14

- **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.

Ref: EST005

Policy Title: Medical Gas Management Policy V2.0

Page Number: 15

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

Ref: EST005

Policy Title: Medical Gas Management Policy V2.0

Page Number: 16

- 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.

Ref: EST005

Policy Title: Medical Gas Management Policy V2.0

Page Number: 18

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.

Ref: EST005

Policy Title: Medical Gas Management Policy V2.0

Page Number: 19

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,

Ref: EST005

Policy Title: Medical Gas Management Policy V2.0

Page Number: 20

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.

Ref: EST005

Policy Title: Medical Gas Management Policy V2.0

Page Number: 21

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

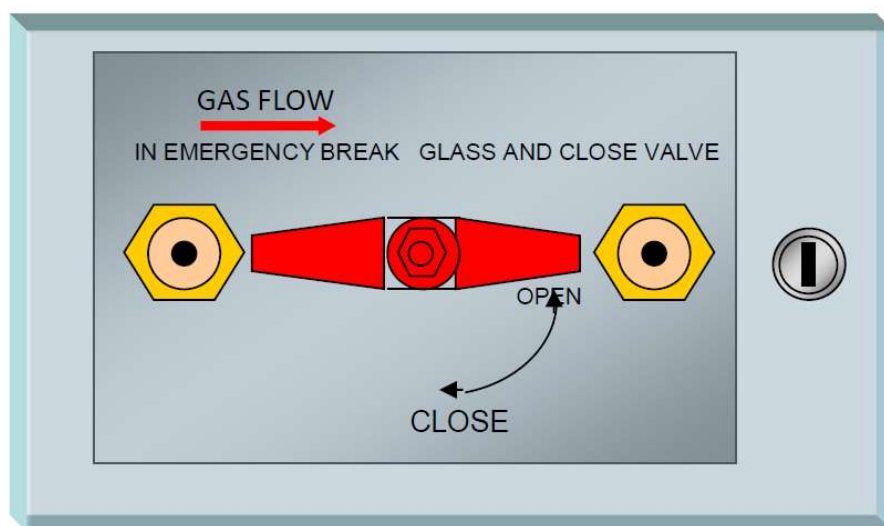
Depending on site contact Porters and Authorised Person for the site via switchboard

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

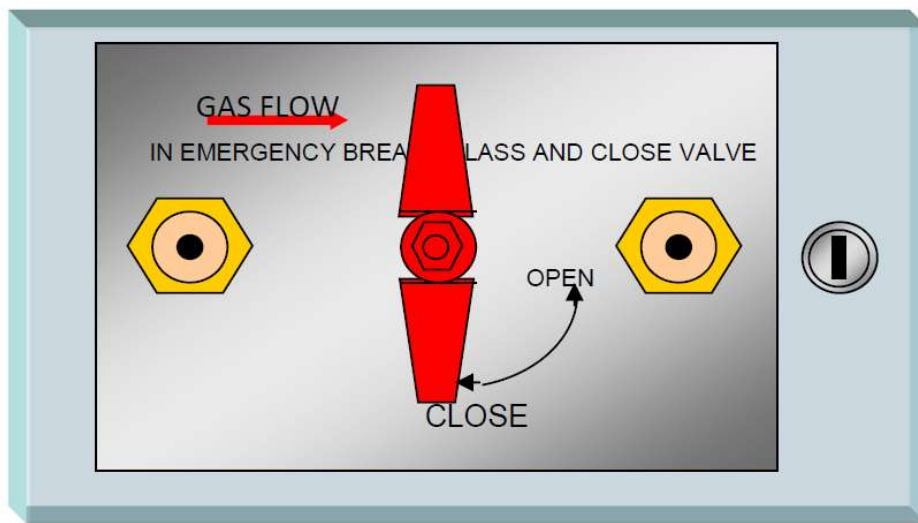
Medical gases must be isolated in the event of a fire or major gas leak. Isolation of the gases and AVSU/scan only be performed by the senior clinical staff member in charge of the ward or department – only after making sure patients are safe and supported

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



Agenda Item

8.1.5

Quality, Safety & Experience Committee

Water Safety Plan

Dyddiad y Cyfarfod / Date of Meeting	25/03/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Christopher Lewis, Assistant Head of Assets, Governance & Technical Services
Cyflwynydd yr Adroddiad / Report Presenter	Sally May, Executive Director of Finance
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Sally May, Executive Director of Finance

Pwrpas yr Adroddiad / Report Purpose	For Approval

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Water Safety Group	09/10/2024	ENDORSED FOR APPROVAL
Capital and Estates Governance Board	18/11/2024	ENDORSED FOR APPROVAL
Sharepoint Consultation	05/03/2025	ENDORSED FOR APPROVAL

Acronyms / Glossary of Terms

WHTM	Welsh Health Technical Memorandum

1. Situation / Background

- 1.1 In accordance with relevant legislation and standards, the Water Safety Plan sets out how the risks from microbiological and scalding hazards associated with the supply and use of water are assessed, managed and controlled.
- 1.2 The objective is to ensure the organisation takes all reasonable precautions to ensure water safety is managed correctly for the safety of patients and staff.

2. Specific Matters for Consideration

- 2.1 Engagement on this Policy and Procedure has taken place with:

Name Title	Date Consulted/Completed
Equality Impact Assessment	04/11/2024
Informal Consultation with interested parties	Through the groups listed on page 1
Formal Consultation	Through the groups listed on page 1
Committee – For approval	This stage

- 2.2 The policy has been reviewed and is consistent with the approach across NHS Wales / legislation.
- 2.3 Organisational values and behaviours have been reflected within the policy.



3. Key Risks / Matters for Escalation

No key risks or matters for escalation to be reported or recorded at this time.



Only minor typographical amendments were made as a result of the various consultation stages.

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))	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	Yes: ☒	No: ☐
	Outcome: Assessment completed, has identified no indicators for a full QIA.	If no, please include rationale below:



<i>Have you undertaken a Quality Impact Assessment Screening?</i>		
Cydraddoldeb a'r Gymraeg <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /</i>	Yes: ☒	No: ☐
Equality and Welsh Language <i>Have you undertaken an Equality and Welsh Language Impact Assessment Screening?</i>	Outcome for Equality (delete as appropriate): NEUTRAL Outcome for Welsh Language (delete as appropriate): 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 <i>(Pobl / Ariannol) /</i> Resource Impact <i>(People / Financial)</i>	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 **approve** the Water Safety Plan.

6. Next Steps

- 6.1 Once approval is sought the author will share the document with the Corporate Governance Team for publication on SharePoint and the Health Board Internet Site.

WATER SAFETY PLAN

Policy Details:

Document Type:	Non Clinical Organisational Wide Policy
Ref:	N/A
Author:	Alan Martin Head of Operational Estates
Executive Sponsor:	Executive Director of Finance & Procurement
Approved By:	Quality & Safety Committee
Approval / Effective Date:	(dd/mm/yyyy)
Review Date:	(dd/mm/2027)
Version:	2.3

Target Audience:

People who need to know about this document in detail	All Estates staff, Estates Managers, Contractors and anyone involved with Water Safety works in Health Board premises.
People who need to have a broad understanding of this document	Heads of Nursing, Senior Estates Managers, 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: 04/11/24 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

Contents

1. DOCUMENT CONTROL	3
2. INTRODUCTION	4
3. GLOSSARY OF TERMS	5
4. THE ROLE OF THE WATER SAFETY GROUP (WSG).....	6
5. SCOPE	7
6. AUGMENTED CARE	7
7. DEPARTMENTAL ROLES & RESPONSIBILITIES.....	8
8. MANAGEMENT OF WATER SYSTEMS.....	16
9. RISK ASSESMENTS.	18
10. DESIGN, INSTALLATION, COMMISSIONING OF WATER SYSTEMS.....	20
11. CONTROLLING THE RISKS OF LEGIONELLA.....	24
12. CONTROLLING THE RISK OF PSEUDOMONAS AERUGINOSA.	51
13. CONTROLLING THE RISK FROM OTHER PATHOGENS.....	51
14. PROVISION OF SAFE DRINKING WATER.	51
15. WATER USED IN THE PROVISION OF FOOD AND DRINK.....	52
16. WATER QUALITY, SUPPLY AND TESTING.....	52
17. AVOIDANCE OF STAGNATION	58
18. COMPETANCE	58
19. RECORD KEEPING	59
20. INCIDENT / OUTBREAK MANAGEMENT	60
21. AUDIT REVIEW	60
22. LIST OF APPENDICES AND ASSOCIATED DOCUMENTS.....	61

1. DOCUMENT CONTROL

1.1. Authorised Holder

This Water Safety Plan (WSP) is owned and managed by the Water Safety Group (WSG) on behalf of CWM TAF MORGANNWG University Health Board (CTMUHB). Updates, changes & amendments must be authorised by the chair of the WSG, and approved by the quorum of the WSG. Any changes will then be notified to, and ratified by the Capital and Estates Health, Safety and Risk Committee.

1.2. Review, Change & Issue Register

Table 1.

Version	Details of Review or Change	Date Amended	WSG Chair Approval Date	Capital Estates Health Safety and Risk Committee Approval Date
V2	Complete rewrite from V1.		23-Sep-2020	28-Sep-2020
V2.1	Additional staff added to WSG membership	12-Oct-2020	12-Oct-2020	
V2.2	Partial rewrite from V2.1	23 Apr 2024		

2. INTRODUCTION

In accordance with CTMUHB Water Safety, Infection and Risk prevention policy, for the Control of Water Safety, this Water Safety Plan sets out how the risks from microbiological and scalding hazards associated with the supply and use of water are assessed, managed and controlled.

Patient exposure to waterborne microorganisms occurs through a variety of sources, including:

- Inhalation of aerosols and breathable water droplets;
- Drinking water;
- Ingestion of ice;
- Ingestion of food prepared using water;
- Skin contact through washing, bathing (inc use of pools) and showering;
- Contact with endoscopes and medical instruments;
- Contact with others (staff, visitors and other patients).

Water safety management is a key aspect of the protection of the health of patients, visitors and staff in accordance with UK H&S law. This WSP has been written to applicable practical guidance:

- Health & Safety Executive (2013) Legionnaires' disease; The control of legionella bacteria in water systems, Approved Code of Practice & Guidance on Regulations (L8)
- Health & Safety Executive (2014) Legionnaires' disease; Part 2 The control of legionella bacteria in hot and cold water systems (HSG 274 Part 2)
- Health & Safety Executive (2013) Legionnaires' disease; Part 3: The control of legionella bacteria in other risk systems (HSG 274 Part 3)
- Welsh Health Technical Memorandum 04-01(2016): Safe water in healthcare premises Part A: Design, Installation & commissioning
- Welsh Health Technical Memorandum 04-01 (2016): Safe water in healthcare premises Part B: Operational Management
- Welsh Health Technical Memorandum 04-01 (2016): Safe water in healthcare premises Part C: *Pseudomonas Aeruginosa* – advice for augmented care units
- Welsh Health Technical Memorandum (2017): Performance specification D 08: thermostatic mixing valves (healthcare premises)
- Welsh Health Technical Memorandum 01-05 (2014): Decontamination in primary care dental practices and community dental services
- British Standards Institute (2015): BS8558:2015 Guide to the design, installation, testing and maintenance of services supplying water for domestic use within buildings and their curtilages – Complimentary guidance to BS EN 806
- British Standards Institute (2019): BS8580:2019 Water Quality – Risk assessments for Legionella Control – Code of Practice
- British Standards Institute (2008): BS7592:20222008 Sampling for Legionella bacteria in water systems – Code of Practice
- NHS Estates (1998); 'Safe hot water and surface temperatures; Health Guidance Note
- Thermostatic Mixing Valve Manufacturer's Association (2000); Recommended Code of Practice for Safe Water Temperatures
- WHBN 00-09 (2016); Infection Control in the Built Environment
- Chartered Institution of Building Services Engineers (2013); TM13:2013 Minimising the risk of Legionnaires' disease
- Spa pool guidance HSG 282 and the current PWTAG guidance for swimming pools and

Ref:

Policy Title: Water Safety Plan V2.3

Page Number: 4

- hydro therapy pools
- BS8580-2:2022 Pseudomonas Risk Assessments

3. GLOSSARY OF TERMS

Approved Code of Practice	(ACOP) A document approved by the Secretary of State giving guidance and technical information to assist in satisfying regulations
Health & Safety Guidance Note	(HSG) A document produced by the HSE to provide guidance in technical areas of health & safety
Welsh Health Technical Memorandum	(WHTM) Department of Health documents providing healthcare specific advice and guidance relating to building and engineering technologies
Thermostatic Mixing Valve	(TMV) A device that mixes hot and cold water with adjustable limits for the prevention of scalding
Senior Operational Manager	(SOM) A manager with operational and professional responsibility for a range of specialist services
Responsible Person	(RP) A person appointed with key operational responsibility for the specialist service
Deputy Responsible Person	(DRP) A person appointed to with key operational responsibility to deputise for and assist the RP.
Authorising Engineer	(AE) An independent professional water advisor
Competent Person	(CP) A person authorised by the AP to provide skilled services, installation and/or maintenance
Tradesperson	A person with specialist skills in a trade background
Augmented Care	Where medical or nursing procedures render the patient susceptible to invasive disease from environmental or opportunistic pathogens
Terms of reference	(TOR) the terms, noting the members of the WSG and how they will deliver the requirements of the WSP.
Risk	The likelihood of a hazard such as hot water or a legionella causing harm
Legionella	A pathogenic bacteria commonly found in water systems. Potential to cause Legionnaires' disease or legionellosis through inhalation of contaminated droplet
<i>Pseudomonas Aeruginosa</i>	A pathogenic bacteria commonly found in wet or moist environments with the potential to cause a number of infections in almost any organ or tissue

Ref:
Policy Title: Water Safety Plan V2.3
Page Number: 5

Scalding	A thermal burn of the skin from contact with hot water
Schematic Drawing	A representative drawing of a water system showing key components and configuration to aid comprehension

4. THE ROLE OF THE WATER SAFETY GROUP (WSG)

The Water Safety Group (WSG) is a multidisciplinary group formed from the many departments within CTMUHB who have collective and individual responsibilities for the safe provision and use of water. In order for the WSG to function, the following roles must be an integral part of the group and attend regular meetings as well as carry out appointed actions:

- Head of Operational Estates (Chair for the WSG).
- Assistant Head of Estates (Vice Chair of the WSG)
- Senior IPC nurse and other members of the IPC team as appropriate;
- Consultant medical microbiologist;
- Senior Capital and Major Projects Representative:
- Senior Operational Manager (SOM) Estates
- Responsible Person's (RP) (Water) Estates
- Deputy Responsible Person's DRP (Water) Estates
- NWSSP-SES - Authorising Engineer (AE) (Water);
- Head of Assets, Governance and Technical Services;
- Facilities Compliance Manager
- Facilities / Hotel Services Manager;
- Senior nurses from relevant augmented care;
- Senior representative from Sterile Services;
- Senior decontamination representatives.
- Senior Primary Care representatives.
- Senior Members from Dental (Community and Hospital based)
- Staff representatives
- Members of relevant external organisations

Note: Relevant external organisations includes persons appointed with responsibility for water safety or in control of premises that are shared or occupied by Health Board staff or patients.

The chair of the WSG will be the Head of Operational Estates. The WSG will always act in an appropriate and timely manner. Individual responsibilities should not be restricted by the need to hold formal meetings.

The WSG is accountable to the Capital and Estates Health, Safety and Risk Committee and will also provide reports to the Infection Prevention & Control Committee (IPCC) and upwards as appropriate to exercise effective governance and assurance.

All matters of water safety and episodes of colonisation or infection thought to be related to water system/s will be reported by the Estates Department, Microbiology or the IP&C team to the Chair of the WSG, who will then be expected to initiate mitigating actions to minimise risk to patients, visits & staff and initiate an appropriate investigation.

The WSG will monitor any proposed developments on the design or installation of the use of

Ref:

Policy Title: Water Safety Plan V2.3

Page Number: 6

the premises and their water systems and check that they are:

Ensuring the risk to patients, especially those treated in augmented care settings is minimised and under effective control, and compliant with legislation, policy and guidance.

All items of equipment that need to be connected to the water distribution system and which may be used in direct care on patients should be approved by the WSG.

The WSG will need to ensure that decisions affecting the safety and integrity of the water system do not go ahead without being agreement and approval by the WSG.

The members and appointments of the WSG group is given in Appendix A, Terms of Reference

5. SCOPE

This WSP applies to all premises whether owned or occupied by the Cwm Taf Morgannwg University Health Board under head lease or other Service Level Agreements (SLA) including:

- All premises owned and occupied exclusively by CTMUHB.
- All premises owned and occupied partly by CTMUHB.
- All premises not owned by CTMUHB but maintained and operated by CTMUHB under a Service Level Agreement
- All premises not owned by CTMUHB but occupied partly or exclusively by CTMUHB on a temporary or permanent basis.

This WSP applies to the control of the risks to health from microbial infection and scalding only – all matters relating to safety of persons in and around water are dealt with separately under direction of Health & Safety policies.

Where the management of premises/areas occupied by Health Board staff and/or patients is carried - out by others, the requirements of this WSP remain applicable. Implementation of the specific risk management must be managed locally and ratified by the WSG. It remains therefore, the Health Board's responsibility to ensure that the requirements of this WSP are notified to and complied with by all other parties described above.

This WSP does not apply entirely to premises owned by the Health Board but occupied exclusively by others due to the inability to dictate or control health and safety arrangements. The Health Board shall delegate, through legally binding lease agreements, the responsibility for management of water safety risks to the occupier.

The WSG will continue to consider new developments and improvements in the field of Water Quality Management & Control, in order to ensure that the control of the prevailing risks, posed by the systems and operations on its sites, is constantly reviewed, improved and maintained at the maximum level.

6. AUGMENTED CARE

This WSP applies to all areas of the CTMUHB estate where persons are exposed to potential waterborne hazards, but has particular relevance in areas designated as augmented care.

Augmented care areas are determined as being where medical or nursing procedures render the patient susceptible to invasive disease from environmental or opportunistic pathogens

Ref:

Policy Title: Water Safety Plan V2.3

Page Number: 7

such as *pseudomonas aeruginosa* and Legionella, including:

- Patients who are severely immunosuppressed because of disease or treatment, including transplant patients and similar patients during high-risk periods in their therapy;
- Patients cared for in units where organ support is necessary, including neonatal and adult critical care, renal, respiratory and other intensive care situations;
- Patients with extensive breaches in their dermal integrity who require contact with water as part of their continuing care, including burns patients.

The list of augmented care areas, as determined by Lead Microbiologist, Including the requirements for water sampling, is provided in Appendix B.

7. DEPARTMENTAL ROLES & RESPONSIBILITIES

The following roles and responsibilities are to be read in conjunction with the Health Board's Policy: Water Safety, Infection and Risk Prevention Policy.

7.1 Duties and responsibilities of staff.

A person intending to fulfil any of the following staff functions should be able to prove that they possess sufficient skill, knowledge and experience to be able to perform safely the designated tasks. They will be asked to accept the responsibilities in writing.

7.2 Duty Holder

The Duty Holder (DH) has overall responsibility for the Health Board, (CEO of the Health Board). The Duty Holder must ensure that staff with designated roles have the resources to fulfil those roles. The duty holder ensures the delegation of duties is carried out through the nominated Designated Person.

7.3 Designated Person.

The Designated Person (DP) is the senior executive board level member who is the Director of Finance, with assigned responsibility for the service, acting on behalf of the Duty Holder. They will appoint in writing the independent Authorising Engineer (AE), and are responsible for appointing in writing the Responsible persons on the specialist advice given by the Authorising Engineer. They are responsible for requesting the independent annual audit carried out by the Independent AE, or any other associated auditors, and ensuring the Water Safety Group is formed, and meets as noted, and has the authority to act on the DH behalf.

7.4 Authorising Engineer

The independent specialist Shared Services technical water expert, nominated to advise CTMUHB on matters relating to this document, and appointed in writing by the designated person on behalf of the Chief Executive Officer. They will act on behalf of CTMUHB to give independent advice to ensuring the delivery of safe water in healthcare premises. They will carry out assessments in deeming RPs and DRPs to be of a level competent to undertake that duty, and will advise the DP accordingly in recommending if the RP/DRP appointment should be made. The Authorising Engineer (AE) will be invited to attend the Water Safety Group (WSG), where they will give expert advice and guidance to the group. They will witness tests and carryout checks under the appointment, and deliver to the DP audits as required, to provide assurances on the management of water systems within CTMUHB. The person must have specialist knowledge, training and experience of water systems.

Ref:

Policy Title: Water Safety Plan V2.3

Page Number: 8

7.5 Microbiologist

The specialist CTMUEB microbiologist nominated by management to advise on infection control policy, and have responsibility for water quality. They will use their experience and competence in assessing risk from microbiological hazards on the specific healthcare population, and advise on areas of specific risk, such as augmented care facilities and that of vulnerable patient groups. They will be responsible for advising on specific requirements for water sampling, including pre and post construction, renovation of capital projects and sign off on completion prior to patient occupation. They will ensure ongoing surveillance of Hot and Cold water systems, and continue to monitor clinical isolates of waterborne pathogens, including the presence of *Pseudomonas aeruginosa* and similar pathogens in "at risk areas" such as augmented care units as an alert organism and be aware of possible outbreaks or clusters of infection with these micro-organism. They will form part of the quorum as a main lead on the Water Safety group. The person must have specialist knowledge, training and experience relating to water in their field of expertise.

Locations deemed as augmented care by the Lead Microbiologist are given in Appendix B

7.6 Infection Prevention & Control - Nurse (IP&C)

The specialist IP&C Nurse is the person nominated by management to advise on infection control policy and to have responsibility for the water quality. They will use their experience and competence in assessing risk from microbiological, chemical and physical hazards on the specific healthcare population, and provide advice on areas of specific risk, such as augmented care facilities and that of vulnerable patient groups.

The principle role of IP&C is to monitor and advise on all matters of the prevention of infection, produce policies and procedures to help safeguard patients and staff, and initiate control and emergency measures as necessary. IP&C will support the microbiologist in organising and policing the WSP to ensure that waterborne hazards are managed in accordance with this WSP. IP&C and Estates are also the primary recipient of all results of water samples directly from the laboratory, and distributes copies to the RP (Water). Results of concern are automatically notified as soon as the test result is shown to be positive in the lab to IP&C and Estates by the Approved laboratory. Those notified, ensure appropriate and timely action is taken in accordance with the principles and procedures of this WSP. They will form part of the quorum as a main lead on the Water Safety Group.

7.7 Facilities Management

The Facilities Manager, is the person nominated by management to advise on control measures to prevent the spread of water pathogens through housekeeping and cleaning activities. This includes management of cleaning Safe Systems of Work (SSOW), disinfection, and outlet flushing measures where required as identified within the risk assessment (this will be a ward/department responsibility to complete as Facilities are a service provider only, Should be noted within 7.12 below), and in the delivery of housekeeping duties. They will ensure that staff have adequate hygiene and legionella awareness training), and that staff are fully aware of their responsibilities to prevent microbiological contamination of plumbing components, and adherence to relevant legislation. Facilities will be required on times to undertake flushing of low use or infrequently used outlets when and where required, this will be documented on each site so all parties are aware of their responsibilities, this practice will continued until confirmed no longer needed. Where facilities teams undertake flushing it is

Ref:

Policy Title: Water Safety Plan V2.3

Page Number: 9

their responsibility to ensure the flushing sheets are completed at the required frequency and records kept to demonstrate compliance, copies of the flushing forms should be sent to the Estates Department, originals should be kept by Facilities.

Facilities will form part of the quorum as a main lead on the Water Safety Group. The person/s attending from each region of the health board will have specialist knowledge, training and experience of water systems in their role.

7.8 Estates Management

The Estates Management team headed up by the Head of Operational Estates, and Senior Operational Managers, reporting directly to the Assistant Director (Capital and Estates) are tasked with managing water maintenance of fixed (i.e. not mobile) water systems, through the designated Planned Preventative Maintenance (PPM) electronic control system. They will ensure that water related maintenance is distributed to relevant trained and qualified engineering staff or appointed contractors with the necessary skills, accreditations and qualifications to undertake maintenance at the required timescales as noted in WHTM04-01 Part B. They will provide a helpdesk where remedial work can be requested, and will ensure timely distribution to qualified in-house or external contractors. They will ensure that Estates staff are trained and that refresher training is carried out when required.

7.8.1 Chair of the WSG

The Head of Operational Estates chairs the WSG, and reports directly in to the Capital and Estates Health Safety and Risk Committee, and any significant water risks to the health board through the appropriate channels. In the absence of the Chair, the Vice Chair or a designated RP (Water) will act as Chair to the WSG.

7.8.2 Responsible Person (RP)

The Responsible Person (RP) has legal responsibility for water quality, and will be nominated from Senior Operational Managers (SOMs) within the Estates function. The RPs must possess adequate professional knowledge and have undertaken appropriate training. The RPs should be appointed in writing by the CTMUHB DP on behalf of the Chief Executive Officer, to devise and manage the necessary procedures for ensuring that the quality of water in CTMUHB premises is maintained. The RPs should be a manager or director, or have similar status and sufficient authority to ensure that all operational changes, procedures, system alterations and any recommendations are carried out in an effective and timely manner to minimise risk.

The Responsible Person is required to liaise closely with other professionals in various disciplines and is able to delegate authority. In addition, the RPs should possess a thorough knowledge of water hygiene and would, ideally, be an Estates Manager, microbiologist or other professionally qualified person.

This role, in association with the Appointed Authorised Engineer, Microbiologist, IP&C Nurses and maintenance staff, involves:-

- Advising on any potential areas of risk and identifying where systems do not adhere to relevant guidance / legislation.
- Liaising with water undertakers and environmental health departments and advising on the continuing procedures necessary to ensure acceptable water quality.
- Monitoring the implementation and efficiency of these procedures.
- Approving and identifying any changes to the procedures.

Ref:

Policy Title: Water Safety Plan V2.3

Page Number: 10

- Ensuring equipment that is to be permanently connected to the water supply is properly installed.
- Ensuring adequate operating and maintenance instructions exist and adequate records are kept.

Implementation of an effective maintenance policy must incorporate the preparation of fully detailed operating and maintenance documentation and the introduction of a log book system. The RPs should appoint a Deputy Responsible Persons (DRPs) to whom delegated responsibilities may be given on all occasions when the RPs is unavailable.

The RP should be fully conversant with the design principles and requirements of water systems and should be fully briefed in respect of the cause and effect of waterborne organisms. The appointment of an engineer is appropriate in that the role can extend to the operation and maintenance of associated plant. It is recognised that the RP cannot be an expert on all matters and must be supported by specialists in specific subjects, such as water treatment and microbiology, but must undertake responsibility for calling upon and co-ordinating the activities of specialists. , and will act as deputy Chair of the WSG in the absence of the nominated Chair.

Procedures and technical standards for ongoing water safety management for the above functions are controlled and issued by the RP (Water), and include the following as a minimum:

- Legionella risk assessments
- Monitoring of legionella controls;
- Cleaning & disinfection of shower heads and hoses and other spray devices
- Testing and maintenance of thermostatic mixing devices
- Maintenance, cleaning and disinfection of other water systems equipment
- Water sampling as directed by the Lead Microbiologist, WSG & IP&C
- Responding to out of specification results and matters of evident concern
- Investigating and carrying out corrective actions;
- Maintenance of legionella control records;
- Cleaning procedures for clinical wash-hand basins;
- Capital design and project management procedures;
- Engineering technical standards;
- Auditing of water quality controls;

7.8.3 Deputy Responsible Person (DRPs)

DRP's, will be nominated from Estate Officers (EOs) and Maintenance Supervisors within the Estates function. Taking responsibility for one's conduct and obligations and held legally responsible and who has sufficient technical knowledge, training and experience to manage the maintenance and routine testing of the water storage and distribution system. Deputise delegated responsibilities on all occasions when the RP is unavailable.

7.8.4 Estates Operational Maintenance teams

Responsible for the maintenance of water systems, including the implementation of aspects of the legionella control scheme using in-house staff, and all associated corrective actions and remedial works by means of a PPM system, and reactive maintenance electronic logging. On occasions, this department will procure the services of specialist water-hygiene / treatment services providers to assist.

Ref:

Policy Title: Water Safety Plan V2.3

Page Number: 11

Implement when instructed to by Microbiology and IP&C, water sampling regimes, monitor, and report back to IP&C any readings that fall outside of the parameters set for that reading. Implement with the assistance of Microbiology and IP&C, control procedures to deal with results outside of the parameters.

This section sets out the procedures that the Estates Department carry out as part of the CTMUHB's overall legionella control system in compliance with ACOP L8 / HSG 274 and WHTM 04-01. The Estates control procedures fall into the following main categories:

- Routine planned preventative maintenance (PPMs) incorporating:
- Inspection and appropriate remedial action
- Monitoring
- Water Temperature Control Regime (primary method of control)
- Flushing Regime
- New Works Procedures

7.9 Competent Person (CP)

A Competent Person (CP) is someone who has sufficient water knowledge, training and experience to work on, supervise, manage and control building construction, installation, renovation, maintenance, remedial work and routine testing of all water systems. This should include Estate engineers who actively work on water systems, facilities operatives involved in cleaning, flushing work, ward staff who are responsible for flushing, IP&C and anyone involved in record-keeping in line with the written scheme of all water systems, and any person having management responsibility over persons working on CTMUHB water systems.

7.10 Architects / Design Engineers / Design Consultants / Principle Contractors / Contractors

Architects / Design Engineers / Design Consultants / Principle Contractors / Contractors are responsible for the design of buildings and need to have an understanding of the operation and requirements associated with water devices and supplies. Architects work with design engineers and other professionals who are responsible for construction details. When renovating or modifying existing and occupied facilities, architects should consult with the users including those involved in management and maintenance of water systems. In the case of hospitals and health-care facilities, this should involve consultation and taking direction and authority to proceed from IP&C staff, microbiologists, RP's / DRPs and AEs Water.

Designs should be in accordance with WHTM 04 – 01, and in particular, Part A, L8, HSG 274 and all other associated water legislation. Design engineers are responsible for translating architectural plans and ensuring compliance with plumbing standards and with WHTM 04 - 01. Project and construction engineers are responsible for the installation of water systems. When buildings are being constructed, renovated or modified, engineers provide a key role in establishing risk-management plan to minimise risks to people using the building. These risk-management plans should include instructions on how they will actively manage the water system during the active works, how to deal with potential problems, disruptions to services, and they should ensure that technical standards and regulations are met.

Risk management plans should include how education of maintenance and construction workers on the task will be undertaken, and ongoing assurances that the standards laid out in the Risk Assessment (RA) are followed, monitored, and addressed should a failure in the plan be found. In relation to the control of Legionella, it is essential to ensure that potential contractors have suitable qualifications, and are Water Safe, and Construction Line approved with their membership active and in date.

Ref:

Policy Title: Water Safety Plan V2.3

Page Number: 12

The above individuals and disciplines also have to ensure compliance and adherence to the Construction Design Management (CDM) regulations to ensure equipment can be maintained effectively & easily and the installation/s don't introduce risk or hazards as a result of their design.

These individuals and disciplines also have responsibilities of designing and specifying safe, well designed installations and buildings. They must ensure the systems operate as designed and within the design parameters, achieving what they were intended to do in terms of flow rates, flow & return temperatures etc. etc.

Contractor/s and Sub-Contractors are responsible for installing systems as specified and as per the specifications and design layouts. They play an important role in ensuring the design and systems installed by them or their staff meet their design criteria specified by the designers. They should also not install modifications or introduce changes to that what was designed or specified without prior agreement by the architect, principle designers, Capital lead or the project group.

They must not introduce risk or hazards through the course of their works and must comply to any arrangements or precautionary measures agreed at the pre-contract meeting by the Capital lead, RP/DRP or IP&C. This could mean covering WHBs and outlets to stop dust & dirt contaminating them, covering pipe work or ensuring taps and fixtures remain in their bags until they are fitted or by flushing the outlets and recording these activities.

Contractors are responsible for ensuring water systems remain safe, clean and help avoid stagnation in their work areas any areas of concern should be raised with the Capital Lead or Project Group.

7.11 Capital Project Managers / Officers

Capital Project Officers are responsible for ensuring any contractors working on CTMUHB premises, meet the competence requirements of this document, and any work meets the requirements of legislation such as ACoP L8, HSG 274, and in particular WHTM 04-01 for healthcare properties. They need to have an understanding of the operation and requirements associated with water devices and supplies.

When constructing new builds or renovating or modifying existing and occupied facilities, Capital Project Officers must consult with the users including those involved in management and maintenance of water systems. In the case of hospitals and healthcare facilities, this should involve consultation with the RP or DRPs, IP&C Nurses / Specialists, microbiologists in particular to any water testing / sampling required as part of the project, RP's and AE prior, during and post construction, and will take specific instruction from these specialists to ensure management controls are in place to manage water systems during projects.

Designs should be in accordance with WHTM 04 – 01 and in particular Part A. They are responsible for supplying correct manuals, documentation, pre-handover training and the familiarisation to operational personnel. Capital / Major Projects, Project Managers are responsible for final certification of satisfactory completion of building construction, including any required sampling, that will be presented to the Microbiologist IP&C and RP or DRP for final sign off of the project.

Capital Leads / Major Project officers and Project Managers have responsibilities while the areas of works are under their control or the control of contractors under their work package. They must ensure along with a project manager if used that the contractors install the systems as per designs and specifications, they must also ensure that any specific requirements agreed with the RP/DRPs, IP&C or other stakeholders are enforced and implemented.

Ref:

Policy Title: Water Safety Plan V2.3

Page Number: 13

Items such as:

- Ensuring accurate "As Fitted" drawings are received prior to handover as per the RIBA plan of Works 2020.
- Ensuring handover documentation and O&M manuals are presented and complete prior to hand over as per RIBA Plan of Works 2020
- Any derogations from WHTM or other guidance, regulations or legislation is presented to the WSG, RP/DRPs and IP&C prior to works starting, they will be responsible for preparing the derogation list and getting appropriate sign off from stakeholders including this in O&M manuals
- They will ensure as part of the project group that all installs comply to the CDM regulations
- Any water dispensers or coolers, vending machines or coffee machines proposed as part of the work or scheme are presented to the WSG and approval granted prior to ordering or installation. If they are installed without prior approval the WSG has the power to request they are removed or arrange removed and cross charge the capital scheme to do so.

Arranging for a valve matrix/s to be compiled by the contractor for the work area or scheme to indicate isolation points of the services by worked on, this will ensure no valves are left closed or off following the scheme, this is an important requirement. This should be the case for all works and schemes regardless of scale and scope.

- Ensure any outlets identified as needing flushing as part of the works or scheme are flushed by the contractor at the required intervals and records kept to demonstrate compliance.
- Ensure the contractors or sub-contractors protect all WHBs, outlets, bathes showers etc. in the work area are covered using a suitable means to prevent possible contamination from dust, dirt and other contaminants.
- Ensure the contractor and any sub-contractors ensure copper pipework is capped, covered or bagged when stored and only uncapped, uncovered or un-bagged when being immediately installed, this must also apply to fixtures and fittings such as taps, valves and TMVs etc.
- Allow for temperature profiling of the work area prior and post works, this is to ensure the works haven't imbalanced the hot flow & return pipework or cold water systems, if there are issues found post works the capital lead will be responsible for implementing and meeting the costs of the correct actions and rebalancing of the systems to ensure they meet the required temperatures. The profiling will also ensure that if any valves have been left in the "OFF" position / "Closed" position this will be highlighted.

There have been occasions where isolation valves have been left in the "OFF" position / "Closed" position and this hasn't been identified until much later, post works which introduces risks as control measures are out of tolerance. The same can be said for balancing / DRV valves, these should not be used for isolation but have been isolated in the past which again has introduced risks where there is no flow on the return circuit.

- The Capital Lead / Project Lead must ensure in line with the valve matrix that all valves are returned to normal operation / position and that balancing valves/ DRVs are

Ref:

Policy Title: Water Safety Plan V2.3

Page Number: 14

returned to their set up commissioning position. This should be the case for all works and schemes regardless of scale and scope.

- The Capital Lead / Project Manager must allow for balancing or rebalancing of the hot water flow and returns circuits and cold water systems, the introduction and installation of just one WHB to a system can imbalance the system, it is extremely important that verification of the temperature control measures is allowed for and if the temperatures are not what they were prior to works commencing then the Capital / Project Lead must again be responsible to returning the system back to a complaint state and meeting the costs of the correct actions and rebalancing of the systems to ensure they meet the required temperatures.
- Chlorination of all new pipework and fittings must be allowed for in every Capital scheme, the Capital Lead / Project Lead will arrange through the use of suitably qualified contractors to chlorinate the system/s for the works areas they have altered or modified. The RAMS must be presented to the RP/DRPs, IP&C and Microbiologist well in advance of the chlorination process, so that consideration and any subsequent comments can be made prior to the chlorination process taking place.
- Sampling must be conducted before and after Capital Works or Schemes, this can be a mixture of CTMUHB samples and contractor samples. The samples will help all parties determine if there is a problem in the system/s prior to works starting or if the problem has been introduced to the system/s by the Capital works or schemes, this will enable CTMUHB to have recourse with the contractor to remedy the issue.

7.12 Directorate / Ward / Area Managers

All Directorate, Ward or managers managing a specific area, have a responsibility to ensure the requirements of the WSP and Water Safety Policy are carried out for requirements under their control. This includes but not limited to, the requirements for the flushing of little used outlets, and ensuring locations where water is present such as bathrooms / shower rooms are kept clear to ensure flushing is possible, and under no circumstances should be used for storage. Notification of ward closures, requests to install Water Coolers or Ice machines, and any other requirement of the WSP. If the areas they are responsible for have no need for the water outlets, showers, baths etc. they must make the Estates Department & IP&C aware and make a request to have these removed and cut back to the nearest "TEE" to remove any risk of stagnation. The areas manager will have to meet the costs of the removal and any alteration works associated with the removal of the outlets, fixtures and pipework.

7.13 Employees

Employees should be aware of the results of risk assessments in their area of activity, including water management, and what they need to do personally to ensure compliance with control measures identified as being necessary. Examples of such action include following a safe system of work or wearing suitable personal protective, flushing of little used outlets in their departments, or the correct disposal of fluids / waste that does not impact adversely on the delivery of wholesome water. Employees need to be aware of the correct methods of reporting faults where water issues are observed. It is the responsibility of all employees to report any concerns to their team leader, supervisor or line manager.

7.14 Procurement

Procurement play an important role in the management of water systems and provision of safe water systems, they must ensure that any newly procured items conform to the latest

Ref:

Policy Title: Water Safety Plan V2.3

Page Number: 15

British Standards (BS) but also comply with other legislation & regulations such as the Water Supply (Water Fittings) regulations 1999 and WHTM 04-01 standards.

Procurement must not purchase, order or agree lease arrangements for equipment such as water dispensers/coolers, portable air conditioning units, dehumidifiers, coffee or water dispensing vending machines without approval and oversight from the WSG.

If rogue requests are intercepted without WSG approval then procurement are to contact the Chair of the WSG or WSG administrator immediately, they are not to approve the purchase, order the items or equipment or agree lease or rental. This applies to their department or when they act on behalf of departments submitting the requesting.

Only after WSG consideration & subsequent approval can the process of purchasing, ordering or rental agreements can be authorised. If the submission/s are declined and not approved the procurement team are to inform the requester/s of the non-approval.

The procurement team should check with the WSG, Estates Department and IP&C department in all matters relating to the purchase of any water based equipment, items or parts that can be connected to any CTMUHB

Procurement must not order any Point of Use (PoU) filters unless agreed by the WSG or Estates Department, if requests come from departments or hospital management they are to decline the request/s and make the WSG & Estates Department aware of the request and the decline of the request.

8. MANAGEMENT OF WATER SYSTEMS

List of associated persons responsible in the management of Water systems within CTMUHB, individual names will be through WSG attendance and designated person in attendance, and RP/ DRP appointments.

Table 2

Role:	Job Title	
Designated Person	Director of Finance	Person In post
CTMUHB AD Estates	Assistant Director (Capital & Estates)	Person In post
AE (Water)	Shared Services Wales	Person In post
Chair of WSG	Head of Estates	Person In post
Deputy Chair WSG	Assistant Head of Estates	Person In post
Lead Microbiologist	Consultant Microbiologist	Person In post
Lead IPC	Lead IPC Nurse	Person In post
Facilities Lead	Facilities Manager	Person In post
Facilities	Facilities Manager	Person In post
Facilities	Facilities Manager	Person In post
CTMUHB Capital Projects	Head of Capital	Person In post
RP Operations - RGH	Senior Estates Officer	Person In post
RP Operations - PCH	Senior Estates Officer	Person In post
RP Operations - POW	Senior Estates Officer	Person In post
DRP Operations RGH	Estates Officer	Person In post
DRP Operations PCH	Estates Officer	Person In post
DRP Operations POW	Acting Estates Officer	Person In post
Projects Capital Lead	Capital Project Manager	Person In post
Directorate / Ward / Area Managers	Directorate / Ward Managers	Person In post
Compliance with this document	All CTMUHB Employees	Person In post

9. RISK ASSESSMENTS.

9.1 Assessing the Risks from Legionella

The risks from legionella shall be formally assessed in accordance with the requirements of the HSE's approved code of practice (ACOP L8). Risk assessments shall be undertaken to the standards outlined in BS8580-1:2019 and the Legionella Control Association's (LCA) service standard for legionella risk assessment. The CTMUHB will commission qualified external consultants to carry out a comprehensive risk assessment for Legionella risks on all buildings owned or occupied by the University Health Board.

The RP (Water) shall retain legionella risk assessments and reviews and shall be responsible for the arranging and execution of legionella risk assessments on behalf of the statutory duty holder, or for overseeing the requirements for capital projects to provide updated risk assessments on completion of changes to water systems as part of capital schemes, including the selection of suitable competent persons to assist.

Risk assessments shall be formally reviewed to ensure they remains up to date no less often than every 2 years, or whenever there is reason to suspect that they are no longer valid or significant changes to the system/s have occurred, resulting from:

- Changes to the water system or its use;
- Changes to the use of the building in which the water system is installed;
- The availability of new information about risks or control measures;
- The results of checks indicating that control measures are no longer effective;
- A case of Legionnaires' disease or legionellosis is associated with the system.

Drawings and schematics are held in the Estates online W drive and MICAD System. This file allows specific schematics / drawings to be reproduced on request.

Water system schematics are produced for all hot and cold water systems and should be in accordance with WHTM 04-01 and BS8580-1:2019. The schematics show the storage systems in plant rooms and tank rooms. Distribution schematics show sentinel outlets. For each water system that presents a risk from Legionella bacteria, a schematic or drawing shall be held, showing:-

- Origin of water supply;
- General layout of the system;
- How the system operates;
- All associated storage and header tanks;
- All standby equipment;
- Any parts of the system that may be out of use temporarily;
- Any problem areas such as dead legs, dead ends;
- Regular operation and test points.

These schematics/drawings may also show:-

- All system plant, e.g. water softeners, filters, strainers, pumps, non-return valves and all outlets, for example showers, wash hand basins etc.;
- All associated pipework and piping routes.

Ref:

Policy Title: Water Safety Plan V2.3

Page Number: 18

Estates staff & Capital projects ensure that any changes to the domestic water systems and associated equipment are recorded so that schematics / drawings held on file are kept up to date. These drawings are managed centrally by the Compliance team.

Drawings/schematics shall be checked to coincide with risk re-assessment, to ensure that they are up to date.

CTMUHB has a drawing specification & requirements that must be followed for all drawings, this details what is required in terms of the colour of the lines required for certain services, symbols required, line weights etc., this specification must be used to ensure continuity of the drawings and standardisation.

In the case of a risk assessment no longer being deemed as valid, a new WRA will be carried out in line with 9.1 requirements.

Where risks prove difficult to control, they will be added to the CTMUHB risk register in accordance with CTMUHB procedures.

9.2 Assessing the Risks from *Pseudomonas Aeruginosa* – Augmented Care Areas

The risks from pseudomonas shall be formally assessed in accordance with the requirements of WHTM 04-01 '*Pseudomonas aeruginosa* – advice for augmented care units'. Risk assessments shall identify potential microbiological hazards caused by *Pseudomonas aeruginosa* and other opportunistic pathogens and the hazardous events and risks that may arise during storage, delivery and use of water in augmented care settings. They should identify actions to minimise the risks and ensure that appropriate sampling, monitoring and clinical surveillance arrangements are in place.

Risk assessments should be undertaken by a representative or appointee of the IPC team on behalf of the IPC with the assistance of an AP Estates. And BS 8580-2 (2022) Risk Assessments for *Pseudomonas Aeruginosa*.

Risk assessments for *Pseudomonas aeruginosa* shall be formally reviewed to ensure they remain up to date no less often than every 2 years, or whenever there is reason to suspect that they are no longer valid, including:

- When results of surveillance identify failure of the control measures; or
- When a case or outbreak is associated with the system or location.

9.3 Assessing the Risks from Scalding

The risk from scalding from hot water supplies shall be assessed in accordance with HSE guidelines and WHTM 04-01 in all areas of the estate, including wards, resident's rooms and areas to which patients, residents and visitors have access. The assessment shall consider the susceptibility of those exposed to hot water including:

- Children;
- Older persons;
- Persons with reduced mental capacity;

Ref:

Policy Title: Water Safety Plan V2.3

Page Number: 19

- Persons with reduced mobility;
- Persons with a sensory impairment;
- Persons who cannot react appropriately or quickly enough to avoid injury.

Risk assessments for scalding shall be formally reviewed annually but more frequently if required under the following circumstances:

- When there are changes to the use of the building in which the water system is installed;
- The availability of new information about scalding risks or control measures;
- A scalding incident has occurred.

10. DESIGN, INSTALLATION, COMMISSIONING OF WATER SYSTEMS.

The design and construction of new, or major additions to existing water systems on CTMUHB property is the responsibility of the Capital Team who maintains engineering technical specifications which contain the following:

- Principle design criteria for water systems;
- Approved water system equipment and materials;
- Standards for installation and commissioning.

The Capital Team ensures that water systems and buildings in which water systems are installed are able to maintain safe water throughout the whole life of the system, with future development taken into consideration where practicable.

The Capital Team / Designer/s / Project Manager/s must ensure the water systems are designed, installed and commissioned in accordance with the requirements of current legislation and guidance as determined in the appropriate WHTM as a minimum, thus enabling the water systems to be compliant to guidance & legislation, in addition perform, be operated and be in accordance with WHTM 04- 01 Parts A&B, ACOP L8 and HSG 274.

During the installation the Capital Team, or Officer must ensure the installer/s adhere to any requirements set out by IP&C or RP / DRP, for example, it's important that outlets are flushed to avoid stagnation but also WHBs and outlets are covered & protected against contamination such as dust and dirt from the work areas.

Maintaining appropriate ongoing controls in water systems post-handover is essential and building designs take into account the need for control measures to be maintained at all times, including seasonal, daily fluctuations in occupancy of the building and use of water.

Prior to design sign off, Water (RP) and IPC must give authority and approval for the design to proceed, guidance can be sought through the Water AE if required, taking into account but not limited to, design, future proofing of the system, construction and water components, and management of existing and new water systems during construction to prevent contamination of the water system. IPC, RP / DRP and Microbiologist will confirm at this stage in the process, pre and post construction, the required sample testing procedures to be adopted, quantities, test and locations. Formal sign off process to record that the above persons have reviewed and are happy with the proposed water system design should be made and recorded within project documents.

Ref:
Policy Title: Water Safety Plan V2.3
Page Number: 20

Commissioning of systems must be fully encompassing, this must include temperature profiling of the hot & cold water system/s to ensure they meet the design and specification flows and temperatures, TMV fail safe test and temperature tests, pump operation and swap over operation from standby to duty etc. Many commissioning paperwork will only include temperatures at the outlets (what is coming out of the outlet) and not necessarily what is behind on the flow and return pipework, if these are the only readings and profiling taken this will not be accepted by CTMUHB, as it does not give full assurance of a safe and compliant system/s.

10.1 Major Capital Projects:

All new construction projects, including all design and construction activity are undertaken under framework agreements with approved specialist design and construction companies, and often includes sub-contracting of installation and commissioning of water systems.

It is recognised that new works that involve changes to or additions to an existing water system are a particularly high legionella risk due to their potential effect on the existing water system and that the systems involved often lie unused for a period between construction and the facility becoming fully operational.

CTMUHB has a number of procedures in place to ensure that any new works associated with water systems are compliant with guidance and that minimise the risk of legionella growth resulting, these are;

- Tender package that includes
- Programme of works
- Code of contractors
- Standard O&M Specification
- Water Safety Plan
- Pre contract agreement on water systems agreed prior to start

All works undertaken on CTMUHB premises by contractors must comply with the Estates & Capital Code of Conduct & Safety Rules for Contractors and Estates & Capital – Control of Contractors Procedure. A copy of the latest version of the Site Rules forms part of every tender that the Capital Department issues and is incorporated in every Capital contract and Health & Safety Plan associated with compliance with the Construction Design Management Regulations 2015 (CDM).

The forms are based upon compliance with WHTM 04-01 Part A, Water Systems Design Requirements.

10.2 Discretionary Capital Projects:

Discretionary Capital Projects can vary in scale and complexity, the extent of work can also vary on the water systems from adding an outlet to major reconfiguration of the system/s with the removal and adding of multiple outlets and assets.

Discretionary Capital Projects should allow for temperature profiling prior to any works to identify if there are any issues with the existing systems control measures. The Estates Department carry out sentinel monitoring of Hot & Cold water services but the works may be undertaken in areas covered by tertiary monitoring and these issues may go unnoticed for

Ref:
Policy Title: Water Safety Plan V2.3
Page Number: 21

some time so important that this is allowed for in every scheme.

Specific mechanical & electrical projects and local property refurbishment projects are often designed in-house or by Mechanical & Electrical (M&E) design consultants employed by the health board, however all installations and commissioning works are delivered by approved contractors following competitive tender and must include RP and DRP approval and oversight of the proposed commissioning.

10.3 Design Risk Assessment:

All water system designs are subjected to a design risk assessment before construction commences where a schematic drawing of the water system and performance criteria (volume, flow, temperatures and other relevant controls) are reviewed and assessed by the Capital team. This should be presented to the WSG for approval having been ratified by the Operational Responsible Persons (Water) and/or the Authorising Engineer (Water), and a representative of IPC for the site.

10.4 Construction Risk Assessment

During construction, the Operational Responsible Person (Water) and/or Authorising Engineer (Water) should be given access to the construction plans by the capital lead to enable a review of the operability and maintainability of water system assets.

10.5 Commissioning

Performance of the water system in line with design criteria must be proved and witnessed by or on behalf of the Responsible Person (Water) and/or Authorising Engineer (Water) during the commissioning process and before the project is handed over. Prior to hand over, IPC and Microbiology will be presented with any required testing results. IPC and Microbiology will sign off on commissioning, only on receipt of satisfactory results, and prior to any patient or staff occupation of the premises served by the water installation. Records of commissioning are issued as part of the Health & Safety Manual or Operation & Maintenance Manual.

As previously mentioned in this WSP, commissioning of the water system/s is extremely important and correctly designed, installed and commissioned system/s will help combat the risk of water borne pathogens.

Commissioning must include:

Temperature profiling – this encompasses the whole system, key measurements of temperatures must be taken at key points and branches throughout the system/s to ensure they are correctly balanced and no low temperatures are recorded on the system/s. A drawings must be produced of the system/s and the profiling points /noted on the drawing/schematic, the temperatures at those points must be recorded for the flow & return pipework at each point. The positions of the profiling must be agreed with the WSG or RP/DRPs. Please note – these are not temperatures taken at or from the outlets.

TMV Fail Safe Test – All tests must be recorded and indicated as “Pass” or “Fail” the temperatures must be recorded and noted. If TMVs fail to pass the fail safe test, these must be replaced or adjusted if possible and retested, the retest results must be recorded against Ref:

Policy Title: Water Safety Plan V2.3

Page Number: 22

the original failure and referenced as such. For every outlets tested with a TMV the room and which fixture it feeds. E.g. – Room 43 – Clinical WHB TMV.

Temperatures at Outlets – These must be checked and results recorded to ensure they meet the requirements set out in HSG 274 and WHTM 04-01 for temperatures feeding outlets. The record sheet must include what the temperature should be and a column allowed for what was measured.

Chlorination RAMS & Certificates – Chlorination RAMS & certificates must be provided as soon as reasonably practicable in relation to the works or scheme, the chlorination RAMS should be provided to the RP/DRPs, IP&C and microbiologist at least 2 weeks before the chlorination works are undertaken or programmed to commence, this will allow all parties to review and provided any scrutiny or comment in relation to the methodology of the processes being used to treat and chlorinate the system/s.

Sampling – Sampling will be allowed for at the commencement of the works, schemes or projects and on completion, prior to the area or department being handed over. The requirements, scope and scale of sampling will be discussed with the RP/DRPs, IP&C and Microbiologist, these requirements will then be followed without deviation or agreement from those parties, this information will include the amount of samples from what positions and outlets and the type of samples taken, e.g. Legionella, TVCS or Pseudomonas. Legionella samples take 10 days to process and return indication of possible presence in the system/s sampled so the contractors or specialist sub-contractors must ensure a contingency period is built into their programme to account for any bad sample results and a cooling off period. All pre & post results sheets must be included in the O&M manuals.

Flow rates – must be checked to ensure they meet the design specified and flows are achieved throughout the system and allow the system to meet or exceed demands place on it by its short or long used. The recorded values must be present in a format that is easy to understand and be available prior to handover, then a copy subsequently included in the O&M manuals.

Valve Matrix – As described earlier in this WSP the need for a valve matrix is extremely important on any work package, scheme or project. The valve matrix must be used throughout the works and a number may be used, this valve matrix can be used by the contractor, RP/DRPs, Estates department representatives and any other stakeholder in checking that the valves have been returned to their correct or installed position/s. The detail of balancing valve positions should also be noted on this sheet – e.g. 3 /4 or position 4 depending on the type of valve used.

Drawings – Design drawings should be provided to the RP/DRPs, IP&C and microbiologist well before the works, scheme or project commences this will allow all parties to review the design and provide any comments or observations – at least 2 months prior to works commencing. It is recognised that these timescales cannot always be adhered to, due to pressures within the system and needs of the service. However, design drawings should be present as soon as reasonably practicable to key stakeholders such as the RP/DRPs, IP&C etc. “As Fitted” drawings should be supplied we before handover and in line with the RIBA Plan of Works 2020, these should be checked for accuracy by the principle contractor, capital lead or project officer, these individuals are responsible for the accuracy of the drawings. The drawings should

Ref:

Policy Title: Water Safety Plan V2.3

Page Number: 23

be witnessed for accuracy by the RP/DRPs, IP&C etc. The drawings should detail valve settings and positions of balancing valves where installed so this data can be cross referenced and used in the future.

The above examples are not exhaustive and more commissioning data may be required for some work packages / schemes depending on scale and complexity, all of the information must be included in the O&M manuals

The Capital Team (Projects) shall ensure that the site installation and commissioning procedures are addressed as part of the commissioning process. These shall include all relevant sections as described in BS8558:2015 and particularly WHTM 04-01 Part A, Chapter 15 and 16.

It is essential that a full report of all commissioning and testing activities are compiled and supplied prior to hand over to be incorporated within the O&M manuals. The must be provided prior to handover as per the RIBA Plan of Works 2020.

10.6 Capital Projects Procedure – Infection Control Approval

In addition to the Infection Control / Microbiology team sign-off required as part of the process described above, the Capital Project team have a detailed Capital Projects Procedure specifically related to interaction with and assurance that appropriate infection control measures are properly incorporated into the entire project delivery process. This includes legionella control issues. A copy of the 'Capital Projects Procedure – Infection Control Approval' document is shown at Appendix D.

11. CONTROLLING THE RISKS OF LEGIONELLA

11.1 Maintenance activities

Will be carried out in accordance with WHTM 04-01 part B and part C and D08, for the management of water systems, and will be undertaken as part of the Estates function using a Planned Preventative Maintenance (PPM) software system.

Due to the source of legionella being the incoming water supply, it is essential to prevent growth within the water system. The principal control measure for maintaining low levels of legionella bacteria in hot and cold domestic water systems is temperature, with the principle aim of avoiding water temperatures between 20°C and 45°C where the risk of legionella proliferation is at its greatest. The temperature controls that are employed are as follows:

- Cold water shall be stored and distributed to all services at no greater than 20°C;
- Cold water temperature shall not increase more than 2°C above that of the supply to the building;
- Hot water, where stored in vessels greater than 15 litres, shall be no less than 60°C;
- Hot water stored in vessels up to 15 litres shall be no more than 55°C
- Hot water shall be distributed to all services in non-healthcare premises at no less than 50°C;
- Hot water shall be distributed to all services in healthcare premises at no less than 55°C;
- Where hot water is circulated, the water returning to the source heater shall be no less

Ref:

Policy Title: Water Safety Plan V2.3

Page Number: 24

than 50°C.

In addition to the above mentioned control measures, water systems will be designed, installed, used and maintained to avoid the deterioration of water quality, including:

- Avoiding the use of materials that would harbour or provide nutrients for bacteria;
- Maintain systems in a clean and sound condition;
- Clear labelling of pipework;
- Avoiding over design, storage and stagnation;
- Avoiding the creation of aerosols and breathable water droplets.

Systems shall be designed to suit the needs of the users, and allow for reasonable fluctuations in consumption due to occupation of the building. Where short-term changes increase the risk of stagnation, flushing shall be undertaken. Where long term changes increase the risk of stagnation and increase the burden of maintenance, consideration shall be given to temporary or permanent draining and removal of the water services.

Where patients are at risk from known legionella problems, showers and outlets that may cause an infection shall be fitted with in-line or point-of-use filters with an aperture of no greater than 0.2µm a temporary basis and until the contamination has been successfully removed. These filters shall be WRAS approved; CE marked and be guaranteed by the supplier to remove legionella, Pseudomonas Aeruginosa and prevent backflow contamination.

11.2 Planned Preventative Maintenance (PPM)

The Health Boards primary method of legionella control is water temperature control, the main control measure. The Health Board undertakes a comprehensive programme of (PPMs) supplemented by remedial maintenance in response to any problems that are identified during the PPM works or inspections.

All Estates maintenance activities are controlled and recorded using the Estates Department's electronic work management system. These are professional software systems designed to monitor, control, record and report on all Estates maintenance activities. PPM's and the frequencies, are generated from these systems, and allocated to appropriate staff through the management chain. Completed jobs are recorded on the system and on site log books, and any non-conformities reported to the supervising officers and RP to initiate remedial actions.

The job tasks, setting out detailed instructions and time frequencies (Weekly, Monthly, Quarterly or Annual) are designed to match the requirements of achieving compliance with HSE ACoP L8, HSG274 Part 2, WHTM 04-01 Part B, and also the additional specific tasks that the Health Board carries out that are considered necessary forms of control

In addition, a number of periodic inspection and monitoring tasks will be undertaken, as listed in table 3 below.

Table 3: PPM Schedule

Ref:
Policy Title: Water Safety Plan V2.3
Page Number: 25

ACTIVITY	FREQUENCY
Cold water storage tank- inspection, maintenance / cleaning	Twice yearly
Cold water distribution storage temperature (summer)	Twice yearly
Calorifier inspection, maintenance / cleaning	Monthly, Quarterly/Annual
Water Temperature monitoring	Refer to Table 1
Shower heads (& associated hose) via quarterly colour coded replacement programme or cleaning fixed shower heads	Quarterly
Water sampling for legionella on instruction for location and frequency to be given to operational RP by microbiology lead.	As Agreed
Water sampling for <i>Pseudomonas aeruginosa</i> in augmented care units	6 monthly

The table is not exhaustive, but for further ppm service requirements, please refer to Table 1 WHTM 04-01 part B

11.3 Temperature Control Regime

The Health Board operates a system of temperature control as its primary method of legionella control in its water systems as recommended in WHTM 04-01 and HSG274 Part2.

The temperature control regime is monitored through detailed work instructions that are contained within the Estates Department's maintenance system described above. Temperature checks are carried out in accordance with HSG 274 Part 2 and WHTM 04-01 guidance as a minimum plus additional tests that the Health Board may introduce based on the risks identified in its water system.

The main features of the temperature control regime are listed below:

- Representative hot and cold water outlets are temperature tested to ensure compliance with WHTM04-01 guidance.
- All TMV hot and cold feed, mixed, and hot return temperatures are tested 6 monthly
- TMV strainers are cleaned and disinfected annually, or more frequently based on risk assessment.
- Subordinate hot water return pipe temperatures are tested every 3 months to ensure that water is returning to the primary circuit at more than 55DegC.
- All hot and cold Primary sentinel outlets are tested monthly, ideally on return pipework, or at least considering the connection of the return connection.
- All water storage tank inlet and bulk water temperatures are tested twice yearly
- All Calorifier and Plate Heat Exchangers flow and return temperatures are tested monthly
- Some cold water storage tanks and the incoming mains supply are monitored by BMS sensors.

Ref:
Policy Title: Water Safety Plan V2.3
Page Number: 26

- All out of specification temperatures are highlighted in the PPM electronic system and log books, and escalated for the RP, DRPs and Supervisors to take the appropriate action and remedy the issue.

Good temperature control is achieved by the addition of suitable and sufficient insulation to the water system components including the water storage tanks and distribution pipe work. The TMV six-monthly maintenance check includes a general check of the pipe insulation related to the system supplying the TMV to ensure that a good standard of insulation is maintained at all times.

Crucially, achieving good temperature control requires water to be kept moving and to avoid stagnation occurring. This is achieved by the following systems:

- Comprehensive flushing regime, where applicable.
- Temperature monitoring local hot water return pipe temperatures every month on Primary loops, 3 months on sub-ordinate and tertiary hot water return loops as per HSG274 Part 2 Table 2.1 and WHTM 04-01 Part B Table 1.
- Correctly configured water storage tanks with cross-flow and delayed action ball valves
- Correctly sized water storage tanks with a target turnover of less than 12 hours
- Correctly configured linked cold water storage tanks, when used, to ensure water movement from each.
- Correctly sized distribution pipe work avoiding cold water pipes that are too large
- Consideration of the use of plate heat exchangers to provide 'instant' hot water and eliminate the risk from stored water in buffer vessels or storage Calorifiers.
- Correctly sized hot water circulation pumps
- Avoidance of the installation of remote secondary hot water circulation pumps where possible.

11.4 General Maintenance Considerations

Equipment and systems which contain water and can affect the water supply, the atmosphere or the user and shall be maintained as follows:

- The systems shall be maintained in a clean and sound condition and must be easily and safely accessible. Water supplies to certain specialist units such as maternity, neo-natal paediatric, general paediatric and renal dialysis units (see the Renal Association, 2002) should be monitored to ensure that water quality is within acceptable limits. In addition, as chlorine dioxide and its breakdown products can be harmful to neonates and renal dialysis patients, this should be removed from the water supply to these units when dosing is in place. All systems shall be frequently used, or suitably flushed to simulate the necessary usage frequency in order to avoid stagnant water which will increase the potential of bacterial growth and proliferation. The usage frequency shall be regularly monitored and reported upon. Any under used outlets should be removed.

Cold Water Storage Tanks Maintenance

Cold-water storage tanks shall be subjected to a periodic "need" test which requires the user to question the presence of each unit and consider its removal if the services it supplies can be equally well, supplied by converting the systems to domestic mains fed only.

Each unit shall be subjected to a "drop-test" designed to ascertain the capacity and demand requirements of each system in order to ensure that excessive volumes of water are not unnecessarily stored. Eliminating storage within a system would also allow the negation of the necessary PPM Programme tasks and their replacement with much less onerous more infrequent and less costly tasks to be carried out.

Cold-water storage tanks must be examined annually and shall be maintained in good condition and clean from presence of foreign objects, biological material and excessive corrosion sludge deposition scale deposition.

On completion of examinations, the tank should be cleaned if required, and any remedial work carried out.

Stored water shall be maintained at a temperature of $<20^{\circ}\text{C}$ or $<2^{\circ}\text{C}$ from the supply temperature).

11.5 Cold Water Distribution Maintenance

- The control of water temperature in the cold-water service (CWS) will essentially rely on good insulation and water turnover.
- Cold-water service should be sized to provide sufficient flow and should be insulated and kept away from areas where they are prone to thermal gains.
- Stagnation must be avoided.
- Cold water draw-off points temperature should not be greater than 2°C above the temperature measured in the source cold water storage tanks within two minutes (and must be $<20^{\circ}\text{C}$)

Checks should be carried out annually to confirm that:

- the system components show no signs of leakage or corrosion;
- the system insulation is in good condition;
- where applicable system filters / strainers have been changed and/or cleaned in accordance with manufacturer's recommendations;
- Every water outlet complies with the backflow protection requirements of the Water Supply (Water Fittings) Regulations 1999.

11.6 Hot Water Storage & Distribution Maintenance

- It is essential to maintain the correct temperatures within the hot water service (HWS) circulating system.
- To some extent, if properly maintained, the calorifier / water heater will provide a form of barrier to *Legionella* and other water borne organisms.
- The minimum flow temperature of water leaving the calorifier / water heater should be 60°C at all times, and 55°C throughout the circulating system.
- The minimum water temperature at the connection of the return to the calorifier / water heater should be at least 50°C .
- Calorifiers should be subjected to regular maintenance inspections and cleaning (to remove sludge, loose debris & scale). Initially quarterly draining is recommended to

Ref:

Policy Title: Water Safety Plan V2.3

Page Number: 28

minimise the accumulation of sludge (this may be extended to annual draining if during inspection it is found that there is little accumulation of debris).

- Calorifiers taken out of service or after an event of major modifications should undergo pasteurisation before returning to service.
- When Calorifiers are isolated from the system (for whatever reason) and taken out of service, the associated distribution system shall be subjected to DAILY flushing. Calorifiers that are to be taken out of service for more than a few days should be drained and not refilled until ready to return to service. The drain valve should be left open while the calorifier is out of use.
- Whenever a calorifier is taken out of service, it should be refilled, drained, refilled again and the entire contents brought up to, and held at, the nominal operating temperature of 60°C for at least an hour.
- Stored flow at $\geq 60^{\circ}\text{C}$
- Return & Distribution at $\geq 50^{\circ}\text{C}$ (ideally $\geq 55^{\circ}\text{C}$)
- Drain at $\geq 50^{\circ}\text{C}$
- It is also important that adequate thermal insulation be maintained on all the Calorifiers, to ensure that there is no heat loss from the vessels that can cause the water temperature to drop.

11.7 Cold and Hot Distribution System Monitoring / Tap temperatures

Normal Parameters:

- *CWS - CWS Mains distribution $< 20^{\circ}\text{C}$ within 2 min at full flow*
- *CWS tanked distribution $< 20^{\circ}\text{C}$ within 2 min at full flow*
- *Cold water storage $< 20^{\circ}\text{C}$*
- *HWS - HWS distribution direct min 55°C at the local return or within 1 min flow at the outlet*
- *HWS storage: Flow - $> 60^{\circ}\text{C}$, Return - $> 50^{\circ}\text{C}$*

If the cold / hot water system temperature parameters are not achieved within the above stipulated range, a further more detailed investigation shall be carried out on the storage and distribution system/s in order to ascertain the reasons behind any high / low temperatures recorded.

The cold / hot water distribution temperatures of the system must be reduced / increased immediately and maintained within the recommended temperature at all times, these must be monitored for a sustained period following any alterations or remedial works to ensure the system/s maintain the correct and complaint temperatures.

Table 4 lists the possible reasons for the deviation from the expected temperature of the systems.

Table 4: Reasons for deviation of temperatures

High CWS temp	Low HWS temp
High ambient temperatures of >20°C Water temperature in storage tanks >20°C Lack of adequate insulation on the distribution pipe-work HWS, LTWS or steam pipes or other heat generating apparatus In close proximity to CWS pipe-work System over-capacity Areas of "low-flow" or dead legs in the system	• Low "set" temp for hot water generation of <60°C • Low "flow" temp • Low "return" temp • Primary circuit failure • Generation units under- capacity • Generation units under- rating • Excessive loss of hot water • Long "non-return" pipe spurs • Lack of adequate insulation on the distribution pipe work • Areas of "low-flow" or dead- legs in the system • Presence of space-heating apparatus on the DHWS system

- All factors listed above shall be investigated and all reported faults rectified at the earliest opportunity. All findings should be logged as appropriate.
- When considered necessary, carry out water microbiological analysis of the system (TVC & Legionella spp.)
- If the recommended temperatures fall outside the parameters on a regular basis, the system must then be considered for an on-line disinfection system to allow for protection against biological growth and proliferation

Table 5 within this WSP, however within WHTM 04-01 this is noted as table 1.

Requirements for temperature performance

Table 1 Checklist for hot and cold water systems (adapted from HSG274 Part 2 (HSE 2014))

Service	Action to take	Frequency
Calorifiers	Inspect calorifier internally by removing the inspection hatch or using a borescope, and clean by draining the vessel. The frequency of inspection and cleaning should be subject to the findings and be increased or decreased based on conditions recorded	Annually, or as indicated by the rate of fouling
	Where there is no inspection hatch, purge any debris in the base of the calorifier to a suitable drain. Collect the initial flush from the base of hot water heaters to inspect clarity, quantity of debris and temperature.	Annually, but may be more frequent as indicated by the risk assessment or result of inspection findings
	Check calorifier flow temperatures (thermostat settings should modulate as close to 60°C as practicable without going below 60°C). Check calorifier return temperatures (not below 50°C)	Monthly
	For non-circulating systems: take temperatures at sentinel points (nearest outlet, furthest outlet and long branches to outlets) to confirm they are at a minimum of 55°C within one minute	Monthly
	For circulating systems: take temperatures at return legs of principal loops (sentinel points) to confirm they are at a minimum of 55°C. Temperature measurements may be taken on the surface of metallic pipework	Monthly

Ref:
Policy Title: Water Safety Plan V2.3
Page Number: 31

Hot water services	For circulating systems: take temperatures at return legs of subordinate loops; temperature measurements can be taken on the surface of pipes, but where this is not practicable, the temperature of water from the last outlet on each loop may be measured, and this should be greater than 55°C within one minute of running. If the temperature rise is slow, it should be confirmed that the outlet is on a long leg and not that the flow and return has failed in that local area	Quarterly (ideally on a rolling monthly rota)
	All HWS systems: take temperatures at a representative selection of other points (intermediate outlets of single pipe systems and tertiary loops in circulating systems) to confirm they are at a minimum of 55°C to create a temperature profile of the whole system over a defined time period	Representative selection of other sentinel outlets considered on a rotational basis to ensure the whole system is reaching satisfactory temperatures for <i>Legionella</i> control
POU water heaters (no greater than 15 liters)	Check water temperatures to confirm the heater operates at 55°C, or check the installation has a high turnover	Monthly—six monthly, or as indicated by the risk assessment
	Inspect the integral cold water header tanks as part of the cold water storage tank inspection regime; clean and disinfect as necessary. If evidence shows that the unit regularly overflows hot water into the integral cold water header tank, instigate a temperature-monitoring regime to determine the frequency, and take precautionary measures as determined by the findings of this monitoring regime	Annually

Combination waterheaters	Check water temperatures at an outlet to confirm the heater operates at 55°C	Monthly
Cold water storage cisterns	Inspect cold water storage cisterns and carry out remedial work where necessary	Annually
	Check the cistern's water temperature remote from the ball valve and the incoming mains temperature. Record the maximum temperatures of the stored and supply water recorded by fixed maximum/minimum thermometers where fitted	Annually (summer) or as indicated by the temperature profiling
Cold water services	Check temperatures at sentinel taps (typically those nearest to and furthest from the cold cistern, but may also include other key locations on long branches to zones or floor levels). These outlets should be below 20°C within two minutes of running the cold tap. To identify any local heat gain, which might not be apparent after one minute, observe the thermometer reading during flushing	Monthly
	Take temperatures at a representative selection of other points to confirm they are below 20°C to create a temperature profile of the whole system over a defined time period. Peak temperatures or any temperatures that are slow to fall should be an indicator of a localised problem	Representative selection of other sentinel outlets considered on a rotational basis to ensure the whole system is reaching satisfactory temperatures for <i>Legionella</i> control
	Check thermal insulation to ensure it is intact, and consider weatherproofing where components are exposed to the outdoor environment	Annually

Showers and spray taps	Dismantle, clean, descale and disinfect removable parts, heads, inserts and hoses where fitted	Quarterly or as indicated by the rate of fouling or other risk factors, e.g. areas with high-risk patients
POU filters	Record the service start date and lifespan or end date and replace filters as recommended by the manufacturer (bacterial-retention filters should be used primarily as a temporary control measure while a permanent solution is developed, although long-term use of such filters may be needed in some healthcare applications)	According to manufacturer's guidelines

11.8 Closures of part or all of a Ward / Department / Area:

During temporary closure of a small section of a ward, department or area; that area's management staff will have the responsibility to ensure that all water outlet facilities are flushed thoroughly (i.e. opening all taps & showers; flushing of toilets & urinal cisterns) for a period of 2 minutes continuously, 3x weekly and recorded in a proforma see **Appendix E**. This form is required to be signed and submitted to the Estates RP / DRPs on a weekly basis for proof of flushing and for audit purposes.

For prolonged or complete closure of a ward, department or area, where the normal occupants will vacate the area; notify the Estates Department & complete a "Notification of Closure of Section / Area Form" see **Appendix F**, and contact made with IP&C and Water RP / DRPs at the earliest possible opportunity.

Procedure in the Event of Closure of Part or All of a Building

Where part or all of a building is going to close for a period of greater than one week, the relevant Ward or Departmental Manager must notify IP&C and the RP / DRPs for their area of the details of the closure.

Following a closure decision, negotiations between the relevant manager, IP&C and the RP / DRPs must take place to ensure that the following procedure is established and documented, and to clearly define what actions named individuals shall perform.

Period of Closure:

The period of closure should be established at the earliest point in negotiations. The period for which an area is closed can play an important part on the cost implication and involvement of a closure.

Temporary Closure:

Where a closure is expected to not exceed 60 days a weekly PPM will be implemented by Estates Maintenance to evoke the little used outlet flushing regime for all outlets within the closure area.

Before the closed area is re-occupied IP&C will instruct the RP / DRPs where required to carry out an inspection and test of the water systems to identify if any remedial works or investigations need to take place prior to the ward or area reopening and reoccupation by patients.

At the end of the 60 day closure period, a review shall take place to identify if the area can be reoccupied. It is the responsibility of the relevant manager to notify IP&C and the RP / DRPs of their intention to re-open a temporarily closed area.

If the area is to be reoccupied within the immediate future (within 30 days) then the three weekly flushing shall continue.

Indefinite Closure:

In the instance that part or all of a building is to close with no planned re-opening date, or where the closure period exceeds 60 days, negotiations must be held as detailed above, and funding made available to the Responsible Person [Water] by the manager of the department that is closing, in order to disconnect and drain the water services within the affected area. The relevant manager should be aware that considerable cost for modifications could be needed to achieve this requirement in some large properties.

Detail of Works for an Indefinite Closure:

Where relevant - all water tanks associated with the affected area shall be drained, cleaned and dried out by a competent person.

All pipework and devices shall be drained and where applicable DHW [or other storage vessels] shall be opened up, cleaned and left open to the atmosphere.

Pipework shall be disconnected from the mains services and capped off, mains cold water services shall be isolated and capped off from the system and all relevant pipework drained.

Notices shall be posted throughout the affected area stating that all water services are disconnected.

The Competent Person shall be authorised to ensure that an adequate water seal exists in unused toilets to prevent odours from the foul drain system entering the premises.

Adequate records of actions, and amended water service schematic diagrams shall be produced by the Estates Department showing the relevant modifications and disconnections made to the water systems. The estates helpdesk generated job card shall be used for record keeping purposes.

Procedure in the Event of Re-occupation of an Indefinitely Closed Area.

In the event of re-occupation of an indefinitely closed area, full negotiations must take place between the relevant Ward / Department Manager, IP&C and the RP / DRPs prior to the re-occupation exercise.

IP&C and the RP / DRPs will require the following information:

- The planned re-opening date;
- Any proposed changes of use of the area;
- Any areas which will not be used.

Ref:

Policy Title: Water Safety Plan V2.3

Page Number: 35

The RP / DRPs will provide the relevant manager with a cost to put the water systems *[for which the relevant manager must provide funding]* back in service, this may include costs for chlorination, sampling and works required to make the system/s operational again, commissioning costs and the cost of any remedial works etc.

Before the water system is put back into service, any necessary modifications and maintenance shall be carried out prior to the cleaning / chlorination of the system.

11.9 UNATHORISED USE OF DESIGNATED WATER SOURCES AS STORAGE AREAS

Use of an area designated for water use such as shower room's, sluice room, bathroom, where there is a requirement to carryout flushing, tap temperature monitoring or maintenance on components such as TMV's associated with water, should under no circumstances be used as a storage area, even on a temporary basis as this increases the likelihood of stagnation and a risk of legionella as a result.

It is deemed by this WSG that such practices are not permitted within any CTMUHB premises. Locations found being used in such a manner will be reported to the manager for that ward, area or department where immediate removal of the items being stored will be required, and the area returned to its normal designated use. Persistent area's found carrying out this practice, shall be reported to the WSG and escalated as a Legionella risk to the organisation through the normal notification of significant risk route.

If the areas where items are stored are no longer needed as the original intended purpose such as showers, bathrooms etc and the ward, area or department manager want to change the use to a store room then a fire build form must be submitted. This form will detail the changes that are needed, from this request costs will be drawn up & determined to make the area fire complaint but also costs developed for the removal of electrical and water services etc. The ward, area or departmental manager must secure the funding to enable these changes to occur. There must be funding available for Estates to cross charge for these work. If there is no funding, the area must be returned the room/s back to their original designated intended use and storage found elsewhere for the items, they must not be stored in the same room.

11.10 Use of Chemical Solutions to Temperature Control.

Where temperature controls are difficult to maintain, any secondary treatment such as utilising chlorine dioxide or chlorine peroxide shall only be considered once all methods of temperature control, redesign of the system, removal of the system, or additional temperature controlled methods are exhausted. Only then would consideration be given to the use of chemical based controls. If granted by the WSG, it shall be stable and consistent using an automated system that doses in accordance with the flow rate into the treated system.

Treatment with chemical solutions shall always be supplementary to temperature and not as a replacement, therefore the use of chlorine dioxide or any similar dosing system shall not be used, unless the WSG deem that there is no alternative than to explore this route.

11.11 Facilities: Hotel Services / Housekeeping - Cleaning and other

Ref:

Policy Title: Water Safety Plan V2.3

Page Number: 36

departments responsible for cleaning internal water assets.

Responsible for carrying out in accordance with Housekeeping Standard Operating Procedure (SOP) cleaning, removal of lime scale and support flushing regimes with individual ward/department as applicable in the control of legionella and other associated bacterial pathogens. In the case of locations where cleaning is carried out by departmental staff such as mortuary areas, HSDU, and maternity birthing pools, those departments must also follow the required standards, and ensure SOP's are in place for their areas of responsibility Appendix N.

Housekeeping clean all sanitary ware daily with a minimum of once per day in office/non clinical areas .to minimum of 3 times per day in clinical areas (main theatres are cleaned once per day with theatre staff cleans after each use)

Housekeeping staff are trained annually on all aspects of cleaning and this information is based in the SOP which clearly notes requirements and appropriate colour coding for daily and decontaminations cleans.

Each site has for wards/departments a cleaning schedule and specification and these are shared with relevant managers and meet the needs of meeting the National Standards for Cleaning in NHS Wales.

11.12 Clinical Boards & All Departments

Clinical boards, their associated departments and wards, and any other department within a CTMUHB property are responsible for ensuring that all parts of the water system in their area of operation are used in accordance with their design and intent, including the connection and use of specialist equipment in a safe manner. Before any equipment is attached or removed to a CTMUHB water system, authority must be gained from the WSG prior to any connection or change.

The Clinical Boards to whom this WSP applies are as follows:

- Medicine
- Surgery
- Mental Health
- Primary Care and Intermediate Care
- Women and Children
- Dental
- Renal
- Specialist Services
- Clinical Diagnostics and Therapeutics

Clinical Boards shall have documented procedures in place that ensure the water used in clinical areas is safe and prevents adverse health effects to patients, staff and members of the public. Key procedures shall be in place relating to use of water and water systems that apply to all clinical boards, as follows:

- Usage evaluation/identification and flushing of little used water outlets.
- Risk assessment for the removal of little used outlets;

Ref:

Policy Title: Water Safety Plan V2.3

Page Number: 37

- Connection of specialist equipment to water supplies;
- Purchasing, installation and maintenance of ice machines;
- Purchasing, installation and maintenance of drinking water coolers.

It will be the individual directorate's wards and department's responsibility while occupied, to identify and document little used outlets. Closures of a small section of a ward, department or area, or full closure, actions are detailed in 11.8. They will carry out flushing regimes in accordance with WHTM 04-01 part B on those outlets.

The actions will be documented on little used flushing paperwork available through the Estates department, and signed as being completed. These documents will be returned to the Estates department on a weekly basis. They will be available at any time for scrutiny by the Water AE, Water RP / DRPs and for any external audit purposes. Where any defects are suspected, these should be logged on the Estates Department Helpdesk for further investigation, and also noted on the flushing documentation.

They also have the responsible for highlighting any concerns with the water systems, this could be low flow, brown water, air in the system or any other suspect operation of the water systems, they are also responsible for identifying any concerning behaviour with their staff, like tipping bowls into clinical wash hand basin (WHB), or tipping milk into a clinical (WHB) these practices must be stopped at source because these introduce contamination risks into the water system/s.

11.13 Hospital Sterilisation & Decontamination Unit (HSDU) / Central Decontamination Services (CDS), Sterile Service Unit (SSU)

The reprocessing of re-useable medical devices excluding endoscopes but including operating theatres, clinics, accident and emergency, maternity and in patient wards is carried out by HSDU, including the cleaning and removal of scale from sinks and WHB's.

Decontamination equipment, including wash-down sinks, washer-disinfectors and autoclaves are supplied with domestic hot and cold water.

Sterile services procedures are strictly managed in accordance with the Health Boards Medical and Management Policy, Decontamination Policy, WHTM 01-01 parts A-E, WHTM 01-06 A Parts A- E and ISO 13485 / 9001. SOP's should be available for inspection by RP's.

11.14 Other Devices & Equipment's and Operational Considerations

11.14.1 Thermostatic Mixing Valves (TMVs) Thermostatic Mixing Taps (TMTs)

- TMVs for baths, showers & taps must comply with the standards of the Welsh Health Technical Memorandum (2017): Performance specification D08: TMVs (healthcare premises) and installed appropriately according to specifications & manufacturer's instructions.
- Scalding control of in-patient areas is achieved with TMV installation. In non-patient areas this is achieved by Risk assessment through a combination of TMVs and where no TMV is required through general "Warning or Caution Hot Water" notices to indicate and warn users of the potential of scalding.
- Temperatures from these outlets will be monitored as specified in Table 1; and the recommend temperature is specified in Table 2 below.

Ref:

Policy Title: Water Safety Plan V2.3

Page Number: 38

- It is essential to check the temperature settings and operation of all water mixing devices 6 monthly. The method of testing should be in accordance with Welsh Health Technical Memorandum (2017): Performance specification D 08: thermostatic mixing valves (healthcare premises).
- TMVs on baths, bidets and showers shall be inspected and subjected to a fail-safe test on a 6 monthly basis.
- Other maintenance should strictly be in accordance with manufacturer's instruction.
- A risk assessment should be carried out on all TMVs to see if they are required and if not replaced with a blended tap, that's operation goes from cold to hot.
- No TMV type 2s will be considered in CTMUHB, if they are installed without prior notification or communication the capital scheme or the contractor will incur the full costs of replacing them all with TMV type 3s and the associated labour costs that go with the works.
- TMVs must be fitted as close to the point of use as possible and must not be in any case be further than 2M away.
- The practice of using one TMV feeding multiple outlets is not permitted in any circumstances or nay premises in CTMUHB, any areas found to have this type of installation must be altered to a compliant standard asap and any capital works where this is found must be altered prior to hand over.

Table 6: Safe water temperatures & delivery devices

2 Recommended devices and outlets		
Activity/area	Maximum recommended set delivery temperature (°C)	Type of device
Areas where TMV type 3 valves should be fitted		Type 3 thermostatic mixing valve
Showers and hair-wash facilities	41	
Unassisted baths	44	
Baths for assisted bathing	46 – To allow for the cold mass of the bath. NB – prior to patient immersion, water should be checked with a thermometer.	
Bidets	38	
Note: Bath fill temperatures of more than 44°C should only be considered in exceptional circumstances where there are particular difficulties in achieving an adequate bathing temperature. If a temperature of more than 44°C is to be used, then a safe means of preventing access to the hot water should be devised to protect vulnerable patients.		

11.14.2 Materials of construction

Systems should comply with the requirements of the Water Supply (Water Fittings) Regulations 1999. Materials used in contact with water for drinking etc. should comply with BS 6920-1:2014 and be listed in the latest edition of the 'Water Fittings and Materials Directory' published by WRAS. In particular, no appliances should be fitted with flexible hoses unless an alternative is not available (e.g. on essential equipment such as hi-low baths or other equipment identified in section 11.14.17 of this WSP).

11.14.3 Showers

- In all patient areas, all showers shall be fed via Type 3, D08 specification TMVs that shall be maintained at 41°C.
- Central "common blending" shower-block systems shall not be used and all pipe-work length from the TMV to the shower-head shall be restricted to a maximum of 2 meters.
- Where "common blending" shower-block systems are already in place, each system shall be fitted with a solenoid valve (at the furthest point from the mixer valve), programmed to automatically purge water for a three minute period each day.
- All showers (shower-heads and associated hoses) shall be maintained in a good and clean condition and free from excessive scale and dirt deposition.
- All shower heads where possible should come under the Estates disposable showerhead contract. Each quarter (3 monthly). The showerhead and shower hose shall undergo full recyclable replacement with a colour coded head to ensure all showerheads within the CTMUHB are within the 3 month cycle. All shower-heads and associated hoses where this is not in force shall be inspected, manually cleaned, descaled and disinfected at least quarterly, and more frequently if required.
- All showers shall be subjected to regular temperature monitoring and be supported with microbiological sampling where considered necessary. When biological results indicate significant local bacterial contamination, the shower shall be either removed from use or fitted with a suitable High Efficiency Particulate Air (HEPA) filter to enable continued use of the facility. Where such filters are fitted, they should be changed according to manufacturer's instruction.
- Adjustable spray heads must not be used.
- Fixed shower heads (including removable parts / inserts) will be cleaned, disinfected and descaled on a quarterly basis.

11.14.4 Point-of-Use (PoU) filtration

CTMUHBs WSG does not support the use of PoU filters and they must not be used to overcome capital programme issues or operational pressures. Each use or batch use must be approved by the WSG or the RP / DRPs & IP&C prior to any ordering or installation, if approval is granted the RP / DRPS & IP&C must inform the Chair of the WSG & the members of the WSG.

- PoU filtration may be necessary in some instances as a temporary solution when microbiological sampling indicates significant local bacterial contamination and the water out-let cannot be de-commissioned, or in instances where an outbreak associated with contaminated water outlet has occurred (guided by the IP&CT & WSG).
- PoU filters must be changed in accordance with the manufacturers' recommendations and agreed by WSG.
- PoU filters will be used and installed in accordance with the manufacturer's instructions.

Ref:

Policy Title: Water Safety Plan V2.3

Page Number: 40

- The install / service start date will be recorded on each PoU filter installed, life span or end date will not be exceeded. The filters will be replaced at the expiry date or before if flow becomes impeded.
- When changing filters, it is recommended that sampling of water quality take place at outlets identified as sentinel points, before refitting a replacement filter.
- Where PoU filters are no longer required, the outlet and associated pipe-work must be disinfected or replaced to remove any accumulated biofilm before the system is returned to service.
- Where PoU filters are installed an active register must to be maintained, this will detail where and what outlets/rooms the PoU filters have been installed, when they were installed and the date of expiry. The register needs to be consulted regularly to ensure no filters go past their expiry date and are changed and replaced within a timely manner not to allow filters to go past their expiry date.

11.14.5 Eyewash Stations and Emergency / Deluge Showers

- Deluge showers (sometimes referred to as emergency showers) are intended for use in an emergency where staff or a patient has suffered external chemical contamination. Similarly, there may be other special outlets used for personal emergencies, for example eyebaths. These should not be installed on the end of lines. They should be dismantled, descaled and disinfected regularly in accordance with the risk assessment, and should be flushed in accordance with the recommendations in HSG274 part 3. HSG274 Part 2 (HSE 2014) recommends that generally, for infrequently used outlets, flushing is carried out once a week but that in healthcare facilities the risk assessment, as agreed by the WSG, may indicate a higher frequency, and water draw-off should form part of the daily cleaning process for a minimum of 2 minutes.
- The water in self-contained eyewash stations must be changed and maintained in accordance with the manufacturer's instruction.
- Emergency showers should be flushed weekly to remove stagnant water in the line and verify correct operation (ensure that the 'Water Outlet Flushing' pro-forma is completed, **Appendix E**).

11.14.6 Baths and Birthing Pools

- In all patient areas, baths shall be fed via Type 3 D08 specification TMVs which shall be maintained and operated at 44°C (non-assisted) and 46°C (assisted).
- Access to the facility must be made by the assisting nursing staff and patients must not be left unattended within the facility at any time.
- Baths must be filled using cold first and made-up to temperature with hot water to achieve the required temperatures. Temperatures of the water for each bathing process must be measured using a calibrated thermometer.

CTMUHB Birthing Pool policy for water quality management located in the intranet policy section Appendix L

11.14.7 Hydrotherapy Pools

Please refer to the Hydrotherapy Pool protocol located on CTMUHB Intranet policies Appendix K (Page 63-64).

11.14.8 Dental Chairs

Ref:
Policy Title: Water Safety Plan V2.3
Page Number: 41

Dental departments are responsible for the provision and use of safe dental equipment in accordance with WHTM 01-05 Decontamination in all dental practices and hospital max fax departments. The risks from legionella shall be assessed the WRA and recommended control measures applied to main water lines prior to connection to dental unit water lines (DUWL) and connected equipment including water bottles where used. Unless otherwise identified, dental staff shall implement controls specific to dental units external to the hot & cold water system, such as dental chairs shall have their reservoir (where applicable), emptied on a daily basis.

All reservoirs shall be cleaned and disinfected after each use using appropriate disinfectant solutions as recommended by the manufacturer, and maintain records accordingly. These procedures, SOPs and method statements need to be reviewed annually by the RP / DRPs, IP&C and microbiologist along with the dental to ensure they comply with latest guidance and manufacturer's recommendations.

Dental chairs must be flushed for a period of two minutes at the start of the patient schedule before patients are seen and again at the end of the patient schedule. They will also be flushed for 30 seconds between each patient.

Representatives of the Dental departments, both community and hospital based shall report on levels of compliance and problems with controls at regular WSG meetings but also provide reassurance that practices and requirements are being adhered to

11.14.9 Humidified Incubators

- All humidified incubators shall have their reservoir (where applicable), filled using only clinical sterile water.
- All humidified incubators shall have their reservoir (where applicable), emptied on a daily basis.
- All humidified incubators shall be cleaned and disinfected after each use using appropriate disinfectant solutions as recommended by the manufacturer.
- Areas where these type of devices and equipment are used need to be operated, maintained and cleaned in line with manufacturers recommendations.
- These devices and equipment also need robust SOPs and method statements for the cleaning & disinfection which the departmental manager is responsible for ensure they are in place and suitable.

11.14.10 Portable Humidifiers & Dehumidifiers

- Portable humidifiers shall not be used without the written permission of the WSG. Ward / department manager would need to ascertain suitability of use following an adequate risk assessment that is presented to the WSG for consideration. If permitted, it will then be the ward manager's responsibility to ensure a maintenance plan is put in place, through external contractors or where suitably competent, internal ward staff, and ensure manufactures cleaning recommendations are carried out, and documented evidence retained to support these requirements. Dehumidifiers carry a risk of legionella due to the inclusion of water reservoirs that collect water. If permission is granted these must be emptied daily and be subject to a thorough cleaning using suitable approved disinfectant.
- All portable humidifiers shall have their reservoir (where applicable), emptied on a daily basis.

Ref:

Policy Title: Water Safety Plan V2.3

Page Number: 42

- All portable humidifiers shall be cleaned and disinfected after each use using appropriate disinfectant solutions as recommended by the manufacturer.

11.14.11 Respiratory Nebulisers

- Respiratory nebulisers are intended for the delivery of a variety of medicinal products and should be used strictly in accordance with the manufacturer's recommendations.
- In no circumstances should these be used in association with domestic water supplies.
- Where these are used the clinical manager for that ward, area or department must have robust SOPs and method statements for their cleaning, sanitisation and if appropriate disinfection.
- The risk associated with these type of equipment lay with the clinical / ward manager

11.14.12 Water Coolers & Ice-Making Machines.

Water coolers & ice machines pose a great risk to water quality and any approved & installed must be for clinical need or processes rather than staff comfort.

The risk of cross contamination is great and must be controlled, staff or patients own bottles cannot be introduced around the outlet / nozzle and used to fill their bottles, this can transmit C19 and other viruses and bacteria through surface contact.

Only plumbed in type water coolers or ice machines will be considered, the bottle top /bottle dispenser type are banned within CTMUHB.

Disposable cups must be used and replenished frequency to stop foreign bottles, cups other vessels being introduced to the outlet.

Where they are installed they must be installed in line with manufactures instructions & recommendations, the installation must comply with the Water Supply Water Fitting) Regulations 1999 and meet the requirements of WHTM 04-01 Part A sections 9.24 – 9.27.

Bottle water or jugs used to dispense water is the promoted and preferred option for staff comfort, bottled water can be stored in staff mess room fridge's and so can a communal cooled jug. The purchase of a small fridge to store the bottles or jugs compared to ongoing lease costs, maintenance and breakdown repair costs as well as the removal of cross contamination / infection risk far outweighs the benefits of having a plumbed in water cooler or ice machine.

If the WSG approve the use and lease of a water cooler or ice machine the final decision will be the responsibility of the site RP / DRPs & IP&C. As detailed above, the equipment must be installed in line with the requirements & recommendations of the manufacturer but also in line with WHTM 04-01 Part A sections 9.24 – 9.27, if these requirements are not met the RP / DRPs and IP&C have the authority to decline the installation and lease proposal. The full system characteristics may not be known at the time of the request so due diligence must be shown not to introduce more risks or hazards into the water system.

Water coolers and ice machines must not be purchased, they must be leased via procurement with the lease proposal and maintenance requirements set out, the costs of the maintenance regimes must not be deviated from for budget savings, no changes will be allowed once the WSG has approved the original request.

If a water cooler or ice machine is approved for clinical use, the full cost of installation will be required to be met by the requesting ward or department.

If water coolers or ice machines are found in areas or departments and have no cleaning or hygiene regimes, no maintenance records or no lease agreement in place the RP / DRPs and IP&C have the authority to have the machine/s removed and stored ready for collection. Any

Ref:

Policy Title: Water Safety Plan V2.3

Page Number: 43

cut back of services that incur costs will again need to be met by the ward or departmental manager via a cross charge against budget cost centres.

The Estates Department have the responsibility and must update drawings/schematics to indicate new services are being provided to new positions to feed any new approved water coolers or ice machines.

Water Coolers & Ice Machines are not and will not be permitted in Augmented Care areas or where the water systems in the area are interconnected.

For further guidance, please refer to the Water Coolers & Ice-making Machine Guidelines (IPC 11) Appendix M (Page 63-64).

11.14.13 Air Conditioning / Handling units

All air conditioning / ventilation plants will be maintained in accordance with manufacturer's recommendations, British Standards, WHTM's and other relevant guidance.

Particular attention must be given to humidification, cooling coils, drainage tray systems and glass traps. Accumulation of dirt in a relatively short period of time is indicative of either:

- poor filter arrangement and design;
- the use of incorrect filters; or
- Failure of the filtration system.

In particularly polluted areas, it may be necessary to consider the installation of high grade final and pre-filters. The quality of filter housing design and in particular the seals are a critical factor in maintaining the efficiency of the filtration system by ensuring that air does not bypass the filter panels.

All information on condition, cleanliness etc. to be recorded in the plant room log book, with any non-compliance or incidents being identified to the AP Ventilation & RP / DRPs immediately on identification, and an incident report record form completed.

Glass traps must be inspected and cleaned at regular intervals, if these are found to be dirty they must be cleaned and

11.14.14 Draining Traps and Pipework

A drainage drip tray should be provided, to collect condensation collecting on cooling coils [including the return bends and headers], and for humidifiers, eliminators and, if necessary, heat recovery devices. The drainage drip tray should be constructed of a corrosion resistant material and be so arranged that it will completely drain - i.e. the drain connection should have no up stand in order to prevent 'pooling'. The drainage tray should be large enough to collect all the water produced by the device it serves.

Provision should be made to allow for inspection of the drainage tray [i.e. viewing window / access panel]. Any jointing materials used to seal the drainage tray to the duct must be listed in the Water Fittings Directory and must not be capable of supporting bacterial growth. A slope of at least 1:20 in all directions towards the drain outlet position should be incorporated.

11.14.15 Portable A/C Units.

From the date that this procedures document was accepted, the Health Board prohibits the use of such devices within any of the Health Board properties. CTMUHB has prohibited the

Ref:

Policy Title: Water Safety Plan V2.3

Page Number: 44

use of such devices on the grounds that WHTM 03:01 paragraph 5.28 states 'units employing an internal water reservoir and wick to promote evaporative cooling must not be used in healthcare premises'. These units also require substantial frequent maintenance, which is costly.

If however, units need to be used to overcome operational issues such as supporting IT Server Hubs if their main form of cooling fails then the units hired in must be new units, they cannot be old or recently off-hired units. They must arrive at site in their boxes.

If old or recently off-hired units arrive, they will be returned to the provider. The provide must then source new units.

Units are only to be retained for 3 months and then off-hired for new units again, this reduces maintenance requirements but also reduces the risk of legionella, some units are impossible to clean effectively and as such have dead spots where bacteria could grow.

Portable A/C units that are bought are not permitted and prohibited by the WSG. If procurement see requests such as these to purchase units outright they must refuse the request and highlight the request to the Chair of the WSG or the administrator of the WSG.

11.14.16 Split Units.

These units incorporate internal recirculation air filters and a drainage system to remove condensate form the cooling coil. The systems used around the Trust properties are not in continuous use (i.e. 24/7) and a review of the condition of these systems has found that the units only require an inspection and clean once a year by an external contractor.

11.14.17 Flexible Tails & Pipes

No flexible pipes, tails or hoses will be installed in any CTMUHB premises or installation, only solid copper tails will be permitted all fittings will be made with fixed tails direct to the outlet.

However, flexible tails and hoses for installations shall only be used when fixed tail installation is not possible on the following appliances: Hi – Lo baths / Hi-Lo wash hand basins, macerators, washing machines, process sinks in pathology departments and dishwashers. When flexible tails have been installed then a check valve shall also be fitted pre flexible tail.

No other areas or circumstances will be considered.

Where flexible pipes or hoses are installed an asset list shall be developed to indicate where they are installed and located and be subject to a replacement programme in line with manufactures instructions and recommendations, they should also be WRAS approved. Normally this is every 5 years.

11.14.18 High Pressure Hoses

These units create considerable aerosol and as previously mentioned the use of such devices should be avoided. Where this is not possible then the water supply to such units must be from a drinking water supply and have a suitable air gap (i.e. the hose end of the device must not be inserted in a body of water whilst in or out of use) to prevent back siphon age.

11.14.19 Anti-Ligature Taps

Anti-ligature taps include the following types:

Ref:

Policy Title: Water Safety Plan V2.3

Page Number: 45

- infra-red,
- tactile,
- Push non-concussive.

These taps are installed for anti-ligature purposes. These types of taps bring with them water saving economies, which could impact on the turnover / through put of water being reduced when compared to a regular turn on / turn off tap. To ensure adequate through put of water from these taps each run time should be programmed for a minimum of thirty seconds whilst having the highest turnover possible (ideally turning over 6 litres of water in a minute).

As part of the housekeeping cleaning regime the anti-ligature taps outlet and shower head outlets are sprayed with a disinfectant solution) once a week. These fittings require specialist tools to remove the diffusers, the once a week spray of the outlets will assist with reducing any potential build-up of dirt and contamination within the fittings.

11.14.20 Clinical - Wash Hand Basins (WHBs)

Clinical WHBs must only be used for hand washing, they must be used regularly and not be used to tip or dispose of waste water, body fluids or milk etc. down them.

Where clinical WHBs are installed it is the ward, area or department manager's responsibility to ensure these are used appropriately by the staff and in line with the requirements of this WSP to stop stagnation and not introduce contamination into the water system.

Any observations of miss practice must be recorded and staff advising of the correct practices. Any continual non-conformances must be escalated to the WSG.

In rooms that have clinical WHBs in the rooms they must not be used as storage areas. The rooms must be kept free and outlets flushed to ensure stagnation does not occur.

Where outlets are identified as low use outlets they must be flushed 3 x weekly and records kept of the flushing activities.

Where the outlets are not likely to be used again the ward or departmental manager must request their removal via the Estates Department.

During capital works, schemes or projects clinical WHBs are not to be used to tip paint, wash paint brushes or tip waste water down etc., they must also not be used to fill containers or other vessels used for the purposes of the works or build.

During the course of any works or projects clinical WHBs should be covered and protected to reduce and illuminate any possible risk of contamination from dust, dirt or sawdust etc. to the outlet or drain. This can be achieved by ensuring protective caps for the taps are kept on at all times only being removed for flushing exercises, covering the WHB with a protective sticky plastic covering or film that can be easily removed or replaced regularly so that no contaminants can enter the bowl or waste.

N.B – the protective cover will require a small slit introduced to it to stop condensation developing under the protection cover / film.

N.B. – No drilling, cutting, sawing or other dust or dirt creating operations may be undertaken while the cap for the tap or protective cover / film for the WHBs is removed. These operations can only start or recommence after all caps and covers / films have been replaced.

Ref:

Policy Title: Water Safety Plan V2.3

Page Number: 46

The WHBs can be covered entirely but this needs agreement with the site RP / DRPs & IP&C.

11.14.21 Trace Heating

Trace heating is used in some circumstances to heat and maintain water temperatures above 60°C where there is no return leg or circuit. Areas such as HSDU, Mortuaries or Pathology departments where the risk of backflow contamination is present and only a flow pipe is installed into the department.

These systems must be checked regularly and in line with manufacturers recommendations or at frequencies determine by the WRA, to ensure the temperature are complaint, these records and temperatures must be recorded.

Trace heating systems are installed and tested in line with PPM schedules on the hot water services at the Royal Glamorgan Hospital in the following locations:

- T120 - Mortuary
- T212 - HSDU
- T114 & 214 - G&FF Pathology

11.14.22 Insulation & Pipe Work Lagging

Pipe insulation & lagging significantly **lowers heat loss around pipes** while also acting as a moisture barrier. It leads to improved thermal performance and higher operating efficiencies, therefore, lower operating expenses. It also helps you save money by lowering your overall energy consumption.

Insulation & lagging plays an important part in maintaining water temperatures in complaint and optimal ranges.

Poor specification and inappropriate insulation & lagging can lead to water temperatures inside pipes that may support the growth of legionella.

Insulation on systems should be checked during maintenance activities by either in-house Estates staff or contractor and if sections are found to be missing or defective they need to be reported and renewed or repaired / replaced.

Designers & Contractors are responsible for specifying the correct insulation & lagging on contracted works and should specify insulation or lagging that eliminates heat gain that could cause rise to temperatures that could support the risk of legionella bacteria.

Estates DOL staff are responsible for checking and reporting any missing or defective insulation or lagging through the course of their work/s. They must report these findings on the PPM Work Orders Cards so the Estates Department – Maintenance Supervisor can create a reactive Works Order Card to replace or repair the defective or missing insulation and lagging.

11.14.23 Blind Ends & Dead Legs

Where blind ends & dead legs are identified they should be removed back to the nearest “tee”, where this is not possible they should be minimised and reduced.

Ref:

Policy Title: Water Safety Plan V2.3

Page Number: 47

Where blind ends or dead legs cannot be removed easily or cost effectively they should be highlighted as a risk, communicated with the WSG and risk managed by adequate means such as flushing where practicable.

The risk needs to be highlighted for capital spend to remove if money is an issue to resolve or remove the risk.

Where blind ends & dead legs are identified as part of capital works, schemes or projects the contractor is to highlight these to the capital lead or project officer. The capital lead or project officer will then communicate these risk items with the RP / DRPs for the relevant site/s, agreement will be sought to confirm if the blind ends or dead legs can be removed as part of the capital works, scheme or project.

If the requests cannot be accommodated within the project allocation a request must be submitted to the capital department, requesting the utilisation of the Legionella budget allocation to remove the blind ends or dead legs identified.

Principal Contractors and any Sub-contractors they use must not through the course of their work introduce blind ends or dead legs, they must act and work responsibly and not introduce risks into the system/s they work on or around. The same is applied to Estates DOL staff

11.14.24 "As Fitted" Drawings & System Schematics

As-fitted drawings shall identify all key components in the installation, i.e. water meters, cisterns, filters, calorifier, water heaters, TMVs, balancing valves & DRVS, isolation valves etc. These drawings should be kept up to date.

Drawings will help inform the risk assessment and are necessary to perform adequate temperature control checks and will be valuable for identifying potential problems with poor temperatures. Schematic drawings are not formal technical drawings, they are intended to be easy to read without specialist training / experience. They provide the reader with an idea of layout and position of components and connections. These drawings should be kept up to date. These drawings assist with the risk assessment process.

Where capital works, schemes or projects are undertaken the drawings & schematics should be updated to include new revision number, date of changes, necessary notes, etc.

Where commissioning is undertaken the flow & return temperatures should be noted on the drawing at key strategic positions and they must note the balancing valve numbered positions.

Drawings must be provided prior to handover in line with the requirements and timescales outlined in the RIBA Plan of Work 2022, any subsequent changes to drawings or schematics after O&M submission can be retrospectively added.

Drawing templates and requirements can be obtained from the CAD officer employed by the Estates Department.

11.14.25 Decorative Internal & External Water Features

No decorative internal or external water features will be allowed or permitted within or on any CTMUHB sites.

Ref:
Policy Title: Water Safety Plan V2.3
Page Number: 48

11.14.26 Garden Hoses or Similar

Garden hoses and similar attachments must be robustly controlled. In certain conditions garden hoses and lawn sprinklers may retain stagnant water in the pipework or hose supplying the hoses or sprinkler head; they may also produce an aerosol spray.

Hoses must be disconnected after every use and drained of all water contained inside them, they must be stored in such a way not to allow contamination to enter the hose head, hose or bib tap by insects, dirt, dust etc.

The paragraph above also applies to hoses on a reel, these must be kept free from possible contaminants, disconnected after every use and hoses totally drained of any water.

Hoses used for filling remote of mobile units should be of materials suitable for use with wholesome water systems and should be drained, capped between uses and kept in cool conditions. They should be disinfected (by immersing in hypochlorite) before every use.

11.14.27 Anti-stratification Pumps

Where anti-stratification pumps are fitted to hot water calorifier & hot water vessels, they will operate for a period of an hour each day at times of low water demand, and are subject to checks in line with PPM to ensure operation.

11.14.28 Expansion Vessels & Pressurisation Units

Expansion vessels & pressurisation units should where practical be the flow through type, where these are not installed and where practicable, they should be flushed through and purged to drain.

Where removal, bladders or diaphragms should be changed according to manufacturer's guidelines or as indicated by the risk assessment.

11.14.29 Mobile Units – MRIs / Endoscopy / Dental Etc.

Mobile units such as mobile MRIs, CTs, Endoscopy and dental units should comply with the same HTMs, WHTMs, HBNs, etc. as conventional builds and hospital / clinical environments. Any designed or leased by CTMUHB will meet the requirements of this WSP and the requirements of the WHTMs, HBNs etc. There should be no deviations.

If there are deviations or derogations then these should be noted and discuss at the outset of the scoping exercise and submitted to the RP / DRPs for the site and the WSG for discussion and comment prior to any agreements, leases or contracts being signed and agreed.

Any deviations or derogations need to be documented, the reasons explained and noted, signed acceptance by the WSG and clinical partners and a copy recorded for future reference

In essence, water tanks should comply with the same requirements set out in the WHTMs, no flexi pipe work, pipe work should be lagged and insulated, cold pipe work should be run below hot water pipework etc.

11.14.30 Infrequently Used Outlets

Infrequently used outlets are outlets that are not normally used for a period equal to or greater than seven days. If outlets are found to match this criteria they must be flushed in line with

Ref:

Policy Title: Water Safety Plan V2.3

Page Number: 49

the requirements of this WSP, flushing the outlets for 3 x times per week and for 2 minutes each, evidence of the flushing activity must be recorded on the flushing sheet (Appendix E). Flushing in augmented care areas should be daily....as clause 3.1 j of WHTM 04-01 Part C

The outlets should be flushed until the temperature at the outlets stabilises and is comparable to supply water and purge to drain regularly to use the outlets and minimise the risk from microbial growth in the peripheral parts of the water systems, sustain and log this once flushing of outlets has started.

Consideration should be given to removing infrequently used showers, taps and any associated equipment that uses water.

If removed, any redundant supply pipework should be cut back as far as possible to a common supply (e.g. to the recirculating pipework / origin pipework or the pipework supplying a more frequently used upstream fitting) removing the feeding "T" and replacing with a straight through coupler / coupling.

11.14.31 Derogations

Derogations will only be allowed or accepted following review and explicit agreement with the WSG. Any potential derogations must be submitted in writing to the WSG prior to works, schemes or projects being started, these will detail explicitly why certain guidance, regulations or other requirements set out in this WSP cannot be met.

Designs must be fully and appropriately scrutinised prior to any works, schemes or projects being tendered or started and any issues should be designed out by that stage.

If derogations are found following the completed works it will be the responsibility of the capital lead or project officer to rectify and the risk will sit with the capital department to fund or resolve while these derogations are still present if they haven't been approved by the WSG.

11.14.32 Statement of Conformity

Is a formal declaration by the manufacturer, or manufacturers' representatives that the product/s to which it applies meets all relevant requirements and safety directives to that product or products?

All statements of conformity will be included in the O&M manuals for the equipment installed, this will include conformity to BS standards, WRAS approved etc.

11.14.33 Contractors

All contractors who install and commission water pipework, equipment and systems within any CTMUHB premises must be suitably trained in water hygiene training and have legionella awareness training, including the presentation of cross contamination from tools and other components and must provide evidence of such training.

The contractor is responsible for ensuring their staff or sub-contracted staff under their responsibility are fully aware and conversant with the contents and requirements of this WSP. Any malpractice or deviation from the requirement set out in this WSP will be addressed and raised with the main / principle contractor.

Any contractors working on water systems within CTMUHB will ideally have "Water Safe" accreditation.

Ref:

Policy Title: Water Safety Plan V2.3

Page Number: 50

12. CONTROLLING THE RISK OF PSEUDOMONAS AERUGINOSA.

Due to uncertainty surrounding the source of *Pseudomonas aeruginosa*, controls for the prevention of growth of *Pseudomonas aeruginosa* shall be implemented both before and after water outlets.

Many of the controls in place for legionella will assist with the control of *Pseudomonas aeruginosa* within water systems, although there shall be a greater focus on the design and selection of water system outlets and fittings, and general hygiene arrangements and procedures to control external impacts.

Guidance on the selection and installation of wash hand basins and other sanitary assemblies with regards to improving the control of *Pseudomonas aeruginosa* is given in the addendum to WHTM 04- 01 and has been adopted as a standard.

In addition, the CTMUHB recognise the importance of providing and maintaining a clean and appropriate environment, and the benefits to avoiding the spread of infection provided by good cleaning procedures.

Controls measures shall be applied to systems and activity associated with the identified risks. Controls shall be monitored and tested to ensure they are effective and records kept. Where controls proved to be ineffective, the risk assessment(s) shall be reviewed.

Where patients are at risk from known contamination of the water system, outlets that may cause an infection can be fitted with in-line point-of-use filters with an aperture of no greater than 0.2µm on a temporary basis and until the contamination has been successfully removed. These filters shall be WRAS approved, CE marked and be guaranteed by the supplier to remove *p. aeruginosa*.

Controlling *Pseudomonas Aeruginosa* should be carried out in accordance with WHTM 04-01, and in particular Part B chapter 5. WHTM 04-01 Part C which deals specifically with *Pseudomonas* .

13. CONTROLLING THE RISK FROM OTHER PATHOGENS.

In recent times, healthcare acquired infections have been linked to waterborne pathogens including *Stenotrophomonas maltophilia*, *Aeromonas spp.*, *Acinetobacter spp.*, *Enterobacter spp.* and non- tuberculosis mycobacterium. It is widely accepted that the measures used to control legionella and *pseudomonas aeruginosa* in water systems also have relevance to other opportunistic pathogens, and therefore the Health Board considers these measures to be sufficient.

14. PROVISION OF SAFE DRINKING WATER.

Drinking water outlets shall, where practicable, be supplied directly from mains water supplies without storage. Where this is not the case, drinking water outlets shall be tested regularly to ensure water remains fit for human consumption.

Drinking from cold water that is subject to continual dosing with silver ions should be avoided.

Where stand-alone water coolers, vending machines and ice makers are required, installation, and maintenance shall only be granted In accordance with current CTMUHB Policy Appendix M (Page 63-64).

The filtering of water where necessary shall be undertaken using appropriately selected filters and shall be maintained and/or replaced in accordance with manufacturer's guidance and local conditions to avoid the effects of failure.

15. WATER USED IN THE PROVISION OF FOOD AND DRINK.

The use of water in the preparation of food and drink to be sold and consumed on CTMUHB premises shall be in accordance with current food safety regulations. This WSG limits its responsibilities to the provision of a continuous supply of wholesome water that satisfies these obligations.

16. WATER QUALITY, SUPPLY AND TESTING

Sampling and analysis of water shall be undertaken in accordance with current legislation depending on the nature of the test being undertaken, sample plans and escalation procedures by, or on behalf of IP&C, in conjunction with the Estates Department by appropriately competent persons following approved procedures. All samples shall be analysed at a UKAS accredited laboratories – the use of dip-slides is not permitted.

Detailed sampling procedures and methodologies for planned and reactive sampling, including transportation and storage requirements shall be controlled by the RP /DRPs and shall be adhered to by any external service providers unless otherwise authorised by the RP / DRPs or AE (Water) in his/her absence. Samples shall always be delivered to the laboratory within 24 hours, kept refrigerated within the required temperature range and processing commenced immediately, always in accordance with current regulations and standards. Refer to BS 7592-2022 Sampling for Legionella

16.1 Reoccupation of Premises, Construction & System Modifications

Sampling and analysis of water prior to reoccupation where premises have been mothballed or otherwise unoccupied, or following construction and modifications to water systems, shall be carried out as determined by the project plan and in accordance with BS8554:2020, and shall include the following parameters as necessary:

Table 7

Parameter	Target
Coliform bacteria	Nil in 100ml
Enterococci	Nil in 100ml
E. coli	Nil in 100ml
Legionella	Not detected in 1000ml (@ LOD 100 cfu/l)
Pseudomonas aeruginosa	0 cfu/

Where systems have been disinfected, samples of the water shall be analysed for disinfection

Ref:

Policy Title: Water Safety Plan V2.3

Page Number: 52

residues in addition to the above microbiological parameters.

Positive sample results in excess of the specified parameters given above shall be dealt with in accordance with the relevant escalation procedures.

Where there are taste or odour problems, microbiological monitoring for total viable counts (TVCs) may be considered necessary. However, routine microbiological monitoring for TVCs is not recommended as there is no direct association with TVCs and the presence of waterborne pathogens. TVC use will only be agreed if the WSG deem it necessary.

16.2 General Surveillance:

Sample plans for routine surveillance shall be produced by IP&C, Lead Microbiologist/s and issued to Estates Department under approval of the WSG. Escalation procedures for dealing with positive results shall be produced and managed by IP&C under the outbreak plan and aided by the RP / DRPs (Water).

Sampling and analysis of water for surveillance of systems and verification of control measures is not normally considered necessary, except in augmented care areas or as otherwise determined by IP&C. Surveillance sampling may also be undertaken to verify the effectiveness of control measures, or where controls regularly or consistently fail to meet the required parameters.

Surveillance sampling for Total Viable Counts (TVCs) as an indicator of water quality is not considered necessary.

Surveillance sampling for legionella shall be pre samples without disinfection of the outlet (also known as combined samples) in order to indicate both local and systemic contamination.

Samples shall be collected, stored and transported to the UKAS accredited laboratory in accordance with BS7592:2022 The temperature of the water and the residual level of any supplementary biocide shall also be recorded at the time of sampling to assist with understanding the impact of any positive counts.

Sample results that exceed the targets in the above table shall be dealt with in accordance with the relevant escalation procedures.

Routine surveillance sampling for *pseudomonas aeruginosa* shall be pre flush sampling without disinfection of the outlet, and shall be carried out after a period of no use of that outlet of at least 2 hours – ideally overnight where practicable. In addition, periodic sampling of taps in close proximity to others should be staggered to avoid "batching" of results. Positive sample results (>1cfu/l) shall be reacted to in accordance with the relevant escalation procedures.

16.3 Investigative Sampling

To determine the extent of a problem identified during sampling, escalation procedures shall be agreed by IP&C, and used under the supervision of the RP / DRPs. Where required, the RP / DRPs shall produce an investigation sample plan which ensures samples are taken from critical points throughout the system.

Where investigations for legionella are undertaken, pre-flush and post-flush (with disinfection of the outlet) samples shall be used to determine if the problem is systemic or local to outlets where relevant.

Ref:

Policy Title: Water Safety Plan V2.3

Page Number: 53

Where investigations for *Pseudomonas aeruginosa* are undertaken, pre-flush and post-flush samples shall be used to determine if the problem is systemic or local to outlets where relevant. Disinfecting or cleaning of taps and outlets shall not be undertaken before collecting pre- or post- flush samples.

16.4 Microbiological Sampling Results

Results will be monitored by IP&C and Estates Department, and records kept in the Estates Department.

i. Water Microbiological analysis results interpretation

Table 8

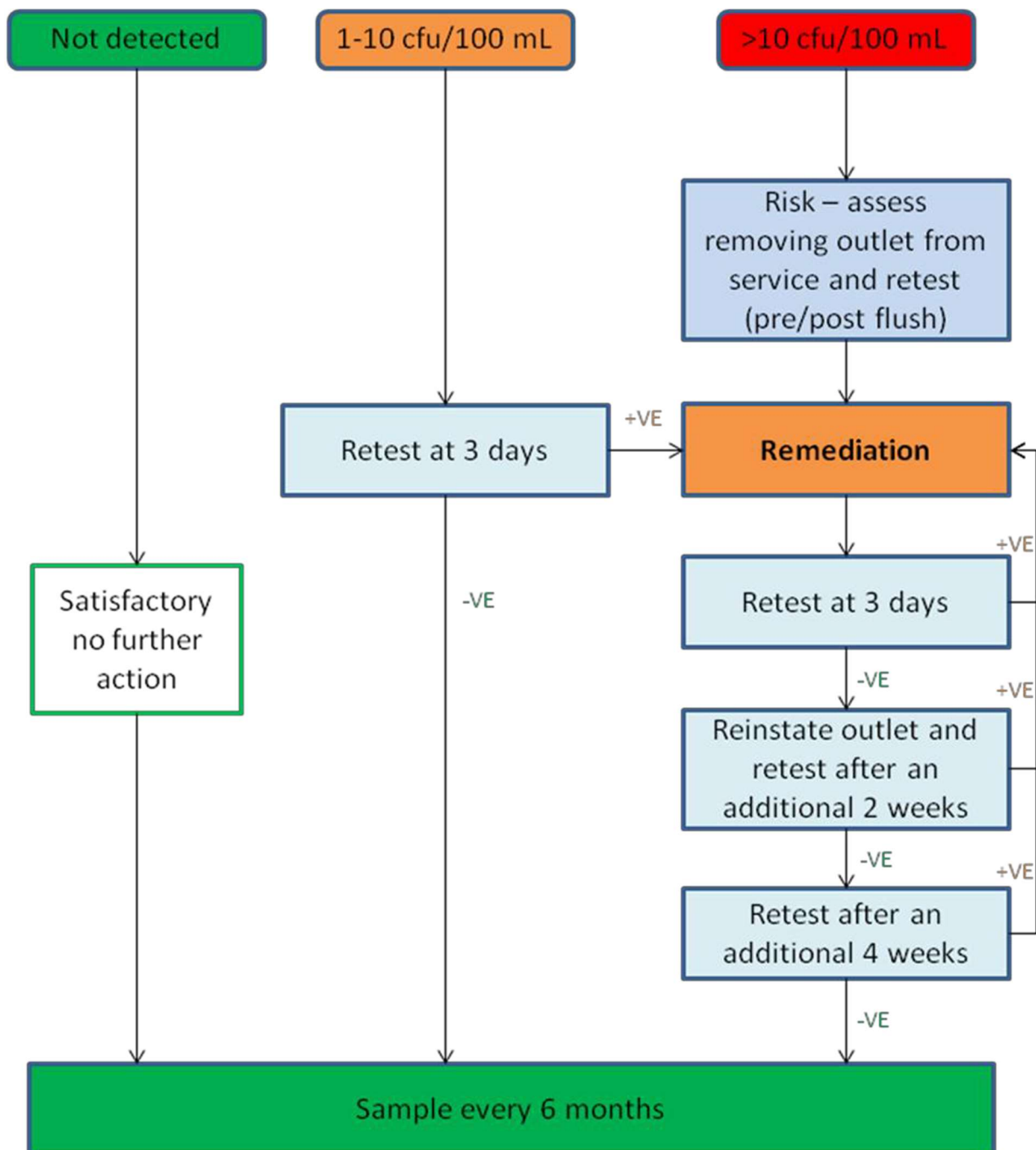
Tests	Results	Action
TVC	Non detected	No further action
@22°C @37°C	Any significant change from previous results	Agree remedial action with IPCT and re-sample
Coliform	<1 cfu/100 ml	No further action
	>1 cfu/ 100 ml	Agree remedial action with IPCT and re-sample
E.coli	<1 cfu/100 ml	No further action
	>1 cfu/ 100 ml	Agree remedial action with IPCT and re-sample

ii. Legionella results interpretation

Table 9

<i>Legionella</i> bacteria (cfu/L)	Action to take
Not detected or up to 100 >100 and up to 1000	The primary concern is protecting susceptible patients, so any detection of <i>Legionella</i> should be investigated and, if necessary, the system resampled to aid interpretation of the results in line with the monitoring strategy and risk assessment. Either: If the minority of samples are positive, the system should be resampled. If similar results are found again, a review of control measures and a risk assessment should be carried out to identify any remedial action necessary, Or: If the majority of samples are positive, the system may be colonised, albeit at a low level. An immediate review of control measures and a risk assessment should be carried out to identify any other remedial action required. Disinfection of the system should be considered.
>1000	The system should be resampled and an immediate review of the control measures and a risk assessment should be carried out to identify any remedial actions, including possible disinfection of the system. Retesting should take place three days following systemic chemical or thermal disinfection and at frequent intervals thereafter until a satisfactory level of control is achieved as agreed by the WSG.

iii. *Pseudomonas aeruginosa* results interpretation



If water sample test results indicate that a particular augmented care unit has a minority of outlets with unacceptable counts, but with the majority classed as satisfactory (e.g. 2 out of 10) this should be reported to the WSG in order that an appropriate risk based decision can be made regarding the continued use of the unit's water system as a whole.

If the samples indicate that the circulating water is the problem, then most outlets would possibly be positive and other points in the water system could then be sampled to assess the extent of the problem.

Should the risk assessment or sampling measures identify contamination with *P.aeruginosa*, the IP&CT should be notified in order for risk reduction and preventive measures to be taken on the unit.

16.5 Remediation of Water Quality Delivery

Check for little used outlets - assess frequency of usage and if necessary remove under used outlet(s). The branch hot and cold water pipes should also be removed back to the main distribution pipework in order to eliminate blind ends;

Assess the water distribution system for non-metallic materials such as flexible hoses and replace as per DH Estates & Facilities Alert (2010) 03: Flexible water supply hoses that was promulgated in Wales. Assess the water system for blind ends (sections of plumbing pipe that have previously been capped off but not removed) and dead legs (sections of stagnant water in pipes in underused outlets, e.g. water supplied to cold water outlets located after a Thermostatic Mixing Valve (TMV) supplying an adjacent blended water outlet. Such cold water outlets in augmented care units are commonly underused);

Point of use filters - where they can be fitted - may be used to provide water of a satisfactory standard, 0 cfu per 100ml. Where fitted, filters should primarily be regarded as a temporary measures until a permanent safe engineering solution is developed.

Where point of use filter as are fitted to taps, the same cleaning regimen applies to the wash-hand basin but the filter itself should be cleaned according to the manufacturers' instructions. Care should be taken to avoid contaminating the external surface of the filter;

It may be necessary to carry out a disinfection of the hot and cold water distribution systems that supply the unit to ensure that contaminated outlets are treated. Guidance on how to carry out the disinfection procedure can be found in WHTM 04-01 Part A, Chapter 17. However, this may not be effective against established biofilms;

if the TMV is not integral to the body of the tap / shower ensure that the TMV providing the 'safe' hot water is located as close to the tap / shower outlet as possible; and

Consider replacing contaminated taps with new taps. However, there is currently a lack of scientific evidence to suggest that this will provide a long term solution. Consider fitting taps that can be readily dismantled for ease of use of cleaning and disinfection. In line with WHTM 04-01 (Chapter 9, paragraph 9.54), TMVs are required to be fitted where there is a risk of patient scalding.

16.6 Non Conformance

If there has been any non-conformance identified with this procedure, incident forms must be completed.

- Routine water sampling for microbiological analysis or Legionella is not required by legislation on a regular basis.
- However to ensure water quality supplied in the CTMUHB premises, random water sampling for microbiological analysis have been adopted. Refer to **Appendix H** for microbiological sample collection protocol.
- Water tests for Legionella will be carried out as required by the system information gathered through the inspection and monitoring programme dictates.

Ref:
Policy Title: Water Safety Plan V2.3
Page Number: 57

Routine water sampling for *Pseudomonas aeruginosa* in augmented care Units are required on a frequency of 6 monthly basis or as determined by IP&CT through clinical surveillance. Refer to **Appendix I** for *Pseudomonas aeruginosa* sample collection protocol.

17 AVOIDANCE OF STAGNATION

Avoiding stagnation in water systems is critical to avoid water quality deterioration. As detailed in Section 7, Departmental Roles & Responsibilities, premises occupiers are responsible for identifying areas of the water system, including individual or groups of outlets, that are not being used on a regular basis (i.e. at least every day) and carrying out flushing to replenish water within the pipework and fittings with fresh water from supply.

All Departments shall have in place appointed persons responsible for this aspect and shall maintain a comprehensive set of signed records locally that are available for inspection at any time. Results should be forwarded to the Estates Department for the Attention of the RP / DRPs at least on a monthly basis to show compliance with WSG requirements.

A representative of the Estates Department team will carry out period audits of flushing across the estate and provide reports to the WSG at each meeting.

Appendix E contains the guidance note and standard flushing record that shall be maintained in each area file.

18. COMPETANCE

For the purpose of water safety, the WSG defines a competent person as someone with adequate knowledge, experience and instruction combined with the personal attributes required to carry out a task in a correct and safe manner.

All members of the WSG and persons allocated with departmental responsibility shall be suitably competent and able to carry out their allocated duties to the standard required, safely and on schedule. Adequately competent deputies shall be available at all times to provide cover during periods of absence that may affect task or duty schedules.

The appointed RP, & Appointed DRPs shall have undertaken formal training in the following areas as a minimum specific to ACOP L8, WHTM 04-01 and HSG 274 parts 2 and 3:

Including Awareness of legionella, pseudomonas aeruginosa and other waterborne pathogens; and Management of the risk for appointed responsible persons;

Competent Persons (CPs) and tradespersons (including contractors and directly employed personnel) whose roles involve working on or around water systems, including those undertaking tasks associated with the scheme of control, shall undergo the following formal training as appropriate:

- Awareness of legionella, pseudomonas aeruginosa and other waterborne pathogens;
- Task specific training as appropriate to the tasks undertaken including awareness of methodologies and standards to be applied;
- Awareness of the requirements of the Water Supply (Water Fittings) Regulations 1999

Ref:

Policy Title: Water Safety Plan V2.3

Page Number: 58

Those involved in the design, installation and commissioning of all water service systems, including minor and major capital works shall be fully aware of the requirements under ACOP L8 to ensure water systems comply with the requirement of ACOP L8, the Water Supply (Water Fittings) Regulations 1999 and WHTM 04-01 parts A, B and C, and are safe and easy to operate and maintain, and that appropriate information is supplied.

All hotel services and cleaning staff shall be aware of the requirements and procedures for avoidance of cross-contamination and the control of *Pseudomonas aeruginosa* when cleaning around water services. The requirements placed upon hotel services and cleaning staff shall be undertaken through job specific training, awareness of legionella and safe systems of work deployed in the process of carrying out tasks associated with water and equipment supplying water.

All staff whose duties include the identification and flushing of little used outlets shall be given suitable instruction on the reasons for and how to carry out the required duty.

The competence of external suppliers and contractors shall be a mandatory requirement of tender procedures and evidenced before any contracts are let. Contractors employed to undertake tasks associated with the implementation, monitoring, testing and inspection of control measures associated with the control of legionella shall be members of the Legionella Control Association (LCA) and where possible "Water Safe" accredited. Whilst this alone does not guarantee competence, it does ensure that service providers have a system for maintaining and assessing the competence of their own staff - this shall be verified by the RP / DRPs & IP&C before engagement.

19. RECORD KEEPING

Records shall show the date and time of any task or duty undertaken and the name and/or signature of the person(s) carrying out the task, as applicable.

Records must be clear and concise, comprehensive and auditable and must be backed-up to ensure continuity in the event of loss for any reason.

Electronic copies of all records are generally preferred due to the robustness of the Health Board's IT system.

This WSP and associated appendices shall be held in the CTMUHB Intranet Site and made available to all members of the WSG as a minimum.

Each building shall have the following records associated with it:

- Documented appointments for water safety management
- Legionella risk assessment;
- *Pseudomonas aeruginosa* risk assessment (if augmented care);
- Scalding risk assessment;
- Schematic drawing of the water system or up-to-date layout drawings
- Results of checks of control measures
- Flushing records
- Non-conformance reports and corrective action records
- Staff training records

Ref:

Policy Title: Water Safety Plan V2.3

Page Number: 59

20. INCIDENT / OUTBREAK MANAGEMENT

Outbreak Plans

In the event of a case of Legionella infection acquired within CTMUHB, the Outbreak Team will be convened in accordance with WHTM 04 – 01 Part B, section 10 Testing for Legionella, and associated actions in accordance with CTMUHB policy - IPC02 on receipt of a positive sample.

The IP&CT will hold the ring and appoint a lead person, who will convene an Outbreak Management Team if there is a significant problem or burden detected via clinical surveillance in any of the Health board estate, and in particular augmented care units for legionella, *pseudomonas aeruginosa* or other pathogens in accordance to the Outbreak Management Procedure WHTM 04 – 01 Part B section 10 Appendix J and IPC02 documentation Appendix K.

Any incidents associated with water safety and hygiene shall be managed by the Lead IP&C Nurse or Lead Microbiologist in accordance with CTMUHB Incident Plans. Members from the WSG shall provide support and assistance where required, including providing emergency services to prevent harm or ill health to patients, staff and visitors. The Estates RP / DRPs shall provide support to the incident management team by coordinating any necessary resources to undertake engineering works required, including assistance with investigation.

21. AUDIT REVIEW

Where checks or audits identify non-compliances, the departmental representative shall ensure that appropriate follow up action is taken in accordance with the risk posed, and records of all corrective action retained.

This WSP shall be reviewed on an annual basis or shorter intervals if required and determined by the WSG.

22. LIST OF APPENDICES AND ASSOCIATED DOCUMENTS.

A	Terms of Reference	 Appendix A - TOR's - 21.07.21.docx
B	Augmented Care Locations as directed by Lead Microbiologist.	 Appendix B - Augmented CAre Lo
C	Premises Occupation & Management List	 Appendix C - Premises Occupation
D	Infection Control Approval	 Appendix D - Infection Control Ap
E	Little Used Outlet Flushing Record	 Appendix E - Little Used Outlet Flushin
F	Notification of closure of part or all of an area.	 Appendix F - Notification of closu
G	Microbiological Sample Protocol	 Appendix G - Microbiological Sam
H	Pseudomonas Sample Protocol	 Appendix H - Pseudomonas Samp
I	Legionella Outbreak Plan	 Appendix I - Legionella Outbreak
J	IPC02 management of an outbreak	 Appendix J - IPC02 management of an c



K	Hydro Therapy pools	 Appendix K - Hydro Therapy pools (need
L	Birthing Pools	 Appendix L - Birthing Pools.docx
M	Water Coolers and Ice Machines (needs updated one)	 Appendix M - Water Coolers and I

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	In progress Assistant Director of Allied Health Professionals and Health Sciences to discuss further with the Executive Director of Allied Health Professionals and Health Sciences and the Executive Director of Nursing in regards to the most appropriate time to present the Annual Quality work plan to the Committee
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	In progress Will be presented to the May 2025 meeting of the Committee.
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 Policy Escalation	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 early 2025.
14 August 2024	Request received by email for this to be presented as a spotlight presentation to a future meeting of the Committee	Senior Nurse Acute Deterioration and Outreach Services	Spotlight Presentation Decision Making around ACP/DNACPR/TEP	Case presentation to highlight the need for more resource in end-of-life education and training	Senior Nurse Acute Deterioration and Outreach Services	Executive Medical Director	25 March 2025	In progress Consideration being given to governance reporting routes for 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	In Progress On agenda for the 25 March 2025 meeting
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	In progress On agenda for the 25 March 2025 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	In progress Will be presented to the May 2025 meeting of the Committee
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	In progress On agenda for the 25 March 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	In progress Will be presented to the May 2025 meeting of the Committee
Completed Items								
18 September 2024	Action captured at the In Committee session held on 18 September 2024	Director of Midwifery	Health Visiting Services Bridgend	Action plan to be presented to a future meeting of the Committee.	Director of Midwifery	Executive Director of Nursing	21 January 2025	Completed Action plan was made available to Members to view on request at the January 2025 meeting
1 October 2024	Request received by email from the Medical Directors Office	Anaesthetic Consultant	Report from the Medicines Safety Committee	To update the Committee on the work of the group since it was established a year ago	Executive Medical Director	Executive Medical Director	21 January 2025	Completed Report received at the January 2025 meeting
22 October 2024	Request received by email from the Assistant Director of Governance & Risk	Director of Midwifery	Infant Feeding Strategy	To be presented to the Committee for Approval	Director of Midwifery	Executive Director of Nursing	21 January 2025	Completed Strategy received and noted at the January 2025 meeting
4 November 2024	Request received by email from the Patient Care & Safety Business Manager for this item to	Head of Safeguarding	Safeguarding Strategy	To be presented to the Committee for Endorsement prior to Board approval	Head of Safeguarding	Executive Director of Nursing	21 January 2025	Completed Strategy Received and Endorsed for Board approval at the

	be added to the agenda for the January 2025 meeting							January meeting 2025
5 December 2024	Request received by email from the Patient Care & Safety Business Manager	Assistant Director Clinical Education	CTM Learning Academy	To be presented to the Committee for endorsing prior to Board Approval	Assistant Director Clinical Education	Executive Director of Nursing	21 January 2025	Completed Strategy Received and Endorsed for Board approval at the January 2025 meeting
6 December 2024	Request received by email from the Patient Care & Safety Business Manager	Patient Care & Safety Business Manager	Pressure Ulcer Prevalence Audit	To be presented to the Committee for noting	Assistant Director of Nursing and People's Experience	Executive Director of Nursing	21 January 2025	Completed Strategy received and discussed at the January 2025 meeting
19 December 2024	Request received by email from the Assistant Director of Governance & Risk	Assistant Director of Governance & Risk	Stroke Services Update	To be presented to the Committee for discussion	Chief Operating Officer	Chief Operating Officer	21 January 2025	Completed Strategy received and discussed at the January 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: Carolyn Donoghue, IM University	Committee Vice Chair Kath Palmer, Vice Chair	Executive Leads for Agenda Planning 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	R		R		R		R		R		R		R If all actions are complete	R 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	R		R		R		R		R		R		R	X
3. Non-Routine Committee Business (Forward Plan)	Director of Corporate Governance / Board Secretary	All Regular Meetings	R		R		R		R		R		R		R	X
4. Annual Cycle of Business	Director of Corporate Governance / Board Secretary	All Regular Meetings	R		R		R		R		R		R		R Except for the annual review in November	R Annual Review only
5. Committee Annual Report	Director of Corporate Governance / Board Secretary	Annually					R								X	R
6. Outcome of Annual Committee Self-Assessment	Director of Corporate Governance / Board Secretary	Annually					R								X	R
7. Terms of Reference Review	Director of Corporate Governance / Board Secretary	Annually					R								X	R

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	R		R		R		R		R		R		X	R
9. Outcome reports - Executive and Independent Member Patient Safety Walkabouts	Executive Director of Nursing / Deputy CEO	Twice per annum.			R To be deferred to the May meeting		R				R					
Setting the Scene – Service Delivery																
10. Thematic Spotlight Presentation	Lead Clinical Executive	All Regular Meetings	R		R		R		R		R		R		X	R
11. Report from the Clinical Executives	Clinical Executives	All Regular Meetings	R		R		R		R		R		R		X	R
12. Care Group Highlight Reports	Care Group Nurse Directors/Care Group Medical Directors	All Regular Meetings	R		R		R		R		R		R		X	R
Delivering our Plan																
13. Quality Dashboard Report	Executive Nurse Director / Deputy Chief Executive	All Regular Meetings	R		R		R		R		R		R		X	R
14. Stroke Services Progress Report <i>(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)</i>	Executive Director of Therapies & Health Science / Chief Operating Officer	Twice per annum	R						R						X	R
Governance, Risk and Assurance																
15. Organisational Risk Register – Risks Assigned to Quality & Safety Committee	Director of Corporate Governance	All Regular Meetings	R		R		R		R		R		R		X	R
16. Health Inspectorate Wales (HIW) Audit Tracker Report	Director of Corporate Governance & Executive Nurse Director / Deputy Chief Executive	All Regular Meetings	R (consent)		R (consent)		R (main)		R (consent)		R (consent)		R (main)		R	R (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			R						R				X	
18. Mortality Indicators and Mortality Reviews	Executive Medical Director	Bi Annually	R										R		X	R
19. Continuing Healthcare (CHC) and Funded Nursing Care (FNC) Activity.	Executive Nurse Director / Deputy Chief Executive	Annually			R To be deferred to the May meeting		R								X	R
20. Infection, Prevention & Control Annual Report	Executive Nurse Director / Deputy Chief Executive	Annually									R				X	R
21. Infection, Prevention & Control Strategy Implementation Plan	Executive Nurse Director / Deputy Chief Executive	Annually					R								X	R
22. Putting Things Right Annual Report	Executive Nurse Director / Deputy Chief Executive	Annually							R						R	X
23. Non Clinical Policies for approval	Executive Portfolio determined.	As and when required													R	X
24. Clinical Policies Highlight Report	Executive Medical Director	Bi-Annually					R						R		R	X
25. Safeguarding & Public Protection Annual Report	Executive Nurse Director / Deputy Chief Executive	Annually											R		R	X
26. Nurse Staffing Levels Wales Act 2016	Executive Nurse Director / Deputy Chief Executive	Twice per Annum					R						R		R	X
27. Medicines Management <i>(Including Controlled Drugs Local Intelligence Network (CDLIN) / Prescribing Annual Report) Prescribing errors captured in quality dashboard)</i>	Executive Medical Director	Annually plus exception reporting					R								X	R
28. Oversight on the delivery of the R&D Strategy	Executive Nurse Director / Deputy Chief Executive	Bi Annually					R						R			
29. Cancer Services Annual Report	Executive Medical Director	Annually					R								R	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														X
41. Organ Donation Sub Committee Highlight Reports	Executive Medical Director	All meetings following a Sub Committee													Unless there is an area for escalation	X
42. Organ Donation Sub Committee Annual Committee 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.																
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 Board Update	Executive Director of Nursing	Twice Per Annum														
46. Annual Duty of Quality Report	Executive Director of Nursing	Annually														



Agenda Item

8.2.3

Quality, Safety & Experience Committee

**HEALTHCARE INSPECTORATE WALES IMPROVEMENT PLAN
TRACKER REPORT**

Dyddiad y Cyfarfod / Date of Meeting	25 th March 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

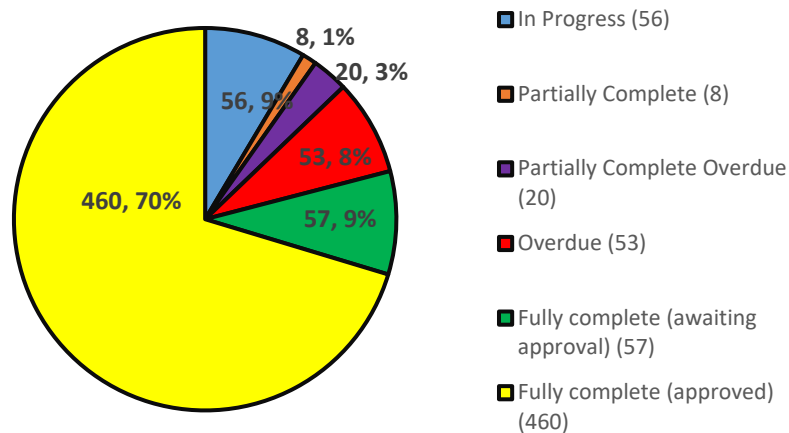
Pwrpas yr Adroddiad / Report Purpose	For Noting

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.	

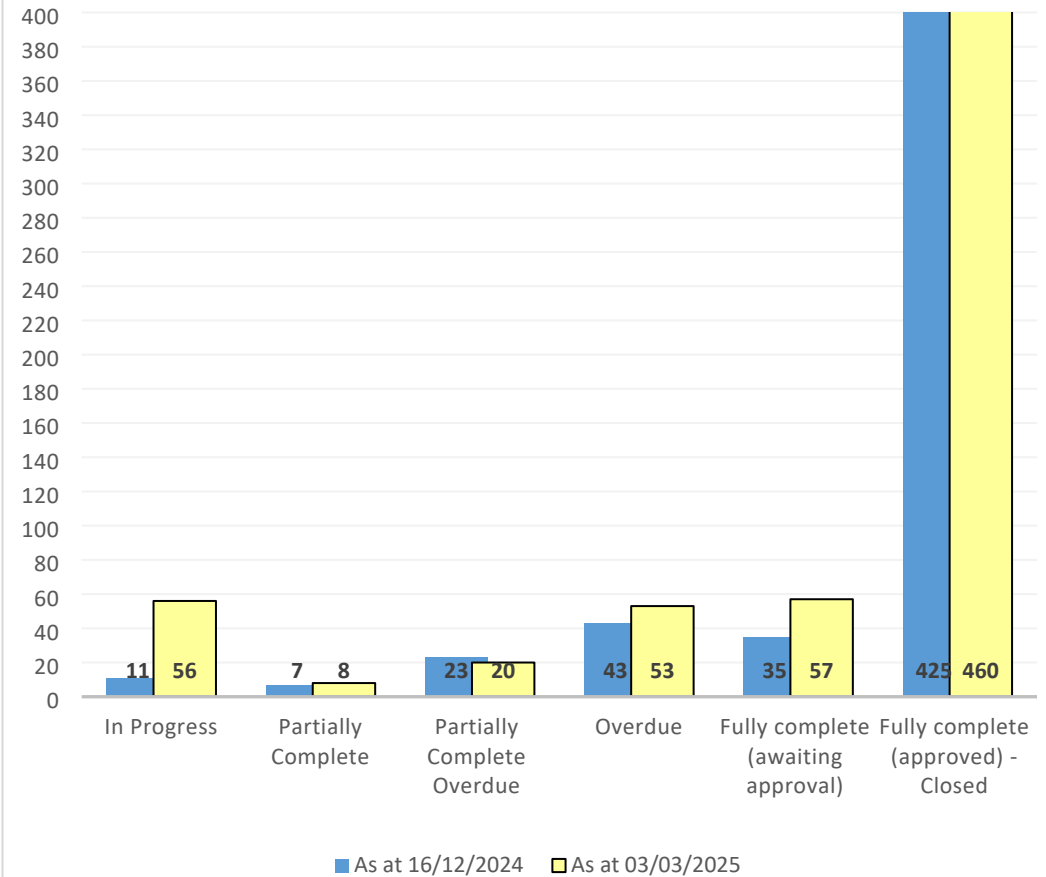
Acronyms / Glossary of Terms	
HIW	Healthcare Inspectorate Wales
AMaT	Audit Management and Tracking

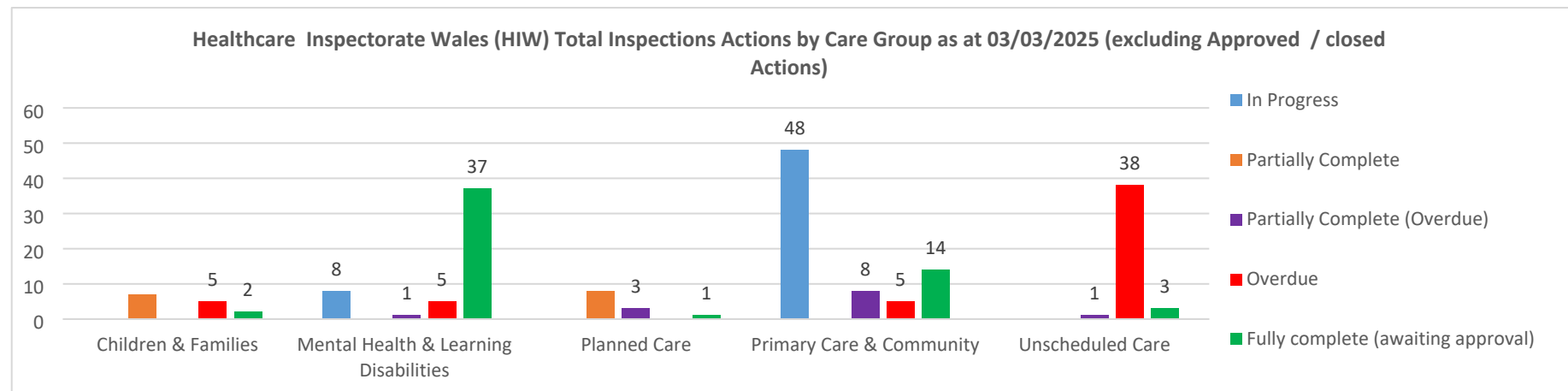
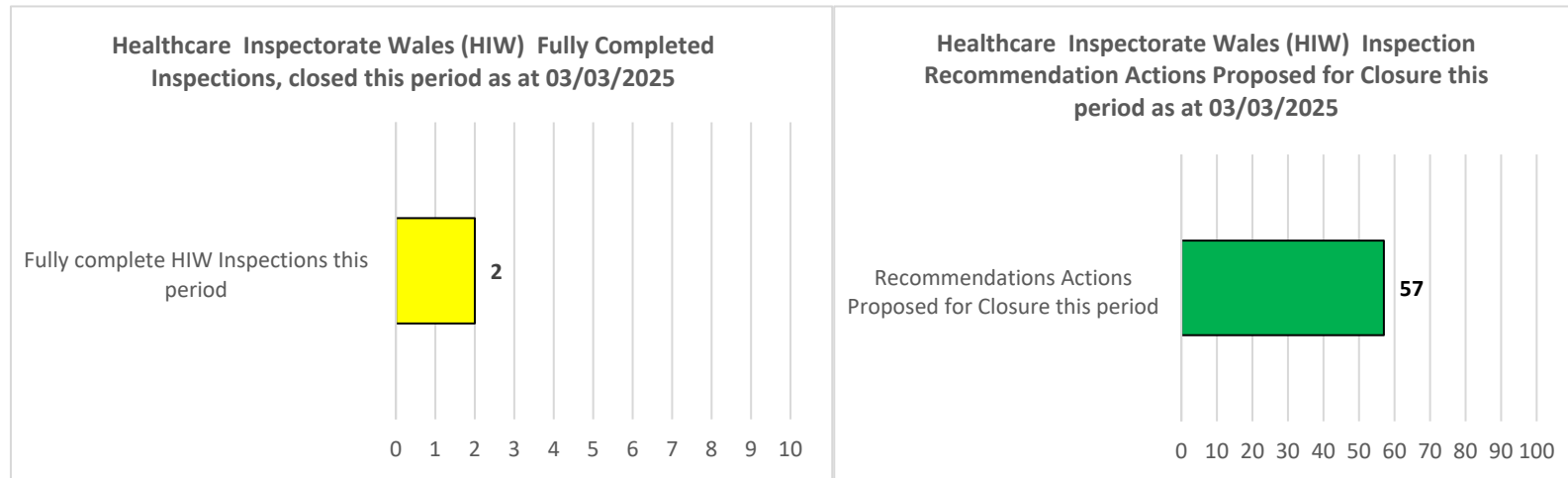


Healthcare Inspectorate Wales (HIW) Inspection Total
Recommendation Actions as at 03/03/2025



Healthcare Inspectorate Wales (HIW) Inspection Total
Recommendation Actions
Progress Monitoring/Change in Status this period as at 03/03/2025





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 18th December 2024 until 3rd March 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 as well as recently updated Death in Custody reports. These have been added onto AMaT and are included in the data figures for reporting. Work is continuing with the Prison Service team to develop the most suitable local process for updating and managing the recommendations and actions from a Death in Custody report.
- 2.3 There remains an element of manual manipulation in order to produce and present the relevant data and report via AMaT but the team continue to work with the system developers in an attempt to use the system for the intent of Governance and Assurance. Care Group Leads have shown engagement in taking ownership of completing updated responses independently prior the deadline for updates as well as in cleansing the historical inspections and actions.
- 2.4 Care Groups are responsible for providing regular updates on the improvement plans within their care group portfolios in order that the tracker can remain live and up to date ensuring all actions are completed in a timely manner. Reminders are sent out in advance via AMaT of reporting deadlines to encourage and request further updates from Care Groups.
- 2.5 The use of AMaT for the intention or Governance and Assurance purposes has begun to increase in momentum with the tracking and Management of Death in Custody reports transitioning onto the AMaT system. Colleagues from the Prison service have shown enthusiasm and initiative in engaging with the Quality Assurance Team.

2.6 Following discussion with the Primary Care and Community Care Group, they have provided assurance that there is already a system in place to track ongoing HIW Improvement plans in their independent practices that serve CTMUHB.

2.7 A breakdown of the status position with regards to all actions up to the 3rd March 2025 is detailed below.

- A total of **654 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.
- **460** Actions were Fully complete, approved and closed with a further **57** actions fully complete and awaiting approval

2.8 New Inspections / Actions

- There were **9** new Improvement Plans and **110** actions added this period. Please note that Death in Custody are included in this data.

3. Key Risks / Matters for Escalation

3.1 Ongoing AMaT system developments and requests are continuing in order to deliver a system and process that is required for improved governance. 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.

3.2 The HIW actions tracker will continue to be updated with a targeted focus on actions where the action agreed due by date has passed or no update has been received.

3.3 Continued engagement is required from Care Groups to continue to update and cleanse the current and historic Inspection actions to make analysis more meaningful. The Quality Assurance and Compliance team will continue to work with Care Groups to continue to track and manage the ongoing improvements to services and to complete outstanding actions and provide sufficient assurance.

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 03/03/2025

Inspection Code	Title	Date of Inspection	Recommendations	Actions	Care Group & DoN Lead
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/197	HMP Parc Prison - DIC (Case Reference: CA 09791/CRM0006681)	14/08/2024	3	3	Primary Care and Community Lucie Owen, Nurse Director
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/198	HMP Parc Prison - DIC (Case Reference: RD 06379/CRM0006682)	14/08/2024	5	5	Primary Care and Community Lucie Owen, Nurse Director
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/222	HMP Parc - DIC (Case Reference: JH/CRM0006848)	26.11.2024	10	10	Primary Care and Community Lucie Owen, Nurse Director
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/223	HMP Parc - DIC (Case Reference: JL/CRM0006961)	28.11.2024	12	12	Primary Care and Community Lucie Owen, Nurse Director
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/224	HMP Parc - DIC (Case Reference: RR/CRM0006960)	26.11.2024	4	4	Primary Care and Community Lucie Owen, Nurse Director
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/225	HMP Parc - DIC (Case Reference: CS/CRM0006988)	02.12.2024	7	7	Primary Care and Community Lucie Owen, Nurse Director
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/226	HMP Parc - DIC (Case Reference: WH/CRM0006787)	23.09.2024	2	2	Primary Care and Community Lucie Owen, Nurse Director
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/227	HMP Parc - DIC (Case Reference: DM/CRM0006823)	23.01.2024	10	10	Primary Care and Community Lucie Owen, Nurse Director
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/228	HMP Parc - DIC (Case Reference: MH/CRM0006031)	16.12.2024	13	13	Primary Care and Community Lucie Owen, Nurse Director
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 and 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)/2022/133	Hospital Inspection Report (Unannounced) Emergency Department, Princess of Wales Hospital [Appendix A - Immediate Improvement Plan - Princess of Wales Emergency Department (Ref: 3326)]	17/10/2022	1	2	Unscheduled Care Emma James, Nurse Director
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 and 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)/2024/217	Appendix C Improvement Plan_Ysbyty Cwm Rhondda Ward B2_11-12 April 2024 (Ref: 03467)	11.04.2024	6	6	Primary Care and Community Lucie Owen, Nurse Director
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.

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
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/197	14/08/2024	HMP Parc - DIC (Case Reference: CA 09791/CRM0006681)	Reception screening for any prisoner with known risks such as significant medical history or substance misuse is undertaken by a qualified nurse, to ensure that any concerns regarding health or risks are recognised and acted upon. Entries in the clinical record is made by a named member of staff and is done so contemporaneously where possible.	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/197/MD1/1	New admissions are now screened by a qualified nurse. A documentation audit to is to be completed and any issues identified to be reported on the Datix management system.	Primary Care & Community	30.09.2024	30.09.2024	Partially complete (Overdue)	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 Update - Evidence to be approved at next QRSE meeting due 05.02.2025.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/197	14/08/2024	HMP Parc - DIC (Case Reference: CA 09791/CRM0006681)	Inter-prison transfers should not be made unless it is clear that a service exists to deliver the health needs of the patient at the appropriate destination, by a confirmed sign off between both prisons heads of healthcare. When arriving at HMP Parc, currently there is no commissioned service for patients with confirmed or suspected ADHD to receive specialist input into care management. CTMUHB commissioners urgently seek to provide a clinical service to HMP Parc that would enable timely assessment and treatment optimisation for prisoners with ADHD.	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/197/MD2/1	A review of the current processes regarding the inter-prison transfers and the sharing of information between prison healthcare departments to be undertaken in partnership with G4S team. For patients who require ADHD assessments are currently reviewed by mental health services within secondary care. Whilst this is in line with the care provided within Community Services, the team are undertaking a review with Mental Health services to understand any further improvements that could be made to the service. Prison Healthcare Directorate representation included as part of the CTM Regional Neurodivergence Steering and Improvement Board to review current provision and identify work streams to improve services.	Primary Care & Community	31.12.2024	31.12.2024	Overdue	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 Update - Progress and evidence: Process to be embedded once agreed.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/197	14/08/2024	HMP Parc - DIC (Case Reference: CA 09791/CRM0006681)	CTMUHB commissioners ensure that all contracted services providing any input into the health of the patient are required to maintain records in the main healthcare clinical record system.	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/197/MD3/1	Email to be sent to all contracted services to remind them of the importance that when providing any input to the health of a patient that all records are maintained with the clinical system. The requirement to add relevant information in the main healthcare clinical record system (System One) to be included in all future SLA and tender documentations. Healthcare Needs Assessment commissioned to provide baseline for service provision and resulting action plan to address identified recommendations.	Primary Care & Community	31.12.2024	31.12.2024	Overdue	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 Update - Progress and evidence: Email to be embedded. Specific part of contract to be embedded. Needs Assessment to be embedded and evidence.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/198	14/08/2024	HMP Parc - DIC (Case Reference: RD 06379/CRM0006682)	The Head of Healthcare should ensure that all prisoners, by the end of second reception screening, have a full set of baseline clinical observations to act as baseline for staff to monitor for changes from the patient normal values. Reception screening should always involve at least one registered health professional undertaking the assessment with the patient. They should arrange clinical audit of compliance against this standard.	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/198/MD1/1	New admissions are now screened by a qualified nurse. Audit for 15 admissions to be undertaken to ensure that clinical observations have been undertaken. All staff have been informed that baseline observations must be recorded on admission screening. All staff will be issued with written guidance.	Primary Care & Community	30.09.2024	30.09.2024	Partially complete (Overdue)	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 Update - Awaiting approval via QRSE Feb 2025.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/198	14/08/2024	HMP Parc - DIC (Case Reference: RD 06379/CRM0006682)	Patients with seizures (full loss of consciousness) without an established diagnosis of the cause of seizures should be treated as a clinical emergency by all healthcare staff, and should receive review urgently by a registered medical practitioner. If none is available onsite, then the patient should be referred to hospital for emergency assessment.	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/198/MD2/1	Emergency medicine training sessions to be devised and provided to ensure that all staff have adequate skills and knowledge to treat clinical emergencies and to identify those who require referral to hospital for an emergency assessment. All staff have been reminded that any patients reporting seizure activity in the absence of a diagnosis of epilepsy must be referred for an urgent GP appointment. All staff have been informed that the GP must be informed of any patients with a diagnosis of epilepsy have any seizure activity. These patients will be reviewed by the practice nurse.	Primary Care & Community	31.10.2024	31.10.2024	Partially complete (Overdue)	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 Update - Awaiting approval via QRSE Feb 2025.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/198	14/08/2024	HMP Parc - DIC (Case Reference: RD 06379/CRM0006682)	Healthcare staff should ensure that when reviewing clinical discharge summaries from hospital teams, the information on which they have based their assessment is accurate (for example, in this case, it was incorrect for the consultant neurologist to state this was a single episode of seizure) from the clinical record. These errors or omissions should be alerted to the relevant specialist, so that they can revise the management plan for the patient.	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/198/MD3/1	Admissions staff to be provided have access to the Welsh Clinical Portal to ensure timely review of discharge summaries. All discharge summaries will be reviewed by a GP and Senior Nurse. The discharge summaries will be checked for accuracy and outstanding actions. Once checked and signed by Senior Nurse and GP they will be scanned onto records. Audit to be undertaken in relation to 10 discharges to ensure all summaries have been checked by the GP and Senior Nurse	Primary Care & Community	31.10.2024	31.10.2024	Partially complete (Overdue)	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 Update - Progress and evidence: Meeting with Digital Health Care Wales w/c 02/09/24. Audit and findings to be embedded.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/198	14/08/2024	HMP Parc - DIC (Case Reference: RD 06379/CRM0006682)	Where a hospital letter is requesting potential actions if a future event should occur (e.g. 'refer back to my service should a further seizure occur') this should be flagged on the clinical record as an 'alert', so this potential action / request is visible to all staff.	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/198/MD4/1	Admissions staff to have access to Welsh Clinical Portal to ensure timely review of discharge summaries. All discharge letters will be checked by a Senior Nurse and a GP and any requests for actions to be taken if a future event should occur this will be flagged as an alert on medical records.	Primary Care & Community	31.10.2024	31.10.2024	Partially complete (Overdue)	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 Update - Progress and evidence: Register of staff with dates of access provided to be embedded. Audit in number 3 will evidence the findings. Awaiting approval via QRSE Feb 2025 - evidence embedded.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/198	14/08/2024	HMP Parc - DIC (Case Reference: RD 06379/CRM0006682)	Clinical teams in other services providing care to prisoners (e.g. psychiatry) should clearly document that they have considered the risk of their prescribing recommendations to general practitioners, where those recommendations increase the risk of worsening of other illness (e.g. increasing risk of seizure). Formal letters of referral and assessment need to be conducted between HMP Parc primary care and In-Reach Psychiatry teams, to ensure that all relevant information on the clinical history of the patient is available to both parties (e.g. to ensure that psychiatric colleagues are aware of risk of seizures, and that these colleagues make recommendations for prescribing that clearly document that risk has been considered in their assessment).	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/198/MD5/1	Recommendation shared and teams reminded of the importance for enhanced communication and documentation between clinical teams providing care to prisoners at HMP Parc. A task and finish Group to be established to address the recommendation and to improve processes between clinical teams and to identify standardisation for referral and assessment to include patient's clinical history, prescribing recommendations, risk assessment and communication protocols.	Primary Care & Community	30.11.2024	30.11.2024	Partially complete (Overdue)	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 Update - Progress and evidence: Email to be embedded. Findings from the task and finish group to be embedded. Awaiting approval via QRSE Feb 2025 - evidence embedded.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/222	26.11.2024	HMP Parc - DIC (Case Reference: JH/CRM0006848)	CTMUHB to train all of their emergency response staff (including agency staff) to an immediate life support (ILS) level which should be Resuscitation Council accredited training.	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/222/MD1/1	Identify the specific ILS competencies required for the team via ESR. Link with resuscitation team to provide ILS training to ensure that regular training sessions are available for all staff to refresh their knowledge.	Primary Care & Community	31.03.2025	31.03.2025	In progress	Added to tracker January 2025.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/222	26.11.2024	HMP Parc - DIC (Case Reference: JH/CRM0006848)	The head of healthcare to ensure that all AED's are available in the emergency medical bag that is taken immediately to scene during an emergency response.	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/222/MD2/1	Develop and implement clear SOPs regarding the storage and deployment of AEDs. Specify that all AEDs should be stored as per resuscitation SOP.	Primary Care & Community	31.03.2025	31.03.2025	Fully complete (Awaiting approval)	Added to tracker January 2025; this action is marked as Completed as per the Action Plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 25th March 2025 as Fully Complete.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/222	26.11.2024	HMP Parc - DIC (Case Reference: JH/CRM0006848)	The head of healthcare to ensure that all staff are reminded of the importance of good record keeping and if they attend an incident they individually need to document their involvement in the patient's records. The head of healthcare to arrange a clinical audit after 3 months of this communication to ensure compliance.	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/222/MD3/1	Provide regular training sessions for healthcare staff on proper documentation practices, emphasising the importance of clarity, accuracy, and thoroughness. Utilise AMaT audit to review clinical records to assess documentation quality and compliance with established protocols.	Primary Care & Community	31.03.2025	31.03.2025	Fully complete (Awaiting approval)	Added to tracker January 2025; this action is marked as Completed as per the Action Plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 25th March 2025 as Fully Complete.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/222	26.11.2024	HMP Parc - DIC (Case Reference: JH/CRM0006848)	The head of healthcare to ensure that prescribers demonstrate they are following the RCGP guidance for 'safer prescribing in prisons' (2019).	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/222/MD4/1	Implement mandatory training sessions for all prescribers working in prisons that focus on the RCGP guidelines and the unique challenges of prescribing in a prison environment. Develop refresher courses to keep prescribers updated on best practices and any changes in guidelines.	Primary Care & Community	31.03.2025	31.03.2025	In progress	Added to tracker January 2025; this action is marked as Completed as per the Action Plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 25th March 2025 as Fully Complete.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/222	26.11.2024	HMP Parc - DIC (Case Reference: JH/CRM0006848)	The head of healthcare to ensure that patients are offered a face to face consultation with a prescriber when requiring a review of their medications if they are prescribed high risk medication (as set out in the RCGP guidance).	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/222/MD5/1	Create and disseminate a clear process outlining the requirement for face-to-face consultations for patients on high-risk medications, based on RCGP guidance.	Primary Care & Community	31.03.2025	31.03.2025	In progress	Added to tracker January 2025.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/222	26.11.2024	HMP Parc - DIC (Case Reference: JH/CRM0006848)	The lead prescriber to ensure that there is a clear and safe governance structure in place for the management of high risk medications in accordance with the RCGP guidance for 'safer prescribing in prisons' (2019).	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/222/MD6/1	Create comprehensive SOPs that detail the processes for prescribing, dispensing, administering, and monitoring high-risk medications.	Primary Care & Community	31.03.2025	31.03.2025	In progress	Added to tracker January 2025.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/222	26.11.2024	HMP Parc - DIC (Case Reference: JH/CRM0006848)	The head of healthcare to arrange trauma informed awareness training for all healthcare staff.	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/222/MD7/1	Review the current level of trauma-informed care knowledge amongst the team. Link with subject matter expert to create a comprehensive training program ensuring it covers principles of trauma-informed care, the impact of trauma on health, and practical application in a prison environment.	Primary Care & Community	31.03.2025	31.03.2025	In progress	Added to tracker January 2025.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/222	26.11.2024	HMP Parc - DIC (Case Reference: JH/CRM0006848)	The head of healthcare to arrange regular multidisciplinary reflective sessions (including prison staff) following an incident. This reflective session will include consideration of how care and decisions can be delivered in a more trauma informed way.	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/222/MD8/1	Ensure hot / cold debrief take place following an incident to include: • Discussion on trauma-informed care principles • Reflection on current practices and decision-making • Identification of areas for improvement • Action planning for future incidents	Primary Care & Community	31.03.2025	31.03.2025	In progress	Added to tracker January 2025.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/222	26.11.2024	HMP Parc - DIC (Case Reference: JH/CRM0006848)	CTMUHB to consider procuring psychology services at HMP Parc in order to be more comparable with community settings and other prison estates across England and Wales.	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/222/MD9/1	Healthcare Needs Assessment commissioned to provide baseline for service provision and resulting action plan to address identified recommendations.	Primary Care & Community	31.03.2025	31.03.2025	In progress	Added to tracker January 2025.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/222	26.11.2024	HMP Parc - DIC (Case Reference: JH/CRM0006848)	The head of healthcare to work with the director to improve the sharing of intelligence relating to the use of substances between prison, healthcare and Dyfodol staff for individual patients.	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/222/MD10/1	Current SLA with Dyfodol for psycho-social substance misuse services at HMP Parc ends 15th June 2025. Discussions with Dyfodol regarding sharing of relevant information between organisations. To meet with HIW to implement an agreed pathway on what information is to be recorded on SystmOne to meet the recommendations from their reports.	Primary Care & Community	31.03.2025	31.03.2025	In progress	Added to tracker January 2025.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/223	28.11.2024	HMP Parc - DIC (Case Reference: JL/CRM0006961)	The head of healthcare and director to liaise with the ambulance service to ensure that there is an agreed communication protocol that does not create unnecessary delays in the ambulance being dispatched (repeated recommendation).	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/223/MD1/1	To enhance collaboration and improve response times a meeting will be coordinated with representatives from WAST, healthcare and G4S colleagues to discuss current communication practices and identify pain points or delays in the dispatch process.	Primary Care & Community	31.05.2025	31.05.2025	In progress	Added to tracker January 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
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/223	28.11.2024	HMP Parc - DIC (Case Reference: JL/CRM00006961)	CTMUHB to train all of their emergency response staff (including agency staff) to an immediate life support (ILS) level which should be Resuscitation Council accredited training (repeated recommendation).	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/223/MD2/1	Identify the specific ILS competencies required for the team via ESR. Link with resuscitation team to provide ILS training to ensure that regular training sessions are available for all staff to refresh their knowledge.	Primary Care & Community	31.05.2025	31.05.2025	In progress	Added to tracker January 2025.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/223	28.11.2024	HMP Parc - DIC (Case Reference: JL/CRM00006961)	The head of healthcare to ensure that all staff are reminded of the importance of good record keeping and if they attend an incident, they individually need to document their involvement in the patient's records. The head of healthcare to arrange a clinical audit after 3 months of this communication to ensure compliance (repeated recommendation).	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/223/MD3/1	Provide regular training sessions for healthcare staff on proper documentation practices, emphasising the importance of clarity, accuracy, and thoroughness. Utilise AMaT audit to review clinical records to assess documentation quality and compliance with established protocols.	Primary Care & Community	31.05.2025	31.05.2025	In progress	Added to tracker January 2025.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/223	28.11.2024	HMP Parc - DIC (Case Reference: JL/CRM00006961)	The head of healthcare to review the current healthcare application process (including those to the IRMHT) and ensure there are more proactive and timely responses built into the process that breaks down the barriers currently within it.	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/223/MD4/1	Create and disseminate a clear process outlining the application to healthcare services.	Primary Care & Community	31.05.2025	31.05.2025	In progress	Added to tracker January 2025.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/223	28.11.2024	HMP Parc - DIC (Case Reference: JL/CRM00006961)	CTMUHB to review the learning in Mr Lewis's case and the difficulties he experienced accessing services, and in response consider developing initiatives and a culture of 'no wrong door' and making every encounter count within their healthcare services.	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/223/MD5/1	Healthcare Needs Assessment commissioned to provide baseline for service provision and resulting action plan to address identified recommendations.	Primary Care & Community	31.05.2025	31.05.2025	In progress	Added to tracker January 2025.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/223	28.11.2024	HMP Parc - DIC (Case Reference: JL/CRM00006961)	The head of healthcare to ensure that when a patient has been referred to the IRMHT they receive a 1-1 assessment, and they are not primarily completed during ACCT reviews.	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/223/MD6/1	A reminder to be sent to the PMHT that all referrals to IRMHT must have a full assessment completed on 1-1 basis assessments should not be completed during ACCT reviews.	Primary Care & Community	31.05.2025	31.05.2025	In progress	Added to tracker January 2025.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/223	28.11.2024	HMP Parc - DIC (Case Reference: JL/CRM00006961)	The head of healthcare to ensure that patients who self-harm are encouraged to develop a safety plan, in line with the NICE guideline [NG225] for 'self-harm: assessment, management and preventing recurrence' (2022).	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/223/MD7/1	Implement a working group to develop training for PMHT to develop safety plans in line with NICE guideline [NG225]. Develop a process for all patients who self-harm to have a safety plan implemented.	Primary Care & Community	31.05.2025	31.05.2025	In progress	Added to tracker January 2025.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/223	28.11.2024	HMP Parc - DIC (Case Reference: JL/CRM00006961)	The head of healthcare and primary care lead must ensure there is a pathway in place to clinically review patients who have started antidepressant therapy in line with the RCGP safer prescribing in prison guidelines, and BNF prescribing guidelines.	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/223/MD8/1	Implement mandatory training sessions for all prescribers working in prisons that focus on the RCGP guidelines and the unique challenges of prescribing in a prison environment. Develop refresher courses to keep prescribers updated on best practices and any changes in guidelines.	Primary Care & Community	31.05.2025	31.05.2025	In progress	Added to tracker January 2025.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/223	28.11.2024	HMP Parc - DIC (Case Reference: JL/CRM00006961)	The head of healthcare to ensure there is a formal process in place that ensures that a member of the PCMHt is invited to all first and last ACCT reviews.	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/223/MD9/1	Review current ACCT Arrangements and implement a policy revision, which clearly identifies that a member of PCMHt attends all first and last ACCT reviews.	Primary Care & Community	31.05.2025	31.05.2025	In progress	Added to tracker January 2025.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/223	28.11.2024	HMP Parc - DIC (Case Reference: JL/CRM00006961)	The head of healthcare to ensure that all patients who are at risk of malnutrition to have a MUST screen completed (to include a care plan) in place in accordance with the NICE CKS for 'management of malnutrition' (2024).	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/223/MD10/1	A flowchart to be developed for actions to be taken for men identified as at risk of malnutrition this will include implementation of care plan.	Primary Care & Community	31.05.2025	31.05.2025	In progress	Added to tracker January 2025.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/223	28.11.2024	HMP Parc - DIC (Case Reference: JL/CRM00006961)	The head of healthcare to ensure that a patient's GP medical records and Summary Care Record are requested / accessed during the reception screening process.	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/223/MD11/1	A full review of current process to be completed. Implementation of process for ensuring all GP Summaries are requested.	Primary Care & Community	31.05.2025	31.05.2025	In progress	Added to tracker January 2025.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/223	28.11.2024	HMP Parc - DIC (Case Reference: JL/CRM00006961)	CTMUHB to work with community GP's to understand why medical records and responses are not forthcoming, and to develop a shared agreement process to ensure there are no delays in medical records being shared (where the patient gives consent).	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/223/MD12/1	• Draft a Memorandum of Understanding that outlines: • Responsibilities of CTMUHB and community GP's regarding medical records sharing. • A clear process for record requests, including timelines, responsible parties, and necessary documentation (e.g., patient consent). • Procedures for handling urgent requests. • Acceptable formats for sharing records (e.g., electronic records, encrypted emails).	Primary Care & Community	31.05.2025	31.05.2025	In progress	Added to tracker January 2025.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/224	26.11.2024	HMP Parc - DIC (Case Reference: RR/CRM00006960)	Head of Healthcare to ensure that recommended follow-up reviews are conducted and properly documented in the clinical record. (Finding 5.19). Report 5.19 identified a delay of 4 days following a review undertaken by the Physiotherapist and occupational therapist for escalation to General Practitioner.	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/224/MD1/1	Establish specific documentation standards that detail what information must be included in the clinical record regarding follow-up reviews, such as date of review, findings, recommendations, and any patient interactions. Establish clear communication channels among staff to facilitate discussion and decision-making regarding follow-up care and documentation and where escalation of care is appropriate.	Primary Care & Community	30.06.2025	30.06.2025	In progress	Added to tracker January 2025.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/224	26.11.2024	HMP Parc - DIC (Case Reference: RR/CRM00006960)	Head of Healthcare to ensure that as per NICE (NG128) guidance, a specialist assessment within 24 hours is recommended for suspected TIA (Transient ischemic Attack) and initiation of aspirin to reduce the risk of stroke while awaiting further investigations. (Finding 5.20)	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/224/MD2/1	Disseminate clear protocols within healthcare settings outlining the process for assessing patients suspected of having a TIA, emphasising the 24-hour assessment window in line with NICE guidance. Conduct training sessions for staff where required on recognising TIA symptoms, the importance of timely assessment, and immediate management strategies, including the initiation of aspirin where appropriate.	Primary Care & Community	30.06.2025	30.06.2025	In progress	Added to tracker January 2025.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/224	26.11.2024	HMP Parc - DIC (Case Reference: RR/CRM00006960)	Head of Healthcare to ensure that observations and examinations appropriate to the clinical concern are undertaken and documented. (Finding 5.22.5.26)	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/224/MD3/1	Conduct regular audits within AMaT of patient records to ensure compliance with documentation standards and address any gaps identified in the observations or examinations performed.	Primary Care & Community	30.06.2025	30.06.2025	In progress	Added to tracker January 2025.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/224	26.11.2024	HMP Parc - DIC (Case Reference: RR/CRM00006960)	Head of Healthcare to improve coordinated medical care and thorough review of clinical notes and task message reviews. (Finding 5.20.5.23, 5.25 and conclusion 7.13,7.14,7.15)	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/224/MD4/1	Create guidelines for how clinical notes and task messages are documented and shared among the team at Parc.	Primary Care & Community	30.06.2025	30.06.2025	In progress	Added to tracker January 2025.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/225	02.12.2024	HMP Parc - DIC (Case Reference: CS/CRM00006988)	The head of healthcare and director to liaise with the ambulance service to ensure that there is an agreed communication protocol that does not create unnecessary delays in the ambulance being dispatched.	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/225/MD1/1	To enhance collaboration and improve response times a meeting will be coordinated with representatives from WAST, healthcare and GAS colleagues to discuss current communication practices and identify pain points or delays in the dispatch process.	Primary Care & Community	31.03.2025	31.03.2025	In progress	Added to tracker January 2025.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/225	02.12.2024	HMP Parc - DIC (Case Reference: CS/CRM00006988)	CTMUHB to train all of their emergency response staff (including agency staff) to an immediate life support (ILS) level which should be Resuscitation Council accredited training	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/225/MD2/1	Identify the specific ILS competencies required for the team via ESR. Link with resuscitation team to provide ILS training to ensure that regular training sessions are available for all staff to refresh their knowledge.	Primary Care & Community	31.03.2025	31.03.2025	In progress	Added to tracker January 2025.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/225	02.12.2024	HMP Parc - DIC (Case Reference: CS/CRM00006988)	The head of healthcare to ensure that all AED's are available in the emergency medical bag that is taken immediately to scene during an emergency response.	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/225/MD3/1	Develop and implement clear SOPs regarding the storage and deployment of AEDs. Specify that all AEDs should be stored as per resuscitation SOP.	Primary Care & Community	31.03.2025	31.03.2025	Fully complete (Awaiting approval)	Added to tracker January 2025; this action is marked as Completed as per the Action Plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 25th March 2025 as Fully Complete.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/225	02.12.2024	HMP Parc - DIC (Case Reference: CS/CRM00006988)	The head of healthcare to report the issue of the faulty bag valve mask to the manufacturer.	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/225/MD4/1	To report defect in equipment to the manufacturer. Regularly conduct a comprehensive inventory check of resuscitation equipment within Parc Prison. Ensure that all equipment is in working order, fully charged, and easily accessible as per SOP.	Primary Care & Community	31.03.2025	31.03.2025	Fully complete (Awaiting approval)	Added to tracker January 2025; this action is marked as Completed as per the Action Plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 25th March 2025 as Fully Complete.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/225	02.12.2024	HMP Parc - DIC (Case Reference: CS/CRM00006988)	The head of healthcare to ensure that all staff are reminded of the importance of good record keeping and if they attend an incident they individually need to document their involvement in the patient's records. The head of healthcare to arrange a clinical audit after 3 months of this communication to ensure compliance.	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/225/MD5/1	Provide reminder for staff to ensure proper documentation practices, emphasising the importance of clarity, accuracy, and thoroughness. Utilise AMaT audit to review clinical records to assess documentation quality and compliance with established protocols.	Primary Care & Community	31.03.2025	31.03.2025	In progress	Added to tracker January 2025.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/225	02.12.2024	HMP Parc - DIC (Case Reference: CS/CRM00006988)	The head of healthcare to work with the director to improve the sharing of intelligence relating to the use of substances between prison, healthcare and Dyfodol staff for individual patients.	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/225/MD6/1	Current SLA with Dyfodol for psycho-social substance misuse services at HMP Parc ends 15th June 2025. Discussions with Dyfodol regarding sharing of relevant information between organisations. To meet with HIW to implement an agreed pathway on what information is to be recorded on SystmOne to meet the recommendations from their reports.	Primary Care & Community	31.03.2025	31.03.2025	In progress	Added to tracker January 2025.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/225	02.12.2024	HMP Parc - DIC (Case Reference: CS/CRM00006988)	CTMUHB to develop a policy for the management of critical medication when a patient is suspected or has been using substances. This policy should include how patients are informed of any prescribing decisions and what care plans should be put in place to monitor the patient for any adverse effects of omitting their medication, in accordance with the RCGP guidance for 'safer prescribing in prisons' (2019).	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/225/MD7/1	Devise critical medication policy for the administration of time-critical medications, detailing information as recommended.	Primary Care & Community	31.03.2025	31.03.2025	In progress	Added to tracker January 2025.

HIW Inspections Recommendation Actions Tracker as at 03/03/2025 (for Quality, Safety and Experience Committee 25/03/2025)										
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
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/236	23.09.2024	HMP Parc - DIC (Case Reference: WH/CRM0006787)	The Prison Healthcare Directorate to ensure that any prisoner arriving at HMP Parc has a reception screening overseen by a registered health professional.	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/236/MD1/1	Daily staffing allocation amended to ensure that registered nurse present in admissions on a daily basis to complete the reception screening	Primary Care & Community	31.10.2024	31.10.2024	Fully complete (Awaiting approval)	Added to tracker January 2025; this action is marked as Completed as per the Action Plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 25th March 2025 as Fully Complete.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/236	23.09.2024	HMP Parc - DIC (Case Reference: WH/CRM0006787)	Cwm Taf Morgannwg UHB to review the service level contract agreement with Dyfodol to consider make it a requirement that relevant information related to health risk either is (a) directly recorded in the HMP Parc electronic patient record or (b) a formal 'secondary care' letter is sent to the primary health care team following each client contact where information relevant to health is obtained.	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/236/MD2/1	Current SLA with Dyfodol for psycho-social substance misuse services at HMP Parc ends 15th June 2025. Discussions with Dyfodol regarding sharing of relevant information between organisations.	Primary Care & Community	31.12.2024	31.12.2024	Overdue	Added to tracker January 2025.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/227	23.01.2024	HMP Parc - DIC (Case Reference: DM/CRM0006823)	Head of Healthcare to ensure that there is good documentation in the clinical records to facilitate continuity of care	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/227/MD1/1	Provide regular training sessions for healthcare staff on proper documentation practices, emphasising the importance of clarity, accuracy, and thoroughness. Utilise AMaT audit to review clinical records to assess documentation quality and compliance with established protocols.	Primary Care & Community	31.03.2025	31.03.2025	Fully complete (Awaiting approval)	Added to tracker January 2025; this action is marked as Completed as per the Action Plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 25th March 2025 as Fully Complete.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/227	23.01.2024	HMP Parc - DIC (Case Reference: DM/CRM0006823)	Head of Healthcare to ensure that all staff are aware of the location of emergency equipment. (Finding 5.5)	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/227/MD2/1	To include on induction a session on emergency procedures and the locations of emergency equipment in the induction program for new staff. Schedule regular training sessions for all staff to refresh their knowledge of emergency protocols and the specific locations of equipment. Place clear, visible signs in strategic locations indicating the locations of emergency equipment (response bags, defibrillators, etc.).	Primary Care & Community	31.03.2025	31.03.2025	In progress	February 2025 Update - this was discussed at PC & C QSR meeting Feb 2025.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/227	23.01.2024	HMP Parc - DIC (Case Reference: DM/CRM0006823)	Head of Healthcare to ensure that blood tests when recommended are completed and documented in the clinical record. (Finding 5.25, 5.33)	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/227/MD3/1	Develop and document a flowchart that outlines the process for ordering, performing, and documenting blood tests. This should include guidelines for when tests should be recommended and by whom.	Primary Care & Community	31.03.2025	31.03.2025	In progress	Added to tracker January 2025.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/227	23.01.2024	HMP Parc - DIC (Case Reference: DM/CRM0006823)	Head of Healthcare to ensure that processes are implemented to improve continuity of care ensuring that recommended investigations and procedures carried out in a timely fashion. (Finding 5.25,5.26,5.28,5.33,5.34,5.35)	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/227/MD4/1	Develop clear clinical pathways for common conditions to guide treatment and investigations.	Primary Care & Community	31.03.2025	31.03.2025	In progress	Added to tracker January 2025.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/227	23.01.2024	HMP Parc - DIC (Case Reference: DM/CRM0006823)	Head of Healthcare to ensure that processes are implemented to monitor the receipt and progress of hospital referrals and investigations. (Finding 5.27,5.37)	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/227/MD5/1	Implementation of WCCG system that allows for easy tracking of referrals and investigations. All administrative staff to have access and training on use of system.	Primary Care & Community	31.03.2025	31.03.2025	In progress	Added to tracker January 2025.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/227	23.01.2024	HMP Parc - DIC (Case Reference: DM/CRM0006823)	Head of Healthcare to ensure that healthcare staff are aware of red flag signs of diseases where a GP referral should take place. (Finding 5.38)	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/227/MD6/1	Conduct regular training sessions and workshops for healthcare staff focused on disease recognition and the importance of identifying red flag symptoms. Develop continuing education programs that include information on various diseases and their associated warning signs.	Primary Care & Community	31.03.2025	31.03.2025	In progress	Added to tracker January 2025.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/227	23.01.2024	HMP Parc - DIC (Case Reference: DM/CRM0006823)	Head of Healthcare to ensure that adequate neurological observations occur following a head injury. (Finding 5.31)	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/227/MD7/1	Establish a protocol for regular neurological checks following a head injury and to share this with the healthcare team.	Primary Care & Community	31.03.2025	31.03.2025	Fully complete (Awaiting approval)	Added to tracker January 2025; this action is marked as Completed as per the Action Plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 25th March 2025 as Fully Complete.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/227	23.01.2024	HMP Parc - DIC (Case Reference: DM/CRM0006823)	Head of Healthcare to implement a recall system for chronic disease monitoring. (Finding 5.54)	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/227/MD8/1	Implement a system to track patient visits and establish timelines for recalls. Link with SystemOne Colleagues to see if viable within the system currently in use.	Primary Care & Community	31.03.2025	31.03.2025	In progress	Added to tracker January 2025.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/227	23.01.2024	HMP Parc - DIC (Case Reference: DM/CRM0006823)	Head of Healthcare to ensure that HMP Parc is in possession of a Home Office medication licence to enable stock controlled drugs to be held on site. (Finding 5.42)	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/227/MD9/1	HMP Parc are now in possession of a Home Office licence.	Primary Care & Community	30.10.2024	30.10.2024	Fully complete (Awaiting approval)	Added to tracker January 2025; this action is marked as Completed as per the Action Plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 25th March 2025 as Fully Complete.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/227	23.01.2024	HMP Parc - DIC (Case Reference: DM/CRM0006823)	Head of healthcare to ensure that clinical staff are aware of the importance of timely administration of critical medication and when to escalate if a prescribed drug is not readily available. If a prison transfer occurs without the appropriate medication a Datix should be completed. (Finding 5.47)	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/227/MD10/1	Create critical medication policy for the administration of time-critical medications, detailing: • Emergency protocols if a medication cannot be administered on time.	Primary Care & Community	31.03.2025	31.03.2025	In progress	Added to tracker January 2025.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/228	16.12.2024	HMP Parc - DIC (Case Reference: MH/CRM0006031)	The head of healthcare to work with the GAS director to improve the sharing of intelligence and important health and social care information between prison, healthcare and Dyfodol (repeated).	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/228/MD1/1	Current SLA with Dyfodol for psycho-social substance misuse services at HMP Parc ends 15th June 2025. Discussions with Dyfodol regarding sharing of relevant information between organisations.	Primary Care & Community	31.01.2025	31.01.2025	Overdue	Added to tracker January 2025.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/228	16.12.2024	HMP Parc - DIC (Case Reference: MH/CRM0006031)	The head of healthcare to complete a clinical audit to ensure that first night checklists completed by healthcare staff are consistently being uploaded onto a person's SystemOne record.	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/228/MD2/1	To develop a first night in custody checklist within AMaT for completion on a monthly basis.	Primary Care & Community	30.06.2025	30.06.2025	In progress	Added to tracker January 2025.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/228	16.12.2024	HMP Parc - DIC (Case Reference: MH/CRM0006031)	CTMUHB to ensure there is a consistently applied handover process in place that covers all of the prison establishments they provide healthcare services within.	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/228/MD3/1	Implement a session for all healthcare staff ensuring everyone understands the importance of handover, the standardised process, and their individual responsibilities. Reinforce the process in regular team meetings.	Primary Care & Community	30.06.2025	30.06.2025	In progress	Added to tracker January 2025.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/228	16.12.2024	HMP Parc - DIC (Case Reference: MH/CRM0006031)	The head of healthcare to complete a clinical audit to ensure that all PER's are viewed in reception by healthcare staff, and that they record they have seen the PER (with associated narrative if appropriate) within the SystemOne template.	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/228/MD4/1	To develop a checklist within AMaT for completion on a monthly basis which includes the following: Verify that the PER was opened and viewed by a healthcare staff member at the reception. Confirm that the healthcare staff has documented their review of the PER in the patient record within SystemOne. Ensure that the record includes a narrative where necessary (e.g., any concerns or actions taken).	Primary Care & Community	30.06.2025	30.06.2025	In progress	Added to tracker January 2025.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/228	16.12.2024	HMP Parc - DIC (Case Reference: MH/CRM0006031)	The head of healthcare to work with the director to ensure that Dyfodol are routinely invited to ACCT reviews for people on their caseload.	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/228/MD5/1	Create a standard operating procedure (SOP) that includes the involvement of Dyfodol in the ACCT review process for individuals on their caseload. This should outline how and when Dyfodol should be invited to these reviews. Ensure that this process is shared with all relevant teams and departments involved in ACCT reviews, including healthcare staff, caseworkers, and prison officers.	Primary Care & Community	30.06.2025	30.06.2025	In progress	Added to tracker January 2025.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/228	16.12.2024	HMP Parc - DIC (Case Reference: MH/CRM0006031)	The head of healthcare to ensure that all healthcare staff, including agency staff, have been given up to date ACCT training.	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/228/MD6/1	Review the training records for all healthcare staff, including permanent, temporary, and agency staff, to ensure they have completed the ACCT training in the past 12 months. Organise refresher training for any staff who have not completed the training in the required time frame. Ensure that ACCT training is included as part of the induction process for any new healthcare staff, whether they are permanent, temporary, or agency staff.	Primary Care & Community	30.06.2025	30.06.2025	In progress	Added to tracker January 2025.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/228	16.12.2024	HMP Parc - DIC (Case Reference: MH/CRM0006031)	The head of healthcare to work with the director to ensure that involving family members in the ACCT process is routinely considered and evidenced within ACCT documents.	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/228/MD7/1	Develop a clear pathway outlining the importance of involving family members in the ACCT process. Ensure this pathway is integrated into standard operating procedures. Include a specific section on how and when family involvement should be documented in ACCT records.	Primary Care & Community	30.06.2025	30.06.2025	In progress	Added to tracker January 2025.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/228	16.12.2024	HMP Parc - DIC (Case Reference: MH/CRM0006031)	The head of healthcare to ensure that the attending RMN on the 2 May 2024 (after the alleged sexual assault) is provided with supportive supervision to enable learning to improve better record keeping and recording of clinical assessments.	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/228/MD8/1	Schedule a meeting between the RMN and Senior Nurse to discuss the specific concerns identified in the report to include feedback on what was done well and areas for improvement in the record-keeping and recording of clinical assessment process.	Primary Care & Community	30.06.2025	30.06.2025	In progress	Added to tracker January 2025.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/228	16.12.2024	HMP Parc - DIC (Case Reference: MH/CRM0006031)	The head of healthcare to ensure that the healthcare team is provided with sufficient ACCT and suicide and self-harm training. To provide supportive supervision to enable learning to improve record keeping and recording of clinical assessments.	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/228/MD9/1	For all the healthcare team to undergo ACCT (Assessment, Care in Custody and Teamwork) and Suicide / Self Harm training, ensuring they are fully familiar with the processes for managing individuals at risk of suicide or self-harm.	Primary Care & Community	30.06.2025	30.06.2025	In progress	Added to tracker January 2025.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/228	16.12.2024	HMP Parc - DIC (Case Reference: MH/CRM0006031)	The head of healthcare to ensure that patients who self-harm are encouraged to develop a safety plan, in line with the NICE guideline [NG225] for 'self-harm: assessment, management and preventing recurrence' (2022).	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/228/MD10/1	Ensure that a clear, standardised protocol for safety planning is in place across all healthcare settings. This protocol should outline the steps for discussing self-harm with patients and how to collaboratively develop a safety plan based on the NICE guidelines. Organise training for the healthcare team, including mental health practitioners, nurses, and general practitioners, on the NICE guidelines related to self-harm. This training should emphasise the importance of safety planning, its components, and effective communication strategies.	Primary Care & Community	30.06.2025	30.06.2025	In progress	Added to tracker January 2025.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/228	16.12.2024	HMP Parc - DIC (Case Reference: MH/CRM0006031)	The head of healthcare to promote a risk formulation and safety planning approach in the management of self-harm and suicide at HMP Parc, and to discourage the use of risk assessments. This is in line with the NICE guideline [NG225] for 'self-harm: assessment, management and preventing recurrence' (2022).	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/228/MD11/1	Organise workshops and training sessions for healthcare team to enhance understanding of the NICE guidelines and the benefits of using risk formulation and safety planning.	Primary Care & Community	30.06.2025	30.06.2025	In progress	Added to tracker January 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
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/238	16.12.2024	HMP Parc - DIC (Case Reference: MH/CRM0006031)	The head of healthcare to ensure there is an MOU in place for the multiagency safeguarding meetings that currently take place routinely at HMP Parc.	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/228/MD12/1	Review the current safeguarding processes, protocols and meetings established at HMP Parc. Identify the agencies involved and their respective roles in safeguarding – Consider G4S / CTMUHB role within safeguarding. Develop and implement an MOU document and ensure that this is effectively communicated and regularly reviewed by all parties.	Primary Care & Community	30.06.2025	30.06.2025	In progress	Added to tracker January 2025.
Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/228	16.12.2024	HMP Parc - DIC (Case Reference: MH/CRM0006031)	The head of healthcare to ensure that all staff are reminded of the importance of good record keeping and if they attend an incident they individually need to document their involvement in the patient's records. The head of healthcare to arrange a clinical audit after 3 months of this communication to ensure compliance.	Healthcare Inspectorate Wales (HIW) - Death in Custody/2024/228/MD13/1	Create and share email with team reminding them of the importance of good recording keeping. Utilise AMaT audit to review clinical records to assess documentation quality and compliance with established protocols – 3 months evidence.	Primary Care & Community	31.03.2025	31.03.2025	In progress	Added to tracker January 2025.
Healthcare Inspectorate Wales (HIW)/2017/141	30/01/2017	National review of Ophthalmology Services	Issues relating to patient referral process. All parties (Welsh Government, NWS, 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 LNH'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	February 2025 Update - No further development to what already implemented within Primary Care. December 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.
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	February 2025 Update - No further update from Secondary Care. December 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.
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)	February 2025 Update - All clinicians aware of FUNB and discussed collectively at weekly RTT meetings. Health Board strategy being developed to manage patients backlog. December 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	February 2025 Update - All Medical Retina injection Flup'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. December 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 WSLs in development - complete by June 2025. New admin post for Appointment Failure Coordinator approved under Glaucoma Diagnostic Hub Business Case, to ensure high risk patients are booked safely and timely across their long-term 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.
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	February 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 Follow Up 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. December 2024 Update - SBAR review of booking pathways/WL (a validation SOP) in development (due Feb and June 2025 respectively). Glaucoma team developing clinician guidance/training/posters on prudent FU intervals & appt booking, including the most appropriate clinic setting by clinical risk (due Feb 2025). A revised implementation date of 01/06/2025 is required.
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)	February 2025 Update - 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. December 2024 Update - O&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	February 2025 Update - Currently shortlisting for Head of Optometry and Head of Orthoptics posts. Anticipating start date by end of April. December 2024 Update - Optometry-led laser pathway successfully implemented x12/12 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 rebranding 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. August 2024 Update - August 2024 Update - Recruitment in progress for additional permanent non-medical staff to create additional capacity in glaucoma clinics (Band 3 tech, Band 4 tech, Band 8a Optometrist) April 2024 Update - Eye drop instillation by unregistered staff in early implementation phase - nursing team signoff complete, in use. Further short term extension of 2x Band 7 0.1wte Specialist Optometrists providing significant clinic activity in Medical Retina - extended to 30/5/24 but urgent longer term/permanent extension required to maximise clinic output/booking. MDT GIMT working group on pause following management changeover. Longstanding vacancies in Heads of Optometry and Orthoptic services - recruitment strategy in evaluation, as risk to service development without these posts. Further review is required / Action to be removed and replaced with a subsequent agreed action December 2023 Update (Date of review: 12/ 12 /23) - New clinical policy approved to allow for unregistered staff to instil eyedrops, freeing up registered staff for more skilled tasks/faster clinic flow - implementation imminent. Optometry Dept SBAR demonstrating value of workforce & need for expansion completed. Secured fixed term contract extension for 2 sessional optometrists supporting Medical Retina clinics for next Q (via VBHC), further extension required to maximise clinic planning. MDT workforce working group for GIMT process due to start in Dec '23, tasked with evaluating non-medic workforce/skill mix and maximising use of MDT (to top of license). Optometrist role expansion into glaucoma laser delivery successful (training, signoff & SOP complete) - SLT WL reduced to 12/52. What next? By when? By whom?
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 (CARROS) 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	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 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 interest or 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.
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) A) Health Boards must ensure that they fully engage with the Ophthalmology Planned Care Board to aid shared learning from/with staff in other areas.	Healthcare Inspectorate Wales (HIW)/2017/141/MD16/1	Weekly performance meeting have been arranged between the Clinical Service Group Manager (CSGM) and Interim Director of Planned Care to discuss key performance measures and any ad hoc issues which arise. CSGM from other sites are in attendance for shared learning purposes. Any risks we have assessed in the service is held on the corporate risk register which we update regularly with mitigations to reduce the risks. We also provide regular updates on the above to the Quality, Safety and Risk Group, as well as to the Planned Care Recovery Finance Group and the Joint Executive Team Meetings.	Planned Care	01.04.2024	01.04.2024	Fully complete (Awaiting approval)	February 2025 Update - Weekly operational management meetings established. Service Improvement Group developed which is being led by DM and CD. Audit meetings from March 2025 will be pan CTM with section of meeting being dedicated to governance which will discuss risks, Data, NRI's, complaints etc. December 2024 Update - CD fully engaged with national Ophthalmology CIN work, good cross-discipline/MDT representation/engagement in all CIN subgroups including CTM helping establish the first national Hospital Optometry Wales's forum (reporting to CIN), to raise the profile of the profession in Wales and share best practice. Local dissemination of new National Clinical Strategy for Ophthalmology complete, and good departmental attendance/engagement at strategy launch events. Action to be reviewed for approval for closure at Care Group SLT 30/12/24.

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
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)	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 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	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 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.
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 IPDS or unscheduled care, Glaucoma community monitoring scheme, AMD referrals refinement and DRKS.	Planned Care	01.04.2024	01.06.2025	Partially complete	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 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 IPDS (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 IPDS (further reducing secondary care pressures). In light of head of service vacancy, a revised implementation date of 01/06/2025 is required
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	February 2025 Update - An update against this recommendation has not been provided 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	20/04/2021	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)	February Update - being presented at Q&RE on 12th March with a view to close. December 2024 Update - Plan to complete TOR within the physical health improvement focus group and to then close by Feb 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))	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	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 - An update against this recommendation has not been provided on this occasion.
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	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 - An update against this recommendation has not been provided on this occasion.
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	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 - An update against this recommendation has not been provided on this occasion. Au
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)	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 - An update against this recommendation has not been provided on this occasion.
Healthcare Inspectorate Wales (HIW)/2022/133	17/10/2022	Hospital Inspection Report (Unannounced) Emergency Department, Princess of Wales Hospital (Appendix A - Immediate Improvement Plan - Princess of Wales Emergency Department (Ref: 3326))	The Health Board must ensure that checks are completed and logged at all times, and that there are robust mechanisms in place to identify and rectify when checks are not completed or logged.	Healthcare Inspectorate Wales (HIW)/2022/133/MD1/1	Plan to work with corporate nursing team to review options of creating a digital solution for audit surveillance and daily checks to further improve oversight of status.	Unscheduled Care	01.02.2023	01.02.2023	Fully complete (Awaiting approval)	February 2025 Update - Ongoing AMaT audits on all areas and daily checks by nurse in charge/band 7/senior nurse. August 2024 Update - The USC Care Group are finalising the last AMaT audit for the three Emergency Departments', this will be achieved by Oct 2024 as needs to go through existing governance process' for sign off prior to use.
Healthcare Inspectorate Wales (HIW)/2022/133	17/10/2022	Hospital Inspection Report (Unannounced) Emergency Department, Princess of Wales Hospital (Appendix A - Immediate Improvement Plan - Princess of Wales Emergency Department (Ref: 3326))	The Health Board must ensure that checks are completed and logged at all times, and that there are robust mechanisms in place to identify and rectify when checks are not completed or logged.	Healthcare Inspectorate Wales (HIW)/2022/133/MD1/2	Work with Care Group Directors of Nursing and Midwifery and Heads of Nursing across the three acute sites and community hospital sites in establishing a consistent model of surveillance and checking practice.	Unscheduled Care	01.12.2023	01.12.2023	Fully complete (Awaiting approval)	February 2025 Update - ED POW- Ongoing AMaT audit being completed in the department and daily checks by NIC/sister/senior nurses. August 2024 Update - The USC Care Group are finalising the last AMaT audit for the three Emergency Departments', this will be achieved by Oct 2024 as needs to go through existing governance process' for sign off prior to use.
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	February 2025 Update - 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 BID 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 December 2024 Update - progress is being made, remains ongoing at this time.
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	February 2025 Update - MH and LD policies remain at 66 •46 are currently in date •9 policies under review. This will reduce to 8 as 2 communities policies 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 MH 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	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 - An update against this recommendation has not been provided on this occasion.
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. •An 8a Senior Nurse for Professional Education has been appointed (July 2022) as part of the new ED Workforce Model agreed following the HIW review in September 2021. •A Training Needs Analysis has been undertaken and a Study Plan has been developed for all Registered Nurses and HCSWs Registered Nurses-the Resuscitation Team have agreed to undertake bespoke ILS and PILS training monthly with 12 spaces being allocated monthly HCSWs - the Resuscitation Team have agreed to undertake bespoke BLS training monthly for ED -8 spaces As an interim measure to ensure patient safety until compliance has improved the senior nurse for ED will have oversight of the roster to provide assurance that each area has an ILS trained nurse on shift. CDU - Registered Nurse ILS currently 70.6% this should also translate to BLS being achieved at 70.6% which was a data entry error to be immediately rectified by the resuscitation team via ESR. There are only 5 further nurses requiring training in order to meet 100%. Training is in line with the PDR process "Have your Conversation"; training compliance is aligned to the Agenda for Change process.	Unscheduled Care	01.11.2023	30.06.2024	Partially complete (Overdue)	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 - An update against this recommendation has not been provided on this occasion.

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
Healthcare Inspectorate Wales (HIW)/2023/140	16/05/2023	HMP Parc Prison	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)	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 - An update against this recommendation 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 Prison	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)	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 - An update against this recommendation 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	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 - An update against this recommendation 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	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	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 - An update against this recommendation 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 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	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 - An update against this recommendation 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 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 Equals 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	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 - An update against this recommendation 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	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 - An update against this recommendation 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	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 - An update against this recommendation 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.
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	Ongoing 2024/25 February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 - An update against this recommendation 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	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 - An update against this recommendation 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 Equals Board.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 - An update against this recommendation 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	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 - An update against this recommendation 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	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 - An update against this recommendation 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.
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 35-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	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 - An update against this recommendation 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	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 - An update against this recommendation 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.

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
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	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 - An update against this recommendation 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	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 - An update against this recommendation 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	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 - An update against this recommendation 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	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 - An update against this recommendation 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	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 - An update against this recommendation 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	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 - An update against this recommendation 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/MD21/1	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	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 - An update against this recommendation 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	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 - An update against this recommendation 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	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 - An update against this recommendation 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	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 - An update against this recommendation 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	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 - An update against this recommendation 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	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 - An update against this recommendation 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	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 - An update against this recommendation 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	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 - An update against this recommendation 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	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 - An update against this recommendation 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	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 - An update against this recommendation 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).

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
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 SGUEC 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	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 - An update against this recommendation 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. 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."
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	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 - An update against this recommendation 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	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 - An update against this recommendation 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.
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	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 - An update against this recommendation 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.
Healthcare Inspectorate Wales (HIW)/2023/157	13/11/2023	Appendix C - Improvement Plan: Angleton Clinic, Glanrhyf 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	February 2025 - Work has been ongoing 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. December 2024 Update - remains on going has been escalated
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	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. August 2024 Update - capital work ongoing - 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. Delayed due to major capital works on site to December 2024.
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	February 2025 Update - 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	February 2025 Update - 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. Whilst 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 an update on the systems in place to improve patient flow through the EU.	Healthcare Inspectorate Wales (HIW)/2023/167/MD11/1	We are currently reviewing through large organisational change, the operational structures that will be key to patient flow and ensure senior leadership is present on site and pan CTM Health Board. Through the 6 goals programme work we are progressing improved patient flow as this is a multi-professional/whole system approach involving our Local Authority colleagues. The E White Board has been introduced across the organisation and this is key to patient flow and implementation of Red2Green as a quality metric for patient care. This will increase bed capacity through more efficient and sustainable processes where we explore value added time, measure internal and external delays and focus on marginal gains in length of stay. Consequently, this will improve flow through EU. As part of this work the senior team are also exploring the continuous flow model to review if this would be suitable for roll out across CTM. The ED Team use the Myrddyn IT System which is monitored by the responsible teams and reviewed as part of the ED Patient Safety Huddles. When it is identified that Triage Times are beginning to increase, there are internal escalation processes in place to ensure timely support and assessment of patients which additional staff being deployed to support. The ED Clinician Team will adopt a Rapid Assessment and Triage (RAT's) model to support any delays in triage, hence there will be senior assessment and streaming at the front door of patients. EU has recently recruited 2.8 wte Patient Flow Coordinators to support timely patient flow and escalation of patient flow delays. The USC group have developed updated Escalation Cards to support actions and provide assurances that ambulance delays are avoided. There are rigorous escalations in place, and when any patient is delayed over 4 hours an internal investigation is undertaken to provide assurances that no harm has occurred.	Unscheduled Care	01.03.2024	01.03.2024	Fully complete (Awaiting approval)	February 2025 Update - Optimise is fully established with appropriate formal reporting processes in place. The Navigation Hub is established to facilitate the appropriate referrals and conveyancing to the acute site. Signposting from WAST Clinical Desk facilitates the appropriate use of Primary Care Services to facilitate safe admission avoidance Further recruitment within the Patient Flow Team means we now have 7 day cover by senior decision makers on the acute site. August 2024 Update - this work is ongoing - This work continues to progress via the Optimise Project which formally reports into 6 goals programme board and onto NHS Executive colleagues. This work continues to progress via the Optimise Project which formally reports into 6 goals programme board and onto NHS Executive colleagues.
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	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 closely 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 Y & 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	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)	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). Commenced September 2023. Due for completion February 2024. 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, costsings 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

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
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/MD1/9	1)Review safe care tool to ensure that red flags according to NICE safe staffing 2015 are included in the tool.	Children & Families	31.01.2024	31.01.2024	Fully complete (Awaiting approval)	December 2024 Update - A review of the Safe Care Tool has been undertaken and system has been updated to capture maternity acuity requirements. Unfortunately Safe Care is unable to capture the acuity across all services within Maternity. A licence to re-instate Birth-rate has been requested and due to start January 2025. August 2024 Update - need to be reviewed at Care Group Workforce Meeting on the 28th August to monitor implementation. Review of safe care tool has been undertaken to ensure that red flags according to NICE safe staffing 2015 are included in the tool
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	1)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)	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)/2024/165	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/MD1/17	1)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	Fully complete (Awaiting approval)	December 2024 Update - Senior midwife on call rota attends daily site section meetings. August 2024 - 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)	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	Partially complete (Overdue)	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 - An update against this recommendation has not been provided on this occasion. 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.
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/MD1/6	Working with finance colleagues to develop a new model for obstetric theatre nursing (releasing midwifery time).	Children & Families	01.03.2024	01.03.2024	Overdue	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 - An update against this recommendation has not been provided on this occasion. 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	Children & Families	31.01.2024	31.01.2024	Overdue	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 - An update against this recommendation has not been provided on this occasion. August 2024 Update - need to be reviewed at Care Group Workforce Meeting on the 28th August to monitor implementation.
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)	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 - An update against this recommendation 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)	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 - An update against this recommendation has not been provided on this occasion. 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)	Data 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)	February 2025 Update - An update against this recommendation has not been provided on this occasion. December 2024 - An update against this recommendation 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)/2024/217	11.04.2024	Appendix C Improvement Plan_Yibty Cwm Rhondda Ward B2_11-12 April 2024 (Ref: 03467)	The health board should display patient feedback and any improvements made as a result of feedback such as a 'You said, we did' board.	Healthcare Inspectorate Wales (HIW)/2024/217/MD1/1	Ward now has "you said, we did" boards displayed in the main reception to provide feedback. Ward now has the Red patient feedback boxes in place for patients/relatives to provide feedback.	Primary Care & Community	30.12.2024	30.12.2024	Fully complete (Awaiting approval)	January / February 2025 Update - Completed actions of Appendix C Improvement plan received by Quality Assurance Team in retrospect. AMaT recording for assurance and governance purpose. Approved by Executive Director of Nursing, Midwifery and Patient Care December 2024
Healthcare Inspectorate Wales (HIW)/2024/217	11.04.2024	Appendix C Improvement Plan_Yibty Cwm Rhondda Ward B2_11-12 April 2024 (Ref: 03467)	The health board should ensure the Putting Things Right policy is displayed on the ward.	Healthcare Inspectorate Wales (HIW)/2024/217/MD2/1	'Putting things right' complaints policy will be displayed on Ward B2 in the main reception area on the relatives information board.	Primary Care & Community	30.12.2024	30.12.2024	Fully complete (Awaiting approval)	January / February 2025 Update - Completed actions of Appendix C Improvement plan received by Quality Assurance Team in retrospect. AMaT recording for assurance and governance purpose. Approved by Executive Director of Nursing, Midwifery and Patient Care December 2024
Healthcare Inspectorate Wales (HIW)/2024/217	11.04.2024	Appendix C Improvement Plan_Yibty Cwm Rhondda Ward B2_11-12 April 2024 (Ref: 03467)	The health board should ensure staff check the identification of patients prior to administering medication	Healthcare Inspectorate Wales (HIW)/2024/217/MD3/1	Staff have been made aware of this policy to be followed to prevent errors/incidents via the staff communication group and will be discussed in the next ward meeting 03.07.2024.	Primary Care & Community	30.12.2024	30.12.2024	Fully complete (Awaiting approval)	January / February 2025 Update - Completed actions of Appendix C Improvement plan received by Quality Assurance Team in retrospect. AMaT recording for assurance and governance purpose. Approved by Executive Director of Nursing, Midwifery and Patient Care December 2024
Healthcare Inspectorate Wales (HIW)/2024/217	11.04.2024	Appendix C Improvement Plan_Yibty Cwm Rhondda Ward B2_11-12 April 2024 (Ref: 03467)	The health board should ensure the sluice is repaired as a matter of priority.	Healthcare Inspectorate Wales (HIW)/2024/217/MD4/1	Reported to estates on 13.03.2024 Fixed on the 08.04.2024 Broke down again on the 11.04.24, this was fixed the next day on 12.04.2024 and sluice remains in working order	Primary Care & Community	30.12.2024	30.12.2024	Fully complete (Awaiting approval)	January / February 2025 Update - Completed actions of Appendix C Improvement plan received by Quality Assurance Team in retrospect. AMaT recording for assurance and governance purpose. Approved by Executive Director of Nursing, Midwifery and Patient Care December 2024
Healthcare Inspectorate Wales (HIW)/2024/217	11.04.2024	Appendix C Improvement Plan_Yibty Cwm Rhondda Ward B2_11-12 April 2024 (Ref: 03467)	The health board should put a system in place where emergency boxes are checked regularly to ensure they have the appropriate equipment in the event of an emergency.	Healthcare Inspectorate Wales (HIW)/2024/217/MD5/1	Staff now to check box every night to ensure that box is appropriately stocked and all items in date. Staff to sign and date check form on board in Treatment room. Ward manager will also audit compliance via spot checks over a period of three months.	Primary Care & Community	30.12.2024	30.12.2024	Fully complete (Awaiting approval)	January / February 2025 Update - Completed actions of Appendix C Improvement plan received by Quality Assurance Team in retrospect. AMaT recording for assurance and governance purpose. Approved by Executive Director of Nursing, Midwifery and Patient Care December 2024
Healthcare Inspectorate Wales (HIW)/2024/217	11.04.2024	Appendix C Improvement Plan_Yibty Cwm Rhondda Ward B2_11-12 April 2024 (Ref: 03467)	The health board should review their use of agency and bank staff.	Healthcare Inspectorate Wales (HIW)/2024/217/MD6/1	Staffing Establishments are reviewed monthly by the senior nurse Current Registered nurse 2.64 wte vacancies: 2.0 wte streamlining students recruited into posts 0.64 wte being advertised on a rolling post on Trac recruitment Current Health Care Support Worker 0.48 wte vacancy to be advertised on Trac recruitment Senior Nurse ensures the bank/agency process is followed as per health board guidelines. Skill Mix is always looked at via the Roster Admin support to ensure there is safe and appropriate skill mix at all times.	Primary Care & Community	30.12.2024	30.12.2024	Fully complete (Awaiting approval)	January / February 2025 Update - Completed actions of Appendix C Improvement plan received by Quality Assurance Team in retrospect. AMaT recording for assurance and governance purpose. Approved by Executive Director of Nursing, Midwifery and Patient Care December 2024
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)	1. The health board must ensure that all patients receive relevant and appropriate physical healthcare assessments on admission alongside their mental health assessment.	Healthcare Inspectorate Wales (HIW)/2024/235/MD1/1	The existing Admission Process requires the completion of a Physical Health Assessment.	Mental Health & Learning Disabilities	14.02.2025	14.02.2025	Fully complete (Awaiting approval)	Added to tracker February 2025; this action is marked as Complete 14/02/2025 as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 25th March 2025 as Fully Complete.
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)	1. The health board must ensure that all patients receive relevant and appropriate physical healthcare assessments on admission alongside their mental health assessment.	Healthcare Inspectorate Wales (HIW)/2024/235/MD1/2	All current patients on Ward 14 and PICU have Physical Health Assessments in place.	Mental Health & Learning Disabilities	14.02.2025	14.02.2025	Fully complete (Awaiting approval)	Added to tracker February 2025; this action is marked as Complete 14/02/2025 as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 25th March 2025 as Fully Complete.
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)	1. The health board must ensure that all patients receive relevant and appropriate physical healthcare assessments on admission alongside their mental health assessment.	Healthcare Inspectorate Wales (HIW)/2024/235/MD1/3	To provide assurance an audit has been carried out to ensure the admission pathway is completed. 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	Mental Health & Learning Disabilities	14.02.2025	14.02.2025	Fully complete (Awaiting approval)	Added to tracker February 2025; this action is marked as Complete 14/02/2025 as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 25th March 2025 as Fully Complete.
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)	2. The health board must ensure that all patients with identified healthcare conditions have a care and treatment plan in place with input from a relevant healthcare professional to help staff safely manage their condition.	Healthcare Inspectorate Wales (HIW)/2024/235/MD1/1	Within the Adult inpatient service there is a Specialist Dietetic Service available to provide support and advice when required to ensure the patients medical needs are met. To provide assurance a spot check audit has been carried out to ensure all patients that require diabetic treatment currently have a care plan in place. Diabetic Champions have been identified on each ward. The diabetes specialist team have agreed to deliver additional training to improve the knowledge and experience of diabetes for staff. Training sessions have been arranged for June to December 2025.	Mental Health & Learning Disabilities	14.02.2025	14.02.2025	Fully complete (Awaiting approval)	Added to tracker February 2025; this action is marked as Complete 14/02/2025 as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 25th March 2025 as Fully Complete.
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)	3. The health board must ensure health promotion information is available to support patients to make decisions that impact positively on their health and wellbeing.	Healthcare Inspectorate Wales (HIW)/2024/235/MD3/1	It is unfortunate at the time of inspection all notice boards had been removed due to a recent Infection Prevention and Control (IPC) audit. IPC compliant notice boards are now in place and information is on display for patients within the ward environment.	Mental Health & Learning Disabilities	14.02.2025	14.02.2025	Fully complete (Awaiting approval)	Added to tracker February 2025; this action is marked as Complete 14/02/2025 as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 25th March 2025 as Fully Complete.
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)	4. The health board must ensure where possible that the environment meets the requirements of the Mental Health Act 1983 - Code of Practice for Wales (2016) regarding designated, gender specific areas and toilet facilities on both wards.	Healthcare Inspectorate Wales (HIW)/2024/235/MD4/1	Ward 14 and PICU have separate male and female toilets. At the time of inspection, all notices were removed on Ward 14 following a recent IPC audit. These have now been replaced with IPC compliant notices. The bedrooms on PICU are all single. On Ward 14 there are multi occupancy bedrooms but these are never mixed sex. On Ward 14 there are also dedicated single sex lounges.	Mental Health & Learning Disabilities	14.02.2025	14.02.2025	Fully complete (Awaiting approval)	Added to tracker February 2025; this action is marked as Complete 14/02/2025 as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 25th March 2025 as Fully Complete.

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
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/MD5/1	A safe system of work was implemented and shared during the HIW inspection across the inpatient services, this process is being adhered to.	Mental Health & Learning Disabilities	14.02.2025	14.02.2025	Fully complete (Awaiting approval)	Added to tracker February 2025; this action is marked as Complete 14/02/2025 as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 25th March 2025 as Fully Complete.
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	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)	6. The health board must do more to ensure that patients are able to participate in a range of individualised therapeutic and social activities to aid in their recoveries.	Healthcare Inspectorate Wales (HIW)/2024/235/MD6/1	Within both wards, individualised activities are provided by Health Care Support Workers under the direction of registered nursing staff.	Mental Health & Learning Disabilities	14.02.2025	14.02.2025	Fully complete (Awaiting approval)	Added to tracker February 2025; this action is marked as Complete 14/02/2025 as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 25th March 2025 as Fully Complete.
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)	6. The health board must do more to ensure that patients are able to participate in a range of individualised therapeutic and social activities to aid in their recoveries.	Healthcare Inspectorate Wales (HIW)/2024/235/MD6/2	Both wards share a team of Occupational Therapists.	Mental Health & Learning Disabilities	14.02.2025	14.02.2025	Fully complete (Awaiting approval)	Added to tracker February 2025; this action is marked as Complete 14/02/2025 as per the plan and will be presented to the Quality, Safety & Experience Committee on Tuesday 25th March 2025 as Fully Complete.
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)	6. The health board must do more to ensure that patients are able to participate in a range of individualised therapeutic and social activities to aid in their recoveries.	Healthcare Inspectorate Wales (HIW)/2024/235/MD6/3	During the inspection the Activity Coordinator post was vacant due to the previous post holder moving on. A permanent, full time, replacement will be taking up post on the 25.02.25. The Activity Coordinator will be responsible for the introduction of the implementation of a structured weekly plan.	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.
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)	6. The health board must do more to ensure that patients are able to participate in a range of individualised therapeutic and social activities to aid in their recoveries.	Healthcare Inspectorate Wales (HIW)/2024/235/MD6/4	Changes have been made to ensure the gym is no longer used for meetings and visiting meaning it is now always available for patient use.	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.
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)	6. The health board must do more to ensure that patients are able to participate in a range of individualised therapeutic and social activities to aid in their recoveries.	Healthcare Inspectorate Wales (HIW)/2024/235/MD6/5	PICU currently have timetable of therapeutic and social activities which is on display. Ward 14 also have an activity timetable of which is on display.	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.
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	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)	8. The health board must ensure that the language preference and communication requirements of patients are recorded on admission as required by the Mental Health (Wales) Measure 2010.	Healthcare Inspectorate Wales (HIW)/2024/235/MD8/1	Patient demographics inclusive of preferred language should be completed as per admission pack. This includes updating electronic systems or clinical records to reflect preferred language for any translations. An Audit of admission notes has been completed on both Ward 14 and PICU. 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.	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.
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)	9. The health board must ensure that the refurbishment work is completed in a timely manner as a matter of priority and provide HIW with a report on progress since the inspection, including an updated timetable for completion of the work.	Healthcare Inspectorate Wales (HIW)/2024/235/MD9/1	The environmental improvement progress is being monitored within the directorate QSRE meeting. Progression of tasks is monitored against estimated dates of completion. The senior nurse has regular meetings with the Capital Planners and Operational Support Manager. Feedback is shared within the Directorate QSRE	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.
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)	10. The health board must also address and resolve any environmental issues that can be fixed independently of any broader planned programme of work.	Healthcare Inspectorate Wales (HIW)/2024/235/MD10/1	As part of the Inpatient Environmental Workstream an estates reporting system is currently being piloted. This is an electric system which allows efficient tracking of job requests and completion status, enabling categorisation by urgency, site, and job type. Excel reports are generated for review in monthly/bi-monthly meetings. Any outstanding jobs > 90 days are formally escalated to Estates. Monthly/Bi-monthly reviews will be conducted by Estates Champions and Operational Support Managers to check on unresolved jobs.	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.
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)	11. The health board must review its current arrangements to determine whether it meets national guidance to ensuring patients and visitors can raise an alarm while at the clinic, particularly when alone in their bedrooms.	Healthcare Inspectorate Wales (HIW)/2024/235/MD11/1	In situations where a patient is at risk to themselves or others, appropriate safety observation levels are implemented. For the safety of visitors, all visits are conducted off the ward. For patients requiring an escort with family, this is incorporated into their care plan. Patients with higher risk profiles are situated close to the nurse's office to optimise observation and enable prompt response if necessary. All patients have up to date risk assessments, which are amended and updated in response to any events that occur during the course of admission. This is the standard procedure following any incident or change in clinical presentation. All staff members have access to individual handheld alarms, which are issued at the beginning of each shift and signed for by the recipient across both wards. The Health Board has reviewed its nurse call system and it is not possible to add move or add additional nurse call points in the bedrooms. To resolve this the Health Board has purchased additional hand held alarms that will be provided for some patients as part of the Care and Treatment Plan when indicated by clinical risk.	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.
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	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/MD13/1	A Monthly cleaning audit is undertaken by the Housekeeping Supervisor. To strengthen this process the audit will now be undertaken with the Ward Manager/Clinical Lead. This will be monitored by the Senior Nurse.	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.
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/MD13/2	The Ward Managers conduct a monthly IPC audit on an agreed Health Board Audit Management and Tracking Tool. All actions, including outstanding and overdue actions, are monitored and reported through the governance structure of the Directorate QSRE and Care Group QSRE	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.
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	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/MD13/4	The sink within Ward 14 clinic is now in full working order	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.
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/MD13/5	The Health Boards Cleanliness Standard Roles, Responsibilities and Audit Tool Procedure policy has been escalated to the Regional Facilities Manager who has reported that at present the update of this Procedure is on hold until the publication of the New National Standards for Cleaning in NHS Wales. The current policy is still appropriate at this time based on current funding /standards.	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.

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
Healthcare Inspectorate Wales (HIW)/2024/235	13.11.2024	Hospital Inspection Report (Unannounced) Cofy Clinic, Princess of Wales Hospital_Appendix C - Improvement Plan_13_14 and 15 November 2024 (Ref: 03710)	14. The health board must set up a child friendly room or space where patients can meet visitors without impacting upon other patients at the clinic.	Healthcare Inspectorate Wales (HIW)/2024/235/MD14/1	As part of patient's recovery plan patients are encouraged to leave the ward and use the public facilities within Princess of Wales Hospital (POWH) for contact with their relatives and friends when deemed appropriate in line with their risk assessment. There are two interview rooms available outside the entrance to ward 14 and a room on the first floor which will be used as a child friendly family visiting room when appropriately risk assessed for both ward 14 and PICU. All efforts will be made to ensure family visiting will be carried out within the child friendly family room on the first floor. On the occasions when patients are restricted and unable to leave the premises, the Ward Managers office will be utilised based on risk.	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.
Healthcare Inspectorate Wales (HIW)/2024/235	13.11.2024	Hospital Inspection Report (Unannounced) Cofy 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/MD15/1	Oxygen cylinders within inpatient ward environments are only situated within the emergency trolley.	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.
Healthcare Inspectorate Wales (HIW)/2024/235	13.11.2024	Hospital Inspection Report (Unannounced) Cofy 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/MD15/2	Emergency equipment daily checks are carried out. These are monitored by 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.
Healthcare Inspectorate Wales (HIW)/2024/235	13.11.2024	Hospital Inspection Report (Unannounced) Cofy 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	Added to tracker February 2025
Healthcare Inspectorate Wales (HIW)/2024/235	13.11.2024	Hospital Inspection Report (Unannounced) Cofy 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	Added to tracker February 2025
Healthcare Inspectorate Wales (HIW)/2024/235	13.11.2024	Hospital Inspection Report (Unannounced) Cofy 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	In progress	Added to tracker February 2025
Healthcare Inspectorate Wales (HIW)/2024/235	13.11.2024	Hospital Inspection Report (Unannounced) Cofy 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/MD16/3	CD checks will be audited 3 monthly by the designated clinical pharmacist for each ward and shared with the ward manager.	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.
Healthcare Inspectorate Wales (HIW)/2024/235	13.11.2024	Hospital Inspection Report (Unannounced) Cofy 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/MD16/4	A CD check will now be monitored as part of the Ward Manager Audit any concerns will be escalated through the Senior Nurse's highlight report to the directorate QSRE meeting.	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.
Healthcare Inspectorate Wales (HIW)/2024/235	13.11.2024	Hospital Inspection Report (Unannounced) Cofy Clinic, Princess of Wales Hospital_Appendix C - Improvement Plan_13_14 and 15 November 2024 (Ref: 03710)	17. The health board must ensure that MAR charts are completed appropriately and accurately.	Healthcare Inspectorate Wales (HIW)/2024/235/MD18/1	A sample audit of MARs charts has been completed by the Senior Nurse. MARs charts will be reviewed through the "Ward Managers Assurance Audit" which is undertaken on a weekly basis by Ward Manager and monitored by the Inpatient Senior Nurse any concerns will be escalated through the Senior Nurse's highlight report to the directorate QSRE meeting.	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.
Healthcare Inspectorate Wales (HIW)/2024/235	13.11.2024	Hospital Inspection Report (Unannounced) Cofy 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	Added to tracker February 2025
Healthcare Inspectorate Wales (HIW)/2024/235	13.11.2024	Hospital Inspection Report (Unannounced) Cofy Clinic, Princess of Wales Hospital_Appendix C - Improvement Plan_13_14 and 15 November 2024 (Ref: 03710)	19. The health board must ensure that enhanced observation records contain sufficient clinically relevant information so that a detailed picture of a patient's wellbeing, mental health and potential risk can emerge.	Healthcare Inspectorate Wales (HIW)/2024/235/MD20/1	The Safe and Supportive Observation specifies the requirements for recording. The safe and Supportive observation has been shared and read by all staff members. An audit has been carried out to ensure that enhanced observation records contain sufficient clinically relevant information so that a detailed picture of a patient's well-being has been recorded, this will be reported through the Senior Nurse highlight report and monitored through the Care Group QSRE.	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.
Healthcare Inspectorate Wales (HIW)/2024/235	13.11.2024	Hospital Inspection Report (Unannounced) Cofy 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 dietic specialst 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	Overdue	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.
Healthcare Inspectorate Wales (HIW)/2024/235	13.11.2024	Hospital Inspection Report (Unannounced) Cofy Clinic, Princess of Wales Hospital_Appendix C - Improvement Plan_13_14 and 15 November 2024 (Ref: 03710)	21. The health board must undertake a review of the catering and food safety arrangements in place on both wards to identify whether any further improvements are required to meet relevant regulations and best practice guidelines.	Healthcare Inspectorate Wales (HIW)/2024/235/MD22/1	During the HIW inspection a Safe System of Work was completed and shared with all staff. Senior Nurse met with the Regional Facilities Manager and Catering Manager in relation to reviewing the directorates current practice. This information will be shared and discussed within the directorates Senior Leadership Team meeting. All staff complete an online Food Safety module.	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.
Healthcare Inspectorate Wales (HIW)/2024/235	13.11.2024	Hospital Inspection Report (Unannounced) Cofy Clinic, Princess of Wales Hospital_Appendix C - Improvement Plan_13_14 and 15 November 2024 (Ref: 03710)	22. The health board must improve the care and treatment planning process and documentation to ensure they meet the requirements of the measure.	Healthcare Inspectorate Wales (HIW)/2024/235/MD23/1	The Health Board appointed two new CTP leads to support improvement in care planning and documentation to meet the needs of the Mental Health Measure. The CTP leads are managed by a newly appointed Senior Nurse for MHLD Professional Development	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.
Healthcare Inspectorate Wales (HIW)/2024/235	13.11.2024	Hospital Inspection Report (Unannounced) Cofy Clinic, Princess of Wales Hospital_Appendix C - Improvement Plan_13_14 and 15 November 2024 (Ref: 03710)	22. The health board must improve the care and treatment planning process and documentation to ensure they meet the requirements of the measure.	Healthcare Inspectorate Wales (HIW)/2024/235/MD23/2	The CTP leads are optimising the training compliance providing training sessions via Teams and offering bespoke sessions for a targeted approach.	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.
Healthcare Inspectorate Wales (HIW)/2024/235	13.11.2024	Hospital Inspection Report (Unannounced) Cofy Clinic, Princess of Wales Hospital_Appendix C - Improvement Plan_13_14 and 15 November 2024 (Ref: 03710)	22. The health board must improve the care and treatment planning process and documentation to ensure they meet the requirements of the measure.	Healthcare Inspectorate Wales (HIW)/2024/235/MD23/3	The CTP leads have identified a number of high quality CTPs which are being used to share good practice and highlight the expected standard.	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.
Healthcare Inspectorate Wales (HIW)/2024/235	13.11.2024	Hospital Inspection Report (Unannounced) Cofy Clinic, Princess of Wales Hospital_Appendix C - Improvement Plan_13_14 and 15 November 2024 (Ref: 03710)	22. The health board must improve the care and treatment planning process and documentation to ensure they meet the requirements of the measure.	Healthcare Inspectorate Wales (HIW)/2024/235/MD23/4	All CTPs are audited to ensure they meet the required standard and the results are recorded on the Audit Management and Tracking system (AMaT). Performance on this is reported through the directorate Senior Nurse highlight report and monitored through the Care Group QSRE. Overall Care Group themes and trends are monitored through by the CTP leads and Senior Nurse for MHLD Professional Development.	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.
Healthcare Inspectorate Wales (HIW)/2024/235	13.11.2024	Hospital Inspection Report (Unannounced) Cofy Clinic, Princess of Wales Hospital_Appendix C - Improvement Plan_13_14 and 15 November 2024 (Ref: 03710)	23. The health board must review any out-of-date policies and procedures to help staff provide safe and effective care and share with staff once ratified.	Healthcare Inspectorate Wales (HIW)/2024/235/MD24/1	All Mental Health policies are monitored by the Mental Health Learning Disability (MHLD) Policy Review Group which has 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. When due for renewal, policies are assigned to an expert group for update, review, and completion, before being sent back to the MHLD Policy Group for ratification. HB wide policies are the responsibility of the policy authors to ensure timely reviews of written control documents within their areas. This is set out in the Policy for the Development, Review and Approval of Organisational Wide Policies. The policy programme is currently under review and aims to introduce an additional step where reminders will be issued to the policy leads ahead of the policy passing its review period.	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.
Healthcare Inspectorate Wales (HIW)/2024/235	13.11.2024	Hospital Inspection Report (Unannounced) Cofy 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.
Healthcare Inspectorate Wales (HIW)/2024/235	13.11.2024	Hospital Inspection Report (Unannounced) Cofy Clinic, Princess of Wales Hospital_Appendix C - Improvement Plan_13_14 and 15 November 2024 (Ref: 03710)	25. The health board must engage further with staff to fully understand their concerns and determine whether the current staffing establishment levels and arrangements are appropriate to help staff provide safe and effective care to patients on Ward 14.	Healthcare Inspectorate Wales (HIW)/2024/235/MD26/1	Following this feedback, the priority was to engage staff in discussions. Within the discussion it was reiterated that the standardisation of the workforce was carried out in line with the safe staffing act, to ensure prudent use of staffing which was associated with the reduction in beds. Nursing establishment review was completed and monitored through the Nursing workforce meeting. Staffing requirements are determined on a day by day basis and when additional staff are required to meet the needs of the patients then additional staffing requests are submitted. All requests since the implementation of the new staffing establishment have been approved.	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.
Healthcare Inspectorate Wales (HIW)/2024/235	13.11.2024	Hospital Inspection Report (Unannounced) Cofy Clinic, Princess of Wales Hospital_Appendix C - Improvement Plan_13_14 and 15 November 2024 (Ref: 03710)	26. The health board must improve its processes in relation to obtaining patient feedback and engage with patients as a group more frequently. The health board must ensure initiatives such as the 'You said, we did' board to inform patients of the outcomes of their feedback are kept up to date.	Healthcare Inspectorate Wales (HIW)/2024/235/MD27/1	Weekly patient meetings are taking place on both Ward 14 and PICU. Time and place for patient awareness are displayed within the patient notice board. PICUs 'you said we did' board has been updated, and will continue to be updated on a monthly basis following patient feedback	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.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	AMoT Reference Number	Action	Care Group	Original Due Date	Current / Revised Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2024/235	13.11.2024	Hospital Inspection Report (Unannounced) Cofy Clinic, Princess of Wales Hospital_Appendix C - Improvement Plan_13, 14 and 15 November 2024 (Ref: 03710)	27. The health board must ensure all relevant information in relation to an incident is captured accurately.	Healthcare Inspectorate Wales (HIW)/2024/235/MD28/1	An audit has been completed to ensure that the 'exact' location has been completed. This information will be shared within the Senior Nurse highlighted report and monitored through the Care Group QGRE.	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

8.2.4

Quality, Safety & Experience Committee

**Cwm Taf Morgannwg University Health Board
(CTMUHB) National Clinical Audit Programme Quarter 3
Update 2024-25**

Dyddiad y Cyfarfod / Date of Meeting	25/03/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Mark Townsend – Head of Clinical Audit & Quality Informatics, Lauren Dyton – Clinical Audit Manager
Cyflwynydd yr Adroddiad / Report Presenter <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	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
TARN	Trauma Audit Research Network
NMTR	National Major Trauma Registry
CA&QI	Clinical Audit & Quality Informatics Department
NEIAA	National Early Inflammatory Arthritis Audit
NELA	National Emergency Laparotomy Audit
SWTN	South Wales Trauma Network
PWH	Princess of Wales Hospital
PCH	Prince Charles Hospital
RGH	Royal Glamorgan Hospital
AMaT	Audit Management and Tracking
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
MINAP	Myocardial Ischaemia Audit Project
NICE	National Institute for Health and Care Excellence
HQIP	Healthcare Quality Improvement Partnership
WG	Welsh Government
NCA&ORP	National Clinical Audit and Outcome Review Plan
COPD	Chronic Obstructive Pulmonary Disease
NHFA	National Heart Failure Audit
CEC	Clinical Effectiveness Committee
EIA	Early Inflammatory Arthritis
NCDA	National Core Diabetes Audit
LFER	Learning From Events Reports
BI	Business Intelligence

1. Situation / Background

- 1.1 The purpose of this report is to provide an update for the Quality, Safety & Experience Committee on progress against the CTMUHB Clinical Audit Forward Plan 2024-2025. The CTMUHB plan based on information from the HQIP directory of United Kingdom wide agreed audits and reviewed against the NCA&ORP for Wales (2024/25) published June 2024.
- 1.2 **32** out of 46 national audits (tier 1) are green fully compliant and 6 amber (NMTR / TARN, NEIAA (PWH), NJR (PWH), NELA (PCH, RGH), MINAP and Heart Failure where the audits are delayed, a backlog exists work is ongoing to partially or fully comply with the national audit deadlines. The NCDA report published 12 December 2024 confirmed that CTMUHB had achieved 100% compliance with data submission requirement for NCDA. The organisation is therefore no longer an 'outlier', and **0** audits are red.
- 1.3 The established CEC programme of meetings was affected by the remedial work required in the PoWH and associated impact on clinical services. The Falls, Frailty & Orthopaedics / Trauma CEC meetings scheduled for 12 November 2024 was postponed until April 2025. The main purpose of the CEC is to use national audit data to monitor quality of care across CTMUHB using evidence-based approaches.
- 1.4 The AMaT system continues to develop with work in progress to develop the use of the inspections module by the CTMUHB corporate governance team and to support ward accreditation and AMaT data to underpin the Ward Accreditation programme of work. Further work has been established to develop BI dashboards for the easy analysis of AMaT data at ward to board level with the Documentation and Record Keeping Audit dashboard going live in December 2024.

2. Specific Matters for Consideration

2.1 Clinical Audit Forward Plan 2024-2025 Current Position

A number of audits are amber due to competing demands on clinician time, these include:

NJR activity at the PWH is now being undertaken, by the Clinical Audit team and a significant reduction in the backlog of cases made during Quarter 3.

NEIAA due to clinical pressures and limited administration resources to support the service particularly in the PWH.

TARN / NMTR new data collection platform is now in place and has extensively used during quarter 3. Focus currently on completing Quarter 1 and 2 cases, to meet requirements of the SWTN. CTMUHB to host the

2025 South Wales Trauma Network Annual Conference, scheduled for October 2025.

NELA (RGH) new surgical NELA lead appointed in Quarter 3, NELA (PCH) additional cases identified for review, therefore activity is below expected level for both RGH and PCH 'amber'.

Fluctuating levels of clinical support for review activity for the cardiology national audits (Heart Failure and MINAP) at PWH, Quarter 1 submissions 'green', Quarter 2 submissions 'amber'.

2.2 Clinical Effectiveness Committee findings and actions (Quarter 3)

The planned Falls, Frailty & Orthopaedics / Trauma CEC meetings scheduled for 12 November 2024 was postponed until April 2025 due to the significant service pressures on the Orthopaedic and Trauma speciality as consequence of the remedial work required at the Princess of Wales hospital site.

The forward plan of themed CEC meetings, has been revised in light of the ongoing adjustments to clinical services.

2.3 Clinical Audit Training

To date over 658 Health Board staff have received training on the ward and area module.

Clinical audit training was delivered to a large group of pharmacy staff in December 2024, with positive feedback received.

2.4 AMaT Implementation

A review has been undertaken of all core nursing ward / area audits in collaboration with the CTMUHB Quality Improvement team. The review identified a number of areas where the audits could be streamlined, stopped or modified to release clinical time to take forward improvement projects. The audit changes are currently under development with a planned go live date of the 1 April 2025.

Information gathered on the AMaT system has been utilised extensively to support evidence for LFERs and Ombudsman cases. The work includes provision of data from existing audits and/or developing new audits based on concerns e.g. Safeguarding audits).

The Documentation and Record Keeping Audit business intelligence dashboard has been launched for nurse managers and ward teams to support data analysis for improvement.



2.5 NICE Compliance Programme of work

The assurance oversight, scrutiny and a governance function in relation to NICE guidance within CTMUHB is the responsibility of the care groups. However, in collaboration with the Medical Director’s office a process to disseminate new NICE guidance, receive feedback from care groups and annotate compliance statements on the AMaT system has been approved and this activity is planned to commence in quarter 4 with the Maternity Unit.

3. Key Risks / Matters for Escalation

3.1 No key risks or concerns to note for Quarter 3.

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 <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality</i> (Duty of Quality Statutory Guidance (gov.wales))	Learning, Improvement & Research
	If more than one applies please list below:
Dolen i Feysydd Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality</i> (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 <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / Quality</i> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: ☒	No: ☐
	Outcome: The potential consequences on quality of service have been considered and any necessary mitigating actions outlined in the paper	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? / Equality and Welsh Language</i> <i>Have you undertaken an Equality and Welsh Language Impact Assessment Screening?</i>	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 not a policy or service review
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 That the committee **NOTE** receipt of the compliance position and mitigating action being taken to achieve compliance for the CTMUHB.

6. Next Steps

- 6.1 To ensure completion of the full CTMUHB Clinical Audit Forward Plan 2024-2025, by the end of March 2025.



Agenda Item

8.2.5

Quality, Safety & Experience Committee

**CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD
(CTMUHB) CLINICAL AUDIT FORWARD PLAN FOR 2025-
26**

Dyddiad y Cyfarfod / Date of Meeting	25/03/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Mark Townsend, Head of Clinical Audit and Quality Informatics
Cyflwynydd yr Adroddiad / Report Presenter <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	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
NCA&ORP	National Clinical Audit & Outcome Review Plan
CA&QI	Clinical Audit and Quality Informatics

1. Situation / Background

- 1.1 The purpose of this report is to provide the Quality, Safety & Experience Committee with the CTMUHB Clinical Audit Forward Plan 2025-2026. WG have not release an All Wales NCA&ORP for 2025-26 therefore the CTMUHB forward plan is based on information from the HQIP directory of United Kingdom wide agreed audits. (See Appendix 1: Clinical Audit Forward Plan 2025-26).

2. Specific Matters for Consideration

- 2.1 The Clinical Audit team are currently working to ensure completion of the full CTMUHB Clinical Audit Forward Plan 2024-2025, by the end of March 2025.

3. Key Risks / Matters for Escalation

- 3.1 The challenging backdrop of reduced budget, decreased staffing and increased demand to deliver an increasing programme of tier 1 national audits resulting in reduced capacity to support tier 2 essential organisation priority clinical audits.

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	Effective



(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality (Duty of Quality Statutory Guidance (gov.wales))	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: The potential consequences on quality of service have been considered and any necessary mitigating actions outlined in the paper	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Cydraddoldeb 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 not a policy or service review
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 That the committee NOTE receipt of the CTMUHB Clinical Audit Forward Plan for 2025-2026.

6. Next Steps

- 6.1 To ensure delivery of the full CTMUHB Clinical Audit Forward Plan for 2025-2026, by the end of March 2026.

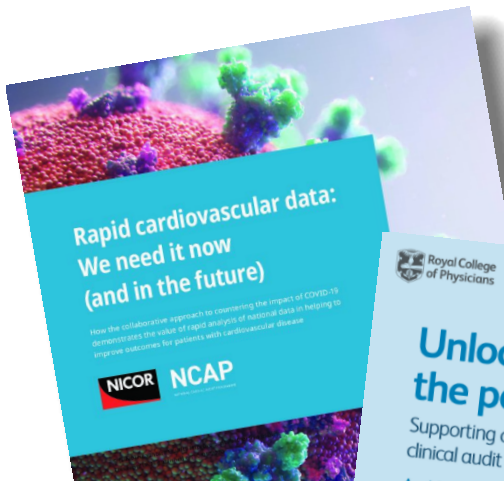


GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Knowing How Well
We Are Doing

Clinical Audit Forward Plan 2025-26



Please click here for the

NELA

Patient Data Entry tool



Unlocking
the potential
Supporting doctors to use national
clinical audit to drive improvement



consultant
TPDs
investment
ARCP
teaching
support
celebrate
valued
learn

Commissioned by:



HQIP

Healthcare Quality
Improvement Partnership



Standard 3.1:
Safe and Clinically Effective Care
Effective Care



Version 1.0, 07 March 2025



NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme

The following key criteria will also be used for judging success:

- 100% participation, appropriate levels of case ascertainment and submission of complete data sets by all health boards and trusts (where applicable) in the full programme of National Clinical Audits and Clinical Outcome Reviews.
- Improvements in the quality and safety of patient outcomes and experience brought about by learning and action arising from the findings of National Clinical Audit and Clinical Outcome Review reports.

The findings and recommendations from national clinical audit, outcome reviews and all other forms of reviews and assessments will be one of the principal mechanisms for assessing the quality and effectiveness of healthcare services provided by health boards and trusts in Wales.

A Welsh Health Circular and Annual Plan is due to be published in June 2025 to clarify the mandatory audit list. The Cwm Taf Morgannwg University Health Board (CTMUHB) Clinical Audit Forward Plan has been developed based on the HQIP audit directory, but may need to be updated following the final release of the Welsh Health Circular by WG.

Clinical Effectiveness Committees (CEC) were established in 2024/25 to monitor quality of care across CTMUHB using evidence-based approaches, predominantly national audit findings for measurement and quality improvement; Provide assurance to the Board that our organisation has effective systems to deliver required standards, and identify areas to progress improvements in the delivery of patient care.

The CEC comprises of representation from Clinical Audit, Heads of Nursing and Clinical Leads, Allied Health Professionals and Pharmacy, Quality Improvement and Patient Safety. National audit action plans are reviewed and agreed through the CECs and enable the monitoring of compliance against the CTMUHB Clinical Audit Forward Plan.

Compliance Key

RED	Cause for concern. Full compliance not achieved by audit deadline.
AMBER	Tier 1: National audit delayed, backlog exists but plan in place to comply with national audit deadline. Tier 2: Organisation priority audit delayed by one quarter, but plan in place to comply with revised audit deadline.
GREEN	Audit on track at 31/03/2025 or completed, evidence of audit compliance documented on AMaT system.
BLUE	Audit and action plan completed by clinical audit leads and signed off on AMaT system.

Submission deadlines and planned report release deadlines are constantly changing and in most cases being delayed.

NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2025/26

Outcome Reviews in which all Welsh Health Boards and Trusts must participate (across sites where services are provided)

National Audit	Audit Period	Submission Deadline	Planned Report Publication	Specialty	Compliance Position 2024/25	RAG Status 2024/25
Acute						
National Joint Registry (NJR)	operates continuous data capture	February 2025	September 2025	Trauma and Orthopaedics	Organisation wide compliance	GREEN
National Emergency Laparotomy Audit (NELA)	operates continuous data capture	N/A	November 2025	Surgery / Anaesthetics	PWH compliant, working towards compliance in RGH/PCH	AMBER
National Emergency Laparotomy Audit (NELA) – No Lap Audit (Non-laparotomy)	operates continuous data capture	June 2025	TBC	Surgery	New for 2024/25	N/A
Case Mix Programme (CMP) ICNARC	operates continuous data capture	Monthly	March 2026	Anaesthetics	Organisation wide compliance	GREEN
Major Trauma Audit # (TARN/ NMTR)	operates continuous data capture	Awaiting details at time of reporting	TBC	Emergency Medicine	National TARN System unavailable for data submissions until October 2024. Currently working to address the backlog case from 01/04/2024	AMBER
Long Term Conditions						

NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2025/26

Outcome Reviews in which all Welsh Health Boards and Trusts must participate (across sites where services are provided)

National Audit	Audit Period	Submission Deadline	Planned Report Publication	Specialty	Compliance Position 2024/25	RAG Status 2024/25
National Diabetes Audit [*] Note this covers the following areas : National Diabetes Foot Care Audit (NDFCA)	operates continuous data capture	N/A	May 2025 (Continuous dashboard reporting now available)	Therapies	Organisation wide compliance	BLUE
National Pregnancy in Diabetes Audit (NPID)	operates continuous data capture	N/A	TBC	Obstetrics and Gynaecology	Organisation wide compliance	GREEN
National Diabetes Inpatient Audit (NDISA)	operates continuous data capture	TBC	TBC	General medicine	N/A	N/A
National Core Diabetes Audit (NCDA)	Data capture from Primary Care at specific intervals	N/A	N/A	Primary Care / Secondary Care	Organisation data extracted	GREEN
National Diabetes Paediatric Audit (NPDA) [*] #	operates continuous data capture	N/A	March 2025	Paediatrics	Organisation wide compliance	GREEN
National Diabetes Integrated Specialist Survey	Annual survey	November 2025	Dashboard Reporting	Organisation Wide	Organisation wide compliance	GREEN
National Respiratory Audit Programme (NRAP) [*] # Note this covers the following areas: Adult Asthma Secondary Care	operates continuous data capture	N/A	June 2025	General medicine	Organisation wide compliance	BLUE

NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2025/26

Outcome Reviews in which all Welsh Health Boards and Trusts must participate (across sites where services are provided)

National Audit	Audit Period	Submission Deadline	Planned Report Publication	Specialty	Compliance Position 2024/25	RAG Status 2024/25
COPD Secondary Care	operates continuous data capture	N/A	June 2025	General medicine	Organisation wide compliance	BLUE
COPD Primary Care (Wales)	Data capture from Primary Care at specific intervals	N/A	TBC	Primary Care	Organisation wide compliance	GREEN
Paediatric Asthma Secondary Care	operates continuous data capture	N/A	June 2025	Paediatrics	Organisation wide compliance	GREEN
Pulmonary Rehabilitation	operates continuous data capture	In Progress	June 2025	Therapies	Service established in 2024/25	N/A
National Early Inflammatory Arthritis Audit * # (NEIRT)	N/A	May 2025	October 2025	Rheumatology	Action being taken to improve compliance at the PWH	AMBER
All Wales Audiology Audit #	operates continuous data capture	N/A	TBC	Ears, Nose and Throat	Organisation wide compliance	GREEN
Older People						
Sentinel Stroke National Audit Programme (SSNAP) (SSNAP) *	operates continuous data capture	N/A	November 2025	General medicine / Therapies	Organisation wide compliance	GREEN

NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2025/26

Outcome Reviews in which all Welsh Health Boards and Trusts must participate (across sites where services are provided)

National Audit	Audit Period	Submission Deadline	Planned Report Publication	Specialty	Compliance Position 2024/25	RAG Status 2024/25
Falls and Fragility Fractures Audit Programme Including: • Inpatient Falls * (NAIF)	operates continuous data capture	March 2025	TBC	General Medicine / Trauma & Orthopaedics	Organisation wide compliance	GREEN
• National Hip Fracture Database (NHFD)	operates continuous data capture	January 2025	TBC	General Medicine / Trauma & Orthopaedics	Organisation wide compliance	GREEN
• Fracture Liaison Service Database (FLS-DB)	operates continuous data capture	TBC	N/A	General Medicine / Trauma & Orthopaedics	Service established 2024/25	N/A
National Dementia Audit * (NDA)	Completed 5 Year cycle	N/A	N/A	Mental Health / Care of the Elderly	N/A	N/A
End of Life						
National Audit for Care at the End of Life (NACEL) *	TBC	TBC	August 2025	Palliative Care / Medicine	Organisation wide compliance	GREEN
Heart						
National Cardiac Audit Programme (NCAP) • National Heart Failure Audit * (NHFA)	operates continuous data capture	June 2025	TBC	Cardiology	Action being taken to improve compliance	AMBER

NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2025/26

Outcome Reviews in which all Welsh Health Boards and Trusts must participate (across sites where services are provided)

National Audit	Audit Period	Submission Deadline	Planned Report Publication	Specialty	Compliance Position 2024/25	RAG Status 2024/25
Cardiac Rhythm Management * (CRM)	operates continuous data capture	N/A	TBC	Cardiology	Organisation wide compliance. (excludes Bridgend)	GREEN
Myocardial Ischaemia National Audit Project (MINAP)*	operates continuous data capture	June 2025	TBC	Cardiology	Action being taken to improve compliance	AMBER
Cardiac Rehabilitation Audit (CRA)	operates continuous data capture	N/A	December 2025	Cardiology	Organisation wide compliance	GREEN
Cancer **						
National Bowel Cancer Audit (NOGCA) *	operates continuous data capture	N/A	April 2025	Surgery	Organisation wide compliance. Managed through cancer services.	BLUE
National Oesophago-Gastric Cancer Audit (NOGCA) *	operates continuous data capture	N/A	April 2025	Surgery	Organisation wide compliance. Managed through cancer services.	GREEN
National Audit of Metastatic Breast Cancer (NAoMe) *	operates continuous data capture	TBC	April 2025	Surgery	Newly added mid year compliance under review. Managed through cancer services.	N/A
National Audit of Primary Breast Cancer (NAoPri) *	operates continuous data capture	TBC	April 2025	Surgery	Newly added mid year compliance under review. Managed through cancer services.	N/A

NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2025/26

Outcome Reviews in which all Welsh Health Boards and Trusts must participate (across sites where services are provided)

National Audit	Audit Period	Submission Deadline	Planned Report Publication	Specialty	Compliance Position 2024/25	RAG Status 2024/25
National Lung Cancer Audit (NLCA) *	operates continuous data capture	N/A	April 2025	Respiratory Medicine	Organisation wide compliance. Managed through cancer services.	BLUE
National Prostate Cancer Audit (NPCA) *	operates continuous data capture	N/A	April 2025	Surgery	Organisation wide compliance. Managed through cancer services.	GREEN
National Ovarian Cancer Audit (NOCA)	operates continuous data capture	N/A	TBC	Gynaecology	Newly added mid year compliance under review. Managed through cancer services.	N/A
National Pancreatic Cancer Audit (NPaCA)	operates continuous data capture	N/A	TBC	Gastroenterology	Newly added mid year compliance under review. Managed through cancer services.	N/A
National Non-Hodgkin Lymphoma Audit (NNHLA)	operates continuous data capture	N/A	TBC		Newly added mid year compliance under review. Managed through cancer services.	N/A
National Kidney Cancer Audit (NKCA)	operates continuous data capture	N/A	TBC		Newly added mid year compliance under review. Managed through cancer services.	N/A
Women's and Children's Health						
National Neonatal Audit Programme Audit * # (NNAPA)	operates continuous data capture	N/A	October 2025	Paediatrics	Organisation wide compliance.	GREEN

NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2025/26

Outcome Reviews in which all Welsh Health Boards and Trusts must participate (across sites where services are provided)

National Audit	Audit Period	Submission Deadline	Planned Report Publication	Specialty	Compliance Position 2024/25	RAG Status 2024/25
National Maternity and Perinatal Audit *# (NMPA)	operates continuous data capture	N/A	May 2025	Obstetrics / Midwifery	Organisation wide compliance.	GREEN
National Perinatal Mortality Review Tool (PMRT)	operates continuous data capture	N/A	The PMRT is available for continuous use	Obstetrics / Midwifery	Organisation wide compliance.	GREEN
Other						
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12) *# (NASECYP)	Series of data collection cohorts within the audit	Various deadlines for cohorts	February 2025	Paediatrics	Organisation wide compliance.	GREEN
National Clinical Audit of Psychosis * (NCAP) EIP Audit	operates continuous data capture	N/A	Dashboard Reports being developed	Mental Health	Organisation wide compliance.	GREEN

(* denotes NCAPOP Audits)

(# denotes reports likely to include information on children and / or maternity services)

NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2025/26

Outcome Reviews in which all Welsh Health Boards and Trusts must participate (across sites where services are provided)

Clinical Outcomes Review Programme (2024/25)

The Clinical Outcome Review Programme (CORP) is designed to help assess the quality of healthcare, and stimulate improvement in safety and effectiveness by enabling learning from adverse events and other relevant data. It aims to complement and contribute to the work of other agencies such as NICE, the Royal Colleges and academic research studies which support changes to improve NHS healthcare.

The Clinical Outcome Review Programme (Tier 1)	Audit Period	Completion Deadline	Report Publication	Programme	Compliance Position 2024/25	RAG Status 2024/25
National Confidential Inquiry into Suicide and Safety in Mental Health	operates continuous data capture	N/A	April 2025	Mental Health Programme	Organisation wide compliance.	GREEN
Rehabilitation after Critical Illness	2023/24	N/A	Spring 2025	Medical & Surgical programme	Organisation wide compliance.	GREEN
Blood Sodium	2024/25	April 2025	November 2025	Medical & Surgical programme	Data submitted	N/A
Acute Limb Ischaemia	2024/25	April 2025	November 2025	Medical & Surgical programme	Organisational Audit ONLY required	N/A
MBRRACE – Perinatal Mortality Surveillance	operates continuous data capture	TBC	October 2025	Maternal, Newborn and Infant Clinical Outcome Review Programme	Organisation wide compliance.	GREEN
MBRRACE – Saving Lives Improving Mothers Care	operates continuous data capture	TBC	October 2025	Maternal, Newborn and Infant Clinical Outcome Review Programme	Organisation wide compliance.	GREEN

Cwm Taf Morgannwg University Health Board Organisation (Tier 2) Priority Annual Audit Programme 2024/25

Organisation Priority Audits (Tier 2)	Audit Period	Completion Deadline	Report Publication	Specialty	Compliance Position 2024/25	RAG Status 2024/2025
Case Note Documentation Audits: - Acute Hospital Documentation Audit - Community Hospital Documentation Audit - A&E Documentation Audit	Revised methodology TBC	TBC	TBC	Acute inpatient activity	Audit process currently under review	N/A
				Community hospital inpatient activity	Audit process currently under review	N/A
				Emergency Medicine	Audit process currently under review	N/A
Consent to Treat Audit	Quarter 1, 2025/26	Quarter 1, 2025/26	Quarter 2, 2025/26	Medicine / Surgery	N/A	N/A
National Ophthalmology Audit (Adult Cataract surgery) * (NOD)	operates continuous data capture	TBC	TBC	Ophthalmology	Participation in RGH and PCH only.	GREEN



Agenda Item

8.2.6

Quality, Safety & Experience Committee

Highlight Report from the Organ Donation Sub Committee

Dyddiad y Cyfarfod / Date of Meeting	25/03/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	Corinna McNeil and Victoria Hughes Specialist Nurses Organ Donation
Cyflwynydd yr Adroddiad / Report Presenter <i>If you do not wish for your name to be included in the public domain, please only include your job title</i>	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 / Individuals	Date	Outcome
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
SNOD	Specialist Nurse Organ Donation

CLOD	Clinical Lead Organ Donation
NHSBT	NHS Blood & Transplant
WTE	Whole Time Equivalent
SIGNET	Statins for Improving Organ outcome in Transplantation

1. Introduction

- 1.1 This report had been prepared to provide the Quality, Safety and Experience Committee with details of the key issues considered by the Organ Donation Sub Committee at its meeting on 31 January 2025.
- 1.2 Key highlights from the meeting are reported in section 3.

2. Purpose of this Meeting

- 2.1 The purpose of the Organ Donation Sub Committee is to influence policy and practice to ensure that Organ Donation is considered in all appropriate situations, and to identify and resolve any obstacles to this.
- 2.2 The Organ Donation Sub Committee will:
- Ensure that a discussion about organ donation features in all end of life care, wherever located and whenever appropriate, recognising and respecting the wishes of the individuals.
 - Maximise the overall number of organs donated, through better support to potential donors and their families. (From Terms of Reference).

3. Highlight Report

Alert / Escalate	- How the Health Board, with the ODC, will continue with excellent practice. - How the Health Board will support the SNOD and CLOD in meeting the key priorities of the 2030 plan. - How the Health Board work with NHSBT to increase the number of CTM residents on the Organ Donation Register and support community engagement to raise awareness. - Supporting NHSBT to ensure the CLOD and SNOD workforce matches the reconfiguration of the Critical Care Services in CTM. Aim to regain 0.2 WTE SNOD hours to ensure adequate cover for all three sites.
Advise	- Cwm Taf Morgannwg UHB is recognised by NHS Blood and Transplant (NHSBT) as a Level 2 Health Board. In 2024/2025, from 7 consented donors, CTMUHB facilitated 23 solid organ donations that resulted in 30 patients receiving lifesaving, or life changing, transplants. - Financial support for Organ Donation activities is funded by NHSBT. These monies are held in a regional fund, which can be easily accessed by the local Organ Donation Committee.

	These funds can support educational events, memorial activities, facilities for visitors to Intensive Care, and artwork installations on hospital sites. Clinical performance and engagement within CTM are excellent. In the year 2024/25, there were not any occasions when organ donation was not raised where appropriate. 100% of patients who meet criteria for neurological death testing were tested, reflecting a confidence within the clinical team with the process. A performance dashboard is available to the public.
Assure	- CTM UHB has a well-attended Organ Donation Committee (ODC), which has representation from all relevant internal and external stakeholders, including patient and family representatives. The ODC is the forum in which Health Board performance is reported, missed opportunities discussed, a communication strategy developed, and education sessions are planned. In March 2022, the Welsh Organ Donation and Transplantation Plan 2030 was launched. This was developed by the Welsh Transplant Advisory Group (WTAG) which identified 5 key targets: vi. Increasing deceased donation opportunities ii. Increasing tissue and eye donation iii. Increasing living donation and transplantation iv. Increasing access to transplantation v. Improving transplant outcomes vii. Supporting a sustainable and diverse workforce - We have had incredible engagement from our CTMUHB Communications team and have regular planning meetings for further comms pieces to ensure all of our communities within CTMUHB have access to accurate information around organ donation to empower everyone to make an informed decision.
Inform	- CTM UHB has two embedded Specialist Nurses for Organ Donation (SNODs) 1.8 WTE, two Clinical Leads for Organ Donation (CLODs), and the current Regional CLOD for South Wales is a CTM Consultant. These are NHSBT funded activities and are subject to annual performance management. A business case has been put forward to NHSBT to apply for a further 0.2 WTE for the Specialist nurses. Historically CTMUHB has had 2 WTE SNOD's to ensure adequate cover and service delivery for all 3 sites. All donor families are invited to an annual memorial event where the Gift of Life is recognised, and they are presented with an Order of St. John Award. - SIGNET research programme has now been rolled out to all 3 sites. This will aid in advancing the future of organ donation and transplantation.



	• SNOD's/CLOD's have collaborated with University of South Wales to film simulation training for nursing, ODP's, physiotherapy and medical students inclusive of the entire process of organ donation. This provides vital education of our further healthcare providers and is also available to all staff within CTMUHB.
Appendices	

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	Dying 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 <i>150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)</i>	A More Equal Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality</i> <i>(Duty of Quality Statutory Guidance (gov.wales))</i>	Whole-systems Perspective
	If more than one applies please list below:
Dolen i Feysydd Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality</i> <i>(Duty of Quality Statutory Guidance (gov.wales))</i>	Safe
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) /	No - Not Applicable
	If more than one applies please list below:



**Environmental
/Sustainability Impact
(5Rs)**

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
Cydraddoldeb 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

Yes (Include further detail below)

All practices are performed in-line with the Human Tissue
Act and Welsh "Deemed Consent" law.

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