Quality & Safety Committee

Thu 16 May 2024, 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, Committee Chair/Independent Member*

1.2. Apologies for Absence

Information *Carolyn Donoghue, Committee Chair/Independent Member*

1.3. Declarations of Interest

Information *Carolyn Donoghue, Committee Chair/Independent Member*

09:05 - 09:35
30 min

2. SHARED LISTENING & LEARNING

2.1. Listening & Learning Story - Ethics

Discussion *Neil Evans, Mental Health Practitioner*

2.2. Spotlight Presentation - Maternity/Neonates Metrics and Assurance Framework'

Discussion *Suzanne Hardacre, Director of Midwifery*

2.2 QSE Perinatal Spotlight Report QSC 16 May 2024.pdf (9 pages)

09:35 - 09:40
5 min

3. CONSENT AGENDA

Decision *Carolyn Donoghue, Committee Chair/Independent Member*

The Chair will ask if there are any items from the Consent Agenda (Item 9) that Committee Members wish to bring forward to the main agenda for discussion

09:40 - 09:45
5 min

4. MAIN AGENDA

4.1. Matters Arising not Considered within the Action Log

Discussion *Carolyn Donoghue, Committee Chair/Independent Member*

09:45 - 10:30
45 min

5. SETTING THE SCENE - SERVICE DELIVERY

5.1. Report from the Clinical Executives

Discussion *Clinical Executive Directors*

Strategic Goals: Improving Care, Creating Health, Inspiring People, Sustaining our Future

Domains of Quality: Safe, Effective, Efficient, Equitable, Person-Centred, Timely

5.1 Clinical Executive Directors report QSC 16 May 2024.pdf (12 pages)

5.2. Care Group Highlight Reports

Discussion *Care Group Leads*

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

Strategic Goals: Improving Care, Creating Health, Inspiring People, Sustaining our Future

Domains of Quality: Effective, Efficient, Person Centred, Equitable, Timely, Safe

5.2a MHLD Highlight Report QSC 16 May 2024.pdf (8 pages)
5.2b Children & Families Care Group Highlight Report 16 May 2024.pdf (7 pages)
5.2c DTPS QSRE report for QSC 16 May 2024 - Post mtg redaction.pdf (11 pages)
5.2b Appendix QSE metrics April 24 FINAL QSC 16 May 2024.pdf (25 pages)
5.2d USC Highlight Report QSC 16 May 2024.pdf (8 pages)
5.2e PCC Care Group Highlight Report QSC 16 May 2024-updated v2.pdf (8 pages)
5.2f Planned Care Highlight Report QSC 16 May 2024.pdf (9 pages)

10:30 - 11:15
45 min

6. GOVERNANCE, RISK AND ASSURANCE

6.1. Organisational Risk Register - Risks Assigned to the Quality & Safety Committee

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

6.1a Org RR May 24 - Cover Paper - QSC.pdf (7 pages)
6.1b App 1 - Master Organisational Risk Register- May 24.xlsx (7 pages)

6.2. Infection, Prevention & Control Report - End of Year Update

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

Strategic Goals: Creating Health, Improving Care, Inspiring People, Sustaining our Future

Domains of Quality: Safe, Timely, Effective, Efficient, Equitable, Person-Centred

6.2 IPC Highlight report QSC 16 May 2024.pdf (8 pages)

6.3. Infection, Prevention & Control Strategy

Decision *Greg Dix, Executive Director of Nursing/Deputy Chief Executive*

Strategic Goals: Improving Care, Creating Health

Domains of Quality: Safe, Efficient, Effective, Equitable, Person Centred and Timely.

6.3a IPC Strategy 2024-27 QSC 16 May 2024.pdf (6 pages)
6.3b Cwm Taf Morgannwg IPC Strategy 2024-2027 QSC 16 May 2027.pdf (26 pages)

6.4. New NICE Guidance Process

Discussion *Dom Hurford, Executive Medical Director*

Strategic Goals: Improving Care

Domains of Quality: Effective, Efficient, Equitable, Person Centred, Timely, Safe

6.4 Proposed NICE Process April 2024 QSC 16 May 2024.pdf (6 pages)

6.5. WHSSC Quality & Patient Safety Committee Chairs Report

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

6.5 Quality Patient Safety Committee Chairs Report QSC 16 May 2024.pdf (16 pages)

6.6. NHS Wales Joint Commissioning Committee

Discussion *Nigel Downes, Assistant Director of Quality & Safety*

Strategic Goals: Improving Care

Domains of Quality: Safe, Timely, Effective, Efficient, Equitable, Person-Centred

6.6 NHS Wales Joint Commissioning Committee Paper - May 24.pdf (5 pages)

11:15 - 11:45
30 min

7. DELIVERING OUR PLAN

7.1. Patient Safety, Quality & Experience Dashboard

Discussion *Nigel Downes, Assistant Director of Quality & Safety*

Strategic Goals: Improving Care

Domains of Quality: Safe

7.1 Patient Safety & Quality Dashboard Report QSC 2024-05-16 FINAL.pdf (22 pages)

7.2. Nursing & Midwifery Delivery Plan

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

Strategic Goals: Inspiring People

Domains of Quality: Effective, Links to all of the domains of quality

7.2a Nursing and Midwifery Plan Cover Report QSC 16 May 2024.pdf (5 pages)
7.2b Nursing and Midwifery Del Plan 24-27 QSC 16.5.24.pdf (26 pages)

11:45 - 11:50
5 min

8. DELIVERING OUR IMPROVEMENT PROGRAMMES

8.1. Mental Health Adult Inpatient Improvement Programme

Discussion *Ana Llewellyn, Care Group Nurse Director*

Strategic Goals: Improving Care

Domains of Quality: Effective, Person Centred, Timely, Safe

8.1 Mental Health Adult Inpatient Improvement Programme QSC 16 May 2024.pdf (6 pages)

11:50 - 11:55
5 min

9. CONSENT AGENDA

9.1. FOR APPROVAL

9.1.1. Unconfirmed Minutes of the meeting held on 14 March 2024

Decision *Carolyn Donoghue, Committee Chair/Independent Member*

9.1.1 Unconfirmed Minutes QSC 14 March 2024 Final QSC 16 May 2024.pdf (16 pages)

9.1.2. Unconfirmed In Committee Minutes of the meeting held on 14 March 2024

Decision *Carolyn Donoghue, Committee Chair/Independent Member*

9.1.2 Unconfirmed In Committee Minutes 14.3.24 QSC 16 May 2024.pdf (3 pages)

9.1.3. Welsh Language Active Offer Policy

Decision *Greg Dix, Executive Director of Nursing/Deputy Chief Executive*

Strategic Goals: Improving Care

Domains of Quality: Person Centred

9.1.3a Welsh Language Active Offer Policy Covering Paper QSC 16 May 2024.pdf (4 pages)
9.1.3b In-patient Active Offer Policy with Appendix QSC 16 May 2024.pdf (20 pages)

9.1.4. Quality & Safety Committee Annual Report 2023-2024

Decision *Carolyn Donoghue, Independent Member/Committee Chair*

Strategic Goals: Improving Care

Domains of Quality: Safe

9.1.4a Cover Report Quality & Safety Committee Annual Report 2023 2024 QSC 16 May 2024.pdf (3 pages)
9.1.4b Appendix 1 Quality Safety Committee Annual Report 2023 to 2024 QSC 16 May 2024.pdf (12 pages)

9.2. FOR NOTING

9.2.1. Action Log

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

9.2.1 Action Log QSC 16 May 2024.pdf (6 pages)

9.2.2. Committee Annual Cycle of Business

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

9.2.2a Cover Report Committee Annual Cycle of Business QSC 16 May 2024.pdf (3 pages)
9.2.2b Quality Safety Committee Cycle of Business QSC 16 May 2024.pdf (4 pages)

9.2.3. Committee Forward Work Programme

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

9.2.3 Quality & Safety Committee Forward Work Programme QSC 16 May 2024.pdf (4 pages)

9.2.4. Clinical Policies Highlight Report

Information *Dom Hurford, Executive Medical Director*

Strategic Goals: Improving Care

Domains of Quality: Effective

9.2.4a Clinical Policies Highlight Report QSC 16 May 2024.pdf (4 pages)
9.2.4b CTM Policy for Safe Administration of Eye Drops By Unregistered Healthcare Practitioners V1.1.pdf (41 pages)

9.2.5. Controlled Drugs Local Intelligence Network (CDLIN) Annual Report

Information *Dom Hurford, Executive Medical Director*

Strategic Goals: Creating Health

Domains of Quality: Equitable

9.2.5 CDAO Annual Report 2023-24 QSC 16 May 2024 v2.pdf (11 pages)

9.2.6. Cancer Services Annual Report

Information *Dom Hurford, Executive Medical Director*

Strategic Goals: Improving Care

Domains of Quality: Timely, Safe, Person Centred, Equitable, Efficient, Effective

9.2.6 Cancer Services Annual Report QSC 16 May 2024.pdf (13 pages)

9.2.7. CTMUHB Nosocomial Covid-19 Incident Management Programme Closure Report

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

Strategic Goals: Improving Care

Domains of Quality: Timely, Safe, Person Centred, Equitable, Efficient, Effective

9.2.7 CTMUHB Nosocomial C19 Incident Mgt Programme Closure Report May 24.pdf (8 pages)

9.2.8. Human Tissue Authority Act Progress Report

Information *Gethin Hughes, Chief Operating Officer/Dom Hurford, Executive Medical Director*

Strategic Goals: Improving Care

Domains of Quality: Safe

9.2.8 HTA compliance Progress Report QSC 16 May 2024.pdf (11 pages)

9.2.9. Healthcare Inspectorate Wales Action Plan Tracker

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

Strategic Goals: Improving Care

Domains of Quality: Effective, Efficient, Equitable, Safe, Timely

9.2.9a HIW Tracker Inspection Improvement Plans-May 24v3.pdf (8 pages)
9.2.9b Appendix 1 -HIW Inspection Actions_Quality & Safety Committee 16.05.2024 v2.pdf (23 pages)
9.2.9c Appendix 2 Audit Tracker Development Work Programme.pdf (2 pages)

11:55 - 12:00
5 min

10. CLOSE OUT BUSINESS

10.1. Any Other Business

Discussion *Carolyn Donoghue, Independent Member/Committee Chair*

10.2. Highlight Report to Board - Verbal

Discussion *Carolyn Donoghue, Independent Member/Committee Chair*

10.3. How did we do in this meeting - Verbal

Discussion *Carolyn Donoghue, Independent Member/Committee Chair*

This provides an opportunity for Board Members to reflect on the meeting and in doing so may find it helpful to consider the following questions:

Is there anything we should do more or less of?

Have we managed our time well 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?

10.4. Identification of Future Spotlights and Thematic Presentations

Discussion *Carolyn Donoghue, Independent Member/Committee Chair*

12:00 - 12:00
0 min

11. PRIVATE/IN COMMITTEE SESSION

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

- MBRRACE-UK Perinatal Mortality Report: 2022 Births

12:00 - 12:00
0 min

12. DATE AND TIME OF NEXT MEETING

Monday 15 July 2024 at 1pm

Perinatal Spotlight Report

Quality & Safety Committee

16th May 2024.

Our Journey to Sustainability

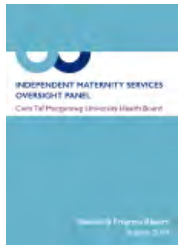
2020

2022
Targeted Intervention (Level 4)

Sept 2022
Conditions of Sustainability met
Dec 2022
Independent Oversight Panel leave

2024
Enhanced Monitoring (Level 3)

2019
Special Measures (Level 5)



2021

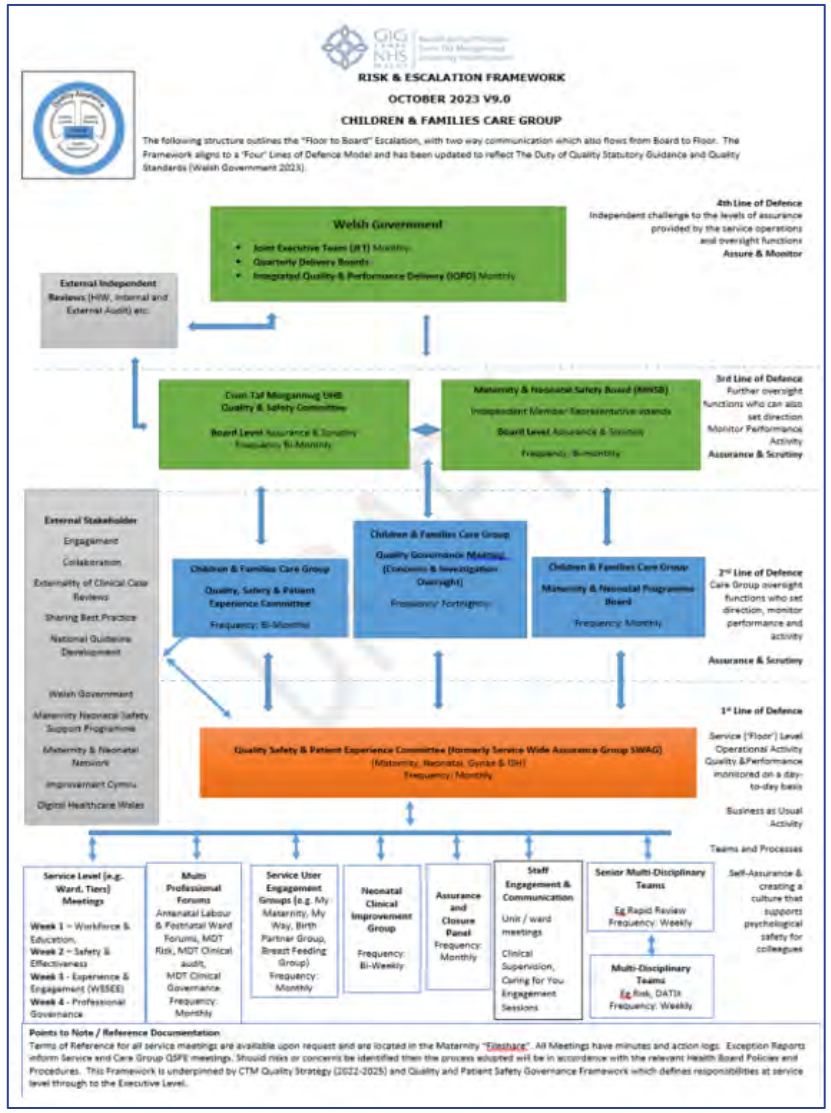
2023
Enhanced Monitoring (Level 3)

June 2023
Delivery Unit visit
July 2023
"Business As Usual"

2024
De-escalation from enhanced Monitoring

Llywodraeth Cymru
Welsh Government

Perinatal Risk Assurance & Escalation Framework



RISK & ESCALATION FRAMEWORK

OCTOBER 2023 V9.0

CHILDREN & FAMILIES CARE GROUP

The following structure outlines the "Floor to Board" Escalation, with two way communication which also flows from Board to Floor. The Framework aligns to a 'Four' Lines of Defence Model and has been updated to reflect The Duty of Quality Statutory Guidance and Quality Standards (Welsh Government 2023).

Welsh Government

- Joint Executive Team (JET) Monthly
- Quarterly Delivery Boards
- Integrated Quality & Performance Delivery (IQPD) Monthly

External Independent Reviews (HIW, Internal and External Audit) etc.

4th Line of Defence
Independent challenge to the levels of assurance provided by the service operations and oversight functions
Assure & Monitor

Cwm Taf Morgannwg UHB Quality & Safety Committee
Board Level Assurance & Scrutiny
Frequency: Bi-Monthly

Maternity & Neonatal Safety Board (MNSB)
Independent Member Representative Attends
Board Level Assurance & Scrutiny
Frequency: Bi-monthly

3rd Line of Defence
Further oversight functions who can also set direction
Monitor Performance
Activity
Assurance & Scrutiny

External Stakeholder
Engagement
Collaboration
Externality of Clinical Case Reviews
Sharing Best Practice
National Guideline Development
Welsh Government
Maternity Neonatal Safety Support Programme
Maternity & Neonatal Network
Improvement Cymru
Digital Healthcare Wales

Children & Families Care Group
Quality, Safety & Patient Experience Committee
Frequency: Bi-Monthly

Children & Families Care Group
Quality Governance Meeting (Concerns & Investigation Oversight)
Frequency: Fortnightly

Children & Families Care Group
Maternity & Neonatal Programme Board
Frequency: Monthly

2nd Line of Defence
Care Group oversight functions who set direction, monitor performance and activity
Assurance & Scrutiny

Quality Safety & Patient Experience Committee (Formerly Service Wide Assurance Group SWAG)
(Maternity, Neonatal, Gynae & ISH)
Frequency: Monthly

1st Line of Defence
Service ('Floor') Level Operational Activity
Quality &Performance monitored on a day-to-day basis
Business as Usual Activity

Teams and Processes

Service Level (e.g. Ward, Tiers) Meetings
Week 1 – Workforce & Education,
Week 2 – Safety & Effectiveness
Week 3 - Experience & Engagement (WSSEE)
Week 4 - Professional Governance

Multi Professional Forums
Antenatal Labour & Postnatal Ward Forums, MDT Risk, MDT Clinical audit, MDT Clinical Governance
Frequency: Monthly

Service User Engagement Groups (e.g. My Maternity, My Way, Birth Partner Group, Breast Feeding Group)
Frequency: Monthly

Neonatal Clinical Improvement Group
Frequency: Bi-Weekly

Assurance and Closure Panel
Frequency: Monthly

Staff Engagement & Communication
Unit / ward meetings
Clinical Supervision, Caring for You Engagement Sessions

Senior Multi-Disciplinary Teams
Eg Rapid Review
Frequency: Weekly

Multi-Disciplinary Teams
Eg Risk, DATIX
Frequency: Weekly

Self-Assurance & creating a culture that supports psychological safety for colleagues

Points to Note / Reference Documentation
Terms of Reference for all service meetings are available upon request and are located in the Maternity "Fileshare". All Meetings have minutes and action logs. Exception Reports inform Service and Care Group QSPE meetings. Should risks or concerns be identified then the process adopted will be in accordance with the relevant Health Board Policies and Procedures. This Framework is underpinned by CTM Quality Strategy (2022-2025) and Quality and Patient Safety Governance Framework which defines responsibilities at service level through to the Executive Level.

- Escalation Framework fully embedded across the Care Group
- Perinatal Safety Board bi-monthly (Senior Responsible Officer oversight, check and challenge)
- Revised leadership structure under Organisational Change Strengthened Quality Improvement and Innovation
- Care Group Leadership structure implemented
- Integrated Performance, Assurance and Assessment Sessions (IPAAF)
- Integrated Quality, Planning and Delivery Meeting (IQPD)
- Targeted Intervention (Enhanced Monitoring) Meetings

Integrated Performance, Assurance & Assessment framework (IPAAF)

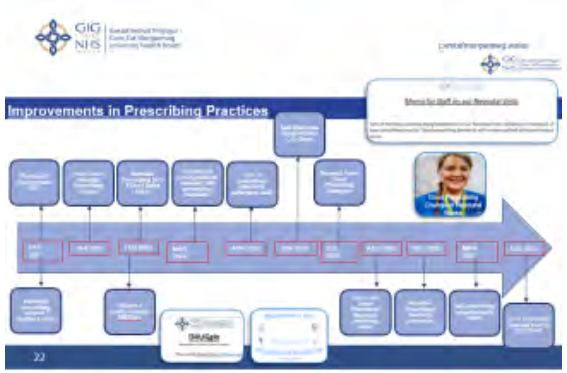
Maternity and Neonatal Joint Working IPAAF Assessment Matrix

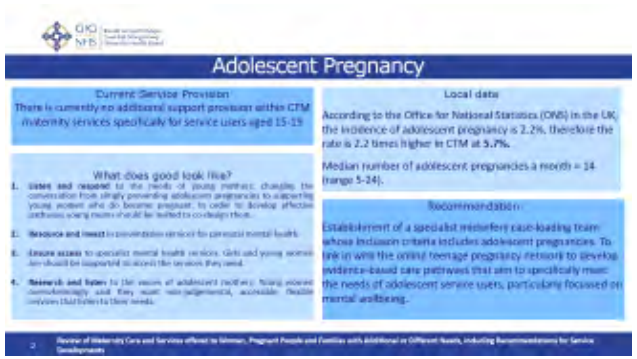
Basic	Early Progress	Results	Maturity	Exemplar
The services operate separately with limited involvement across boundaries.	The service acknowledges and understands the importance of joint working.	The service has established good practice for joint Maternity and neonatal service working	The service has mature good practice for joint working Maternity and neonatal service working	The services are fully integrated with a agreed joint strategy/vision and are setting the standards around joint working.
Relationships are overly pleasant or strained and leaders behaviours are focused only on gain for their service from the joint working. Heavy reliance on co-ordinator roles. Trust is low.	Relationships demonstrate some trust, although there is evidence of political behaviours. Behaviours also centre around representing the views of their own service and seeking the perspectives the other service. Joint values emerge. Trust is supported by rules.	Relationships are good, with challenge and new ideas being dealt with in a mature and objective way. Leaders understand the behaviours and leadership necessary for successful joint working but aren't yet consistent. Behaviours inconsistent with agreed values are challenged. Trust demonstrates an understanding and acceptance of views from the other partner.	Leaders have effective joint working relationships. They demonstrate a mature, open and objective response. Behaviours are centred around the success of both services. Features of High Trust are evident.	All staff and leaders have effective joint working relationships. They demonstrate a mature, open and objective response. Behaviours are centred around the success of both services. Features of High Trust are evident at all levels.
Key Words: Confusion, unreliable, immature, unplanned.	Key Words: self-aware, emerging, fledgling, understand, acknowledge	Key words; planned, variable, progressing, inconsistent	Key words: stable, resilient, clear, evidenced, embedded, consistent, reliable, sustained	Key words: Excellent, excel, first to..., best practice, setting the standard, innovative

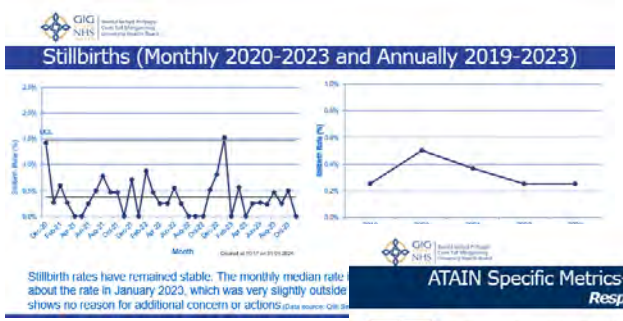
Maternity Assessment 30.11.23	Basic Level	Early Progress	Results	Maturity	Exemplar
Safe and Effective Care				Y	
Quality of Women's and Family Experience					Y
Quality of Leadership and Management				Y	
Joint Maternity & Neonatal Working				Y	

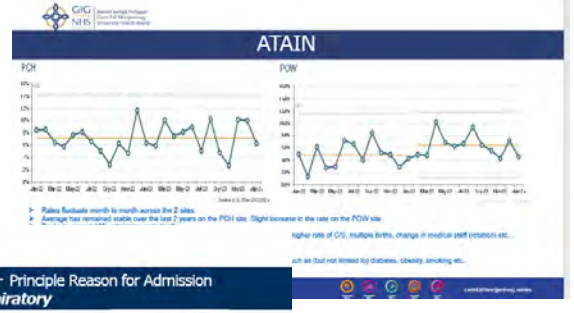
Neonatal Assessment 6.12.2023	Basic Level	Early Progress	Results	Maturity	Exemplar
Safe and Effective Care				Y	
Quality of Women's and Family Experience				Y	
Quality of Leadership and Management				Y	
Joint Maternity & Neonatal Working				Y	

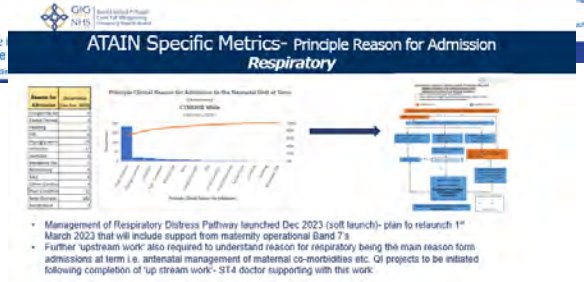
Safe & Effective Care







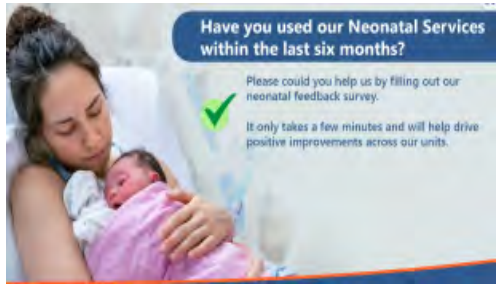




- Clinical Dashboard – Time Series Data (Exemplar across Wales)
- Perinatal Safety Support Champion
- Improvements in prescribing
- Gap Analysis
- 'Wash Up Plan' Monitoring
- Sustained high compliance with Emergency Skills & Drills, Fetal Monitoring and Surveillance
- Research & Development – Midwife & Nurse led research opportunities
- Quality Improvement Framework – Improvement in Practice training
- Shared Learning across Wales
- Gynae Hub
- Review of Population Health to aid service development and workforce planning
- MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) – Thematic Reviews
- Safe Care
- Safe to Start

Quality of Women, Birthing People & Families Experience

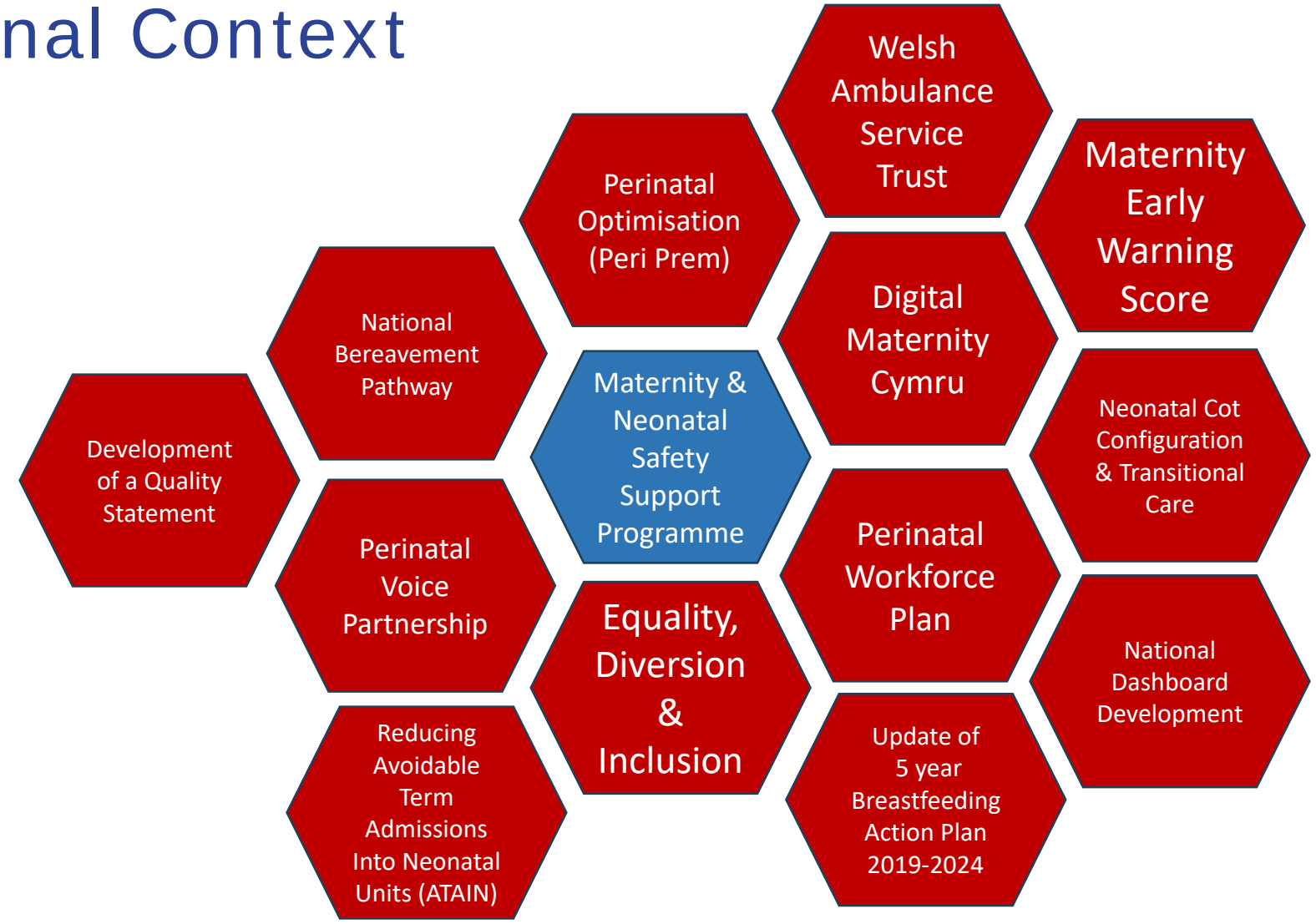
- 15 step challenge
- Annual thematic review – benchmarked against Care Quality Commission Standards (NHS England)
- Presented as per Assurance Framework
- 7 Minute Briefings (concerns)
- Health Board Patient Reported Experience Measures (PREM) & Engagement highlighted as exemplary across Wales (Framework)
- Breast Feeding Initiative Accreditation – achieved within both Neonatal Units, Maternity at Princess of Wales. Prince Charles Hospital Maternity Unit Assessed 10 & 11 April
- Family Integrated Care Embedded (continually benchmarking best practice across United Kingdom)
- Vast improvements in bereavement care (early pregnancy loss)
- Infant Feeding Strategy
- Transgender Guideline
- Baby Showers, partnership working with Local Authorities
- Bump Talk / Social Media Engagement
- Equality, Diversity and Inclusion - Cultural Competency Training



Quality of Leadership & Management

- All nursing and midwifery leadership posts permanent
- Two Consultant Midwives in post, Senior Nurse Neonates 6.5.24, Head of Midwifery for Princess of Wales Hospital recruited 24.4.24
- Medical lead roles assigned
- Clinical Directors for obstetrics, gynaecology, paediatrics appointed April 2024.
- Caring for You / Leadership & Culture Plans in place
- Leadership development (courses, away days, shadowing opportunities)
- Behaviour Garage
- External facilitation – Human Factors & Psychological Safety
- Targeted support from Employee Well-Being Teams
- Wellbeing Activists, Learning Reps, Health and Safety Reps
- Awards, Conferences, Shadowing
- Labour Ward Coordinator Development Framework
- Preceptorship
- Supporting Guernsey with Clinical Supervision for Midwives
- Dealing with conflict role play
- Active recruitment (rolling midwifery and nursing adverts)
- Streamlining
- Training & Learning Needs Analysis in place

The National Context



Challenges & Next Steps

On the 26th of April 2024, the Cabinet Secretary for Health and Social Care announced that maternity and neonatal services at CTM will be de-escalated from enhanced monitoring to routine arrangements, along with quality and governance, leadership and culture, and trust and confidence. Our journey of continuous improvement and our mission to achieve clinical excellence will continue, ensuring positive engagement with stakeholders and our communities.

- Maternity & Neonatal Voice Partnership – Remunerated Chair
- Single Maternity Digital Information System
- Perinatal Engagement Strategy Update
- Perinatal Vision Update
- Outstanding neonatal workforce actions to be completed (Allied Health Professionals)
- Perinatal Staff Survey to be repeated
- Review of Internal Governance, Assurance & Compliance Process
- Maternity Neonatal Safety Support Programme Cymru Implementation
- Princess of Wales Maternity and Neonatal Refurbishment
- Rising Intervention Rates
- Perinatal Morbidity & Mortality
- Safe to Start
- Perinatal Workforce Plan
- Community Transformation Project

Agenda Item
5.1

Quality & Safety Committee

Clinical Executive Directors Report

Dyddiad y Cyfarfod / Date of Meeting	16/05/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	• Greg Padmore-Dix – Executive Director of Nursing / Deputy CEO • Dom Hurford-Executive Medical Director • Lauren Edwards-Executive Director for Therapies and Health Sciences, • Philip Daniels-Executive Director Public Health
Cyflwynydd yr Adroddiad / Report Presenter	Greg Padmore-Dix- Executive Director of Nursing / Deputy CEO • Dom Hurford-Executive Medical Director • Lauren Edwards-Executive Director for Therapies and Health Sciences, • Philip Daniels-Executive Director Public Health
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Greg Padmore-Dix- Executive Director of Nursing / Deputy CEO • Dom Hurford-Executive Medical Director • Lauren Edwards-Executive Director for Therapies and Health Sciences, • 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 / Individuals	Date	Outcome
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
RGH	Royal Glamorgan Hospital
CTM UHB	Cwm Taf Morgannwg University Health Board
POW	Princess of Wales
AHP	Allied Health Professionals
CD	Clinical Directors
HB	Health Board
HEIW	Health Education and Improvement Wales
PCH	Prince Charles Hospital
GMC	General Medical Council
HTA	Human Tissue Act
HTARI	Human Tissue Act Reportable Incident
ABUHB	Aneurin Bevan University Health Board
DHCW	Digital Health and Care Wales
CEO	Chief Executive Officer
RGH	Royal Glamorgan Hospital
ITU	Intensive Care Unit
CMU	Clinical Medical Unit
DERS	Drug Error Reduction Software
MS	Member of the Senedd
RCSLT	Royal College of Speech and Language Therapists
SLT	Speech and Language Therapists
MDT	Multi-Disciplinary Team
SAD	Speech Awareness Day
AHP	Allied Health Professional
HCS	Health Care Support
SDEC	Same Day Emergency Care
MSK	Musculoskeletal
WHC	Welsh Health Circular
MMR	Measles Mumps Rubella
PTR	Putting Things Right
PALs	Patient Advice Liaison Service
IPC	Infection Prevention Control
HCAI	Health Care Acquired Infections

1. Situation /Background

1.1 This paper presents to the Quality & Safety Committee an overarching update from the four Clinical Executive Directors, this being:

- Greg Padmore-Dix, Executive Director Nursing/Deputy Chief Executive
- Dom Hurford-Executive Medical Director
- Lauren Edwards-Executive Director of Therapies & Health Science
- Philip Daniels-Executive Director of Public Health

The paper highlights to the Committee some of the key successes and challenges from across the organisation together with identifying the associated risks as we continue to advance with our commitment to provide high quality patient centred care across the whole of Cwm Taf Morgannwg University Health Board.

Additional information and assurance against the quality metrics, together with Patient Experience activity continues to be reported to the committee through the Quality, Safety & Patient Experience Dashboard.

2. Clinical Executive Directors updates:

Section 2.1

Nursing & Midwifery-CTMUHB Executive Director of Nursing / Deputy CEO Report

This Executive Summary presents a comprehensive overview of the current landscape at CTM University Health Board (UHB), highlighting the pivotal achievements and ongoing challenges faced by the Nursing Directorate. As we navigate through a dynamic healthcare environment, our commitment to advancing patient care, staff well-being, and operational efficiency remains steadfast. This report outlines our recent successes which demonstrate our dedication to innovation, quality improvement, and effective leadership. Simultaneously, it acknowledges the challenges that lie ahead, requiring strategic focus and collaborative efforts to ensure the continuous provision of high-standard healthcare services. Through this summary, we aim to provide a clear understanding of our progress, the hurdles we face, and the strategies employed to overcome them, reflecting our dedication to excellence in nursing and healthcare delivery within CTM UHB.

2.1.1 Achievements

Realignment within the patient care and safety team

As of April 2024, the Deputy Executive Director of Nursing has set out to realign some of the portfolios in order to improve and streamline processes to meet the needs of the organisation. Peoples experience is now delivered under the direction of the Assistant Director of Quality and Safety, this will ensure closer alignment to

the PTR function, with closer partnership working between our concerns team and our PALs officers.

This change will also enable the Assistant Director of Nursing to oversee the harm free care agenda, through supporting the Deputy Executive Director of Nursing in providing leadership on areas such as pressure damage prevention, safeguarding, inpatient falls reduction, hydration and nutrition; IPC as well as clinical/nurse education and professional nursing.

2.1.2 CTM Infection prevention and control strategy 2024-27

The strategy has been developed with the aim of supporting the Health Board's to provide the safest, most effective care possible whilst attending to All Wales national drivers. The strategy seeks to provide the Board and CTM community with sufficient assurance that appropriate structures and processes are in place to minimise the risks of health care acquired infections (HCAI) to patients, staff. The strategy will be the road map to how the IPC service is delivered across CTM, seeking to improve access for clinicians seeking operational and strategic IPC advice, organisation surveillance as well as providing assurance in better uses of data and clinical intelligence.

2.1.3 Substantive funding for clinical leadership in bereavement care

CTM has been provided with substantive funding to ensure the commitment to bereavement care across the region. The successes realised in CTM of the past year, led by our Clinical Lead for bereavement care, will mean we continue to prioritise care for some of most vulnerable patients and relatives as well as continue to innovate on new ways of working both internally and through working with our partners.

2.1.4 Present Challenges

2024/25 financial efficiencies

Ensuring the balance between financial efficiency and the delivery of high-quality care can be a challenging balance to strike. This year, the patient care and safety team will be designing processes to ensure that additional scrutiny is applied to decisions on service delivery as well as non-pay in order to demonstrate value for money whilst maintaining high standards in quality.

Portfolio leads will continue and develop the work started in subsequent years, whilst also providing the Executive Director of Nursing a full options briefing to ensure decisions made for financial efficiencies are fully understood both in benefits as well as consequences.

2.1.5 Strategic review of services

Concurrent to new CTM wide strategies for 2024-27, IPC and safeguarding are also strategically reviewing service delivery models to ensure both alignment to the new organisational structure as well as regional and national priorities and policy. In realising the output for both IPC and safeguarding services, leaders will

be ensuring engagement locally and regionally to ensure service teams, stakeholders and wider networks are able to participate in expressing their views and provide evidence to inform the resulting decisions. It is anticipated that processes for both IPC and safeguarding will draw to a conclusion in Q3 2024.

2.1.6 Boarding Beds

Unscheduled care provision and the additional boarding beds continue to place increased pressure on our nursing staff and the poor experience of our patients. In light of several incidents, our escalation protocol is under revision which will include a revised risk assessment process for those patients who are allocated into boarding beds.

Section 3.1 Medical Directorate-CTMUHB Medical Director

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:

- New Breast Theatre in RGH (South Theatre RGH)
- Ward 10 POW
- Conclusion of the CD appointment process and new Care Group structure.
- National Epilepsy Audit (Royal College of Paediatrics and Child Health)

3.1.1 Achievements

New Breast Theatre in RGH (South Theatre RGH)

The former Maternity theatre in RGH has been refurbished and opened for the Breast surgery team. This allows for a dedicated place for the pan-CTM service and will lead to an improved experience for our patients and teams in a dedicated area.

3.1.2 Ward 10 POW

Recent ward round with the Chair has shown progress of the Multi-Disciplinary team approach (nurses, doctors, AHPs) in using the Whiteboard and championing the Red to Green approach for discharges. We were told team morale has improved and the whole team are working closer together and supporting one another. Really positive to hear the changes.

3.1.3 Conclusion of the CD appointment process and new Care Group structure.

There has been a huge effort to adopt the new successful, more robust, appointment process. From this, there is now a mix of experienced and new senior leaders across CTMUHB from all specialties and areas. A development programme is being developed for these staff members as we move to a CTM approach across the Health Board.

3.1.4 National Epilepsy Audit (Royal College of Paediatrics and Child Health)

CTM were confirmed as an 'excellent outlier' for the audit measure of Epilepsy nurse input for children with epilepsy.

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

- HEIW PCH Emergency Department placed under GMC enhanced monitoring
- Human Tissue Act (HTA) issue (HTA Reportable Incident – HTARI)
- Patient Data sharing and records between CTUHB and ABUHB.

3.1.6 HEIW PCH Emergency Department placed under GMC enhanced monitoring.

This has happened despite a very positive HEIW review of training where trainees have rated their experience and training very highly by the PCH Emergency Department team. The rationale for the referral has been due to perceived concerns over the sustainability of the Consultant body's ability to deliver training (of the current high standard). We have very clear plans in place to mitigate any risks and to develop the training further on the site. The Unscheduled Care Group are working closely with the Assistant Medical Director for Education to deliver this. The PCH Emergency Department is an essential component of the future direction of CTM.

3.1.7 Human Tissue Act (HTA) issue (HTA Reportable Incident – HTARI)

This is regarding the outsourcing of tissue samples for histology. We have had 5 cases of retained tissue samples that have now been returned by an external provider. Our learning is from a governance perspective on tracking of any external samples. We no longer use this outsourcing company. Relatives are being contacted and the sensitive disposal of any remaining samples is being undertaken.

3.1.8 Patient Data sharing and records between CTMUHB and ABUHB.

There is a difference in software between the two Health Boards with ABUHB using a different system to other HBs in Wales – CTM use the Welsh Clinical Portal. As such, we are unable to access and share patient records or results between ABUHB and CTM – this is a particular issue in PCH where there are a lot of patient cross over of borders. It is an area we are actively managing but the solution is not in CTM's control. We are reliant on DHCW managing a solution and at this stage the proposed solution is not immediate and there are no practical steps to resolve in the near future. This is a risk and needs to be registered as such, however, we cannot resolve it ourselves other than continuing to raise it as an urgent matter at an All Wales level.

Section 4.1 Therapies and Health Science- Executive Director of Therapies and Health Sciences

This section of the paper provides an update from the Therapies and Health Science portfolio.

4.1.1 Audiology Department

The Audiology Department recently underwent a number of external quality audits regarding their provision of tinnitus and balance services. Scores are yet to be fully ratified, but both services were positively appraised.
The CEO will receive a report in due course.

The Head of Audiology was instrumental in the collaboration with colleagues from Health Education and Improvement Wales (HEIW) to continue with the national drive to introduce job planning for healthcare scientists.
A time and motion study was completed, it is anticipated that this will feature in a National Healthcare Science Research and Innovation strategy document.

4.1.2 Clinical Engineering

Following three years of supporting the Covid-19 pandemic, the Clinical Engineering backlog of planned preventive maintenance and reactive work has now reduced significantly.
Clinical Engineering plan to regain ISO9001:2015 quality certification in the future.
Clinical Engineering colleagues have been carrying out vital small group 'train the trainer' work for bladder scanners. This well-received work ensures the consistent quality of care for patients. The department is planning the installation of a support central station monitoring system (for RGH and PCH). This will be used to centrally monitor patient telemetry systems, for example in ITU/CMU.

Clinical Engineering are leading the roll out planning for new infusion pumps in POW. When installed, they will enhance safety and security and have drug error reduction software (DERS) built in.

4.1.3 Medical illustration

Healthcare Scientist colleagues in medical illustration continue to drive down dermatology waiting lists by having a significant input into the tele-dermatology clinics.

4.1.4 Speech and Language Therapy

MS Huw Irranca-Davies visited POW stroke ward in February with RCSLT Wales and our local stroke specialist SLT as part of the 2024 Swallow Awareness Day

(SAD2024). An excellent plenary speech later given by the MS, along with good social media coverage (link to plenary clip).
As part of SAD2024, one of the Head and Neck Specialist SLTs also attended the Senedd event. As a result, MS Sarah Murphy is now planning to visit the MDT Head and Neck support clinic held on the Tenovus bus in Bridgend in the summer.

4.1.5 Physiotherapy

As part of building an Advanced Practice and Extended Scope workforce as articulated within the AHP framework for Wales and our Health Board AHP/HCS Delivery Plan, we have developed two such roles within physiotherapy. An Advanced Clinical Practitioner Physiotherapist started as part of SDEC (same day emergency care) work in POW in March and we will be interviewing for our first Consultant MSK physiotherapy post in April 2024.

Section 5.1 Public Health-Executive Director of Public Health

This section of the paper provides an overarching update on the following areas within the remit of Public Health and highlights the achievements, challenges and issues/risks.
This section of the report covers the following areas and highlights the achievements, issues and challenges:

- Health Protection, including vaccination and immunisation
- Healthy Weights
- Henry Programme

5.1.1 Health Protection, including Vaccination and Immunisation

Key achievements in this work areas include:

- In line with Welsh Health Circulars (WHC), establishment of MMR vaccination catch up programmes for schools with <90% uptake, and CTM staff.
- Development of measles pathway for use within UHB, and planning group established to support measles pathway planning for Parc prison.
- Roll out of spring COVID booster programme.

5.1.2 Key Issues and Challenges:

- In relation to the staff MMR WHC, ongoing Information Governance considerations/queries in relation to process for confirming staff vaccination status.
- Limited vaccinator resource to manage ongoing spring COVID booster programme as well as MMR catch up programmes.
- Limited capacity and resource to fulfil wider health protection asks due to team structure (fixed term contracts/lack of progression with recruiting into Health Protection roles).

5.1.3 Healthy Weights

Grant Funding Continuation:

We are pleased to report confirmation of our grant funding of at least the same amount as 23/24 by the Welsh Government until March 2025. This continued support enables us to persist in our mission of promoting health and well-being within our communities. The exact amount of the grant is still to be determined but we expect a letter confirming the figure in the near future.

Collaborative Efforts:

Our team collaborates closely with Local Authorities, community groups, and key public services to draw together effort towards our goal. We focus on making healthy choices accessible while providing solid support to individuals striving for healthier lives.

Holistic Approach:

Central to our strategy is a holistic, whole-system approach that addresses the underlying factors contributing to obesity. Rather than focusing solely on individual behaviours, we tackle broader community issues to create sustainable change.

Stakeholder Engagement:

Over the past year, we have engaged with over 150 stakeholders across Cwm Taf Morgannwg, gathering insights into the root causes of obesity in our communities. This input has highlighted three critical areas for our focus: Babies' First 1000 Days, Access to Good Quality Food, and the use and design of Community Spaces.

Initiatives and Collaborations:

We have already seen progress through collaborative initiatives, such as the development of a Healthy Travel Charter and an infant feeding strategy. Our partnerships with organisations like Merthyr Valleys Housing Association have facilitated positive changes within the community.

Ongoing Efforts:

Our work continues as we engage with families to better understand their experiences and needs regarding infant feeding and community spaces. Guided by a human learning systems approach, we seek to drive meaningful, lasting change in our region.

Alignment with Strategies:

Our initiatives align with the Healthy Weight Healthy Wales Strategy and the Cwm Taf Morgannwg University Health Board Our Health Our Future 2030 vision, ensuring coherence with broader health objectives.

5.1.4 Revolutionizing the HENRY Programme for 2024

Healthy Education and Nutrition for the Really Young (HENRY) provides a wide range of support for families from pregnancy to age 12 including workshops, programmes, resources and online help.

Programme Transformation:

In preparation for this transformative shift, we have temporarily paused referrals for the 8-week programme. This hiatus allows us to prioritize the voices of our families, ensuring that our revamped service offering truly meets their needs.

Core Principles:

While undergoing transformation, the core principles of the HENRY programme remain unchanged. We continue to focus on bolstering parenting confidence, promoting healthy family lifestyle habits, and fostering nurturing routines and mealtimes.

Community Engagement:

Our free bespoke workshops, available across CTM, remain a vital component of our commitment to supporting families. We have invited families throughout the region to join us on this journey towards a brighter, more inclusive future.

Communication Channels:

To keep the community informed, regular updates are provided via our Facebook Page: Healthy Start Healthy Future. Additionally, families can reach out to the HENRY team directly via email for more information.

The revamped HENRY programme represents our dedication to adapting and evolving to better serve the needs of our community. We look forward to embarking on this journey towards improved health and well-being with families across CTM.

6. Specific Matters for Consideration

Matters for consideration are detailed in the sections above.

7. Key Risks / Matters for Escalation

7.1 There are currently no further risks which require escalation to the Quality and Safety Committee as all risks have been highlighted under each section of the report. Assurance is provided that all matters outlined within this report are being addressed through each of the four reporting teams led by the respective Clinical Executive Directors.

8. 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	Living Well
	If more than one applies please list below: 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))*	Safe
	If more than one applies please list below: Effective Efficient Equitable Person Centred Timely
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* Quality *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: 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.
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): NEUTRAL Outcome for Welsh Language (delete as appropriate): NEUTRAL	If no, please include rationale below: Content of this report is applicable to all patients and provides equal access to healthcare with specific EqIAs completed at the right point of time. All reports are available in Welsh.
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 report covers items as a broad update for assurance to the committee however, under the directorship and leadership of the four Clinical Executive Directors who hold joint responsibility for this report, there is a collective strive and dedicated commitment to protect the health board's reputation.	
Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

9. Recommendation

9.1 The Quality and Safety Committee are asked to NOTE the contents of this bi-monthly report.

10. Next Steps

10.1 The Quality and Safety Committee will continue to receive progress updates together with achievements, new challenges and identified risks through future reporting via this Clinical Executive Directors bi-monthly report. In addition, some verbal updates to this report will be provided where applicable by the respective Clinical Executive Director.

Agenda Item
5.2a

Quality & Safety Committee

Highlight Report from the Mental Health and Learning Disabilities Care Group

Dyddiad y Cyfarfod / Date of Meeting	16/05/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Lloyd Griffiths, Head of Nursing
Cyflwynydd yr Adroddiad / Report Presenter	Ana Llewellyn, Nurse Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	
AMAT	Audit Management and Tracking system
CDAT	Community Drug and Alcohol Team
CMHT	Community Mental Health Team
CSIW	Care Standards Inspectorate Wales
HIW	Health Inspectorate Wales
HMP	His Majesty's Prison
LA	Local Authority
MHA	Mental Health Act
MHLD	Mental Health and Learning Disability
NRI	Nationally Reportable Incident

OPMHS	Older Peoples Mental Health Services
PICU	Psychiatric Intensive Care Unit
PPPF	Care Group Planning Performance People and Finance Meeting
QSRE	Quality Safety Risk and Experience Meeting
RGRP	Right Care Right Person
RGH	Royal Glamorgan Hospital
RCT	Rhondda Cynon Taf
SBUHB	Swansea Bay university Health Board
SSP	Student Streamlining Project
SWP	South Wales Police

1. Introduction

1.1 This report had been prepared to provide the Committee with details of the key issues considered by the Mental Health and Learning Disabilities Care Group at its meeting on 10th April 2024.

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

2. Purpose of this Meeting

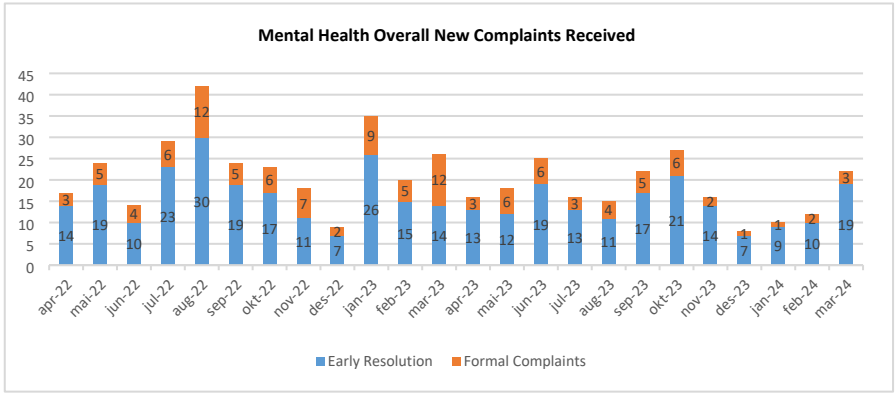
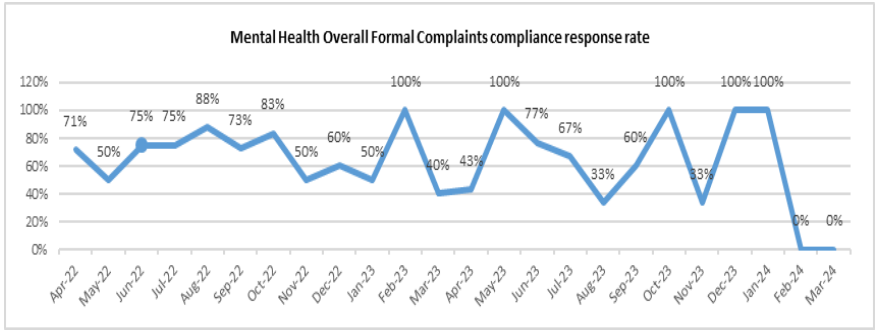
2.1 The purpose of the Care Group is to provide assurance to the Board on the provision of workplace health & safety and safe and high-quality care to the population we serve, including prevention through public health, primary and secondary care.

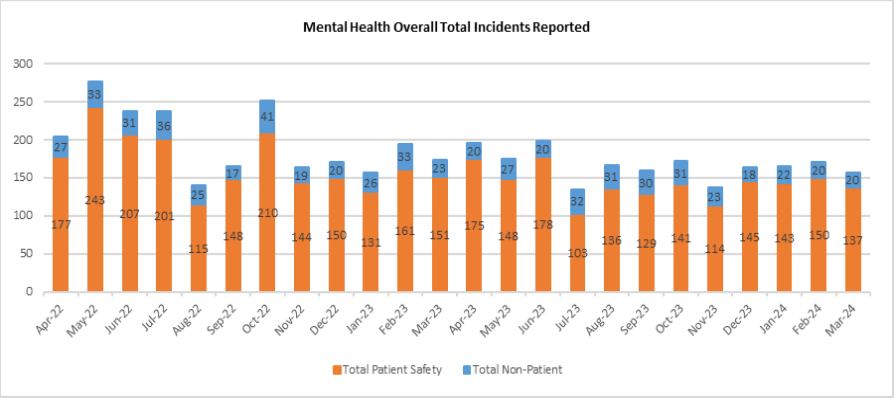
2.2 The Mental Health and Learning Disabilities Care Group QSRE Board will:

- Put the needs of patients, carers and the public at the centre of all its business.
- Provide evidence based and timely advice to the Mental Health and Learning Disabilities Care Group, based on local need, to assist in discharging its functions and meeting its responsibilities.
- Provide assurance to the Mental Health and Learning Disabilities 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	• Acuity and occupancy levels on the adult acute wards has been consistently high during this reporting period. This is manifested in increased episodes of violence and aggression, with limited access to psychiatric intensive care. This is being managed by utilisation of increased staffing levels, increased presence of clinical leaders and robust care and treatment planning. • Registered Nurse vacancies remain a significant challenge and a key area of focus, for example the band 5 RN vacancy rate in the Adult Inpatient directorate is 46%. This picture is mirrored on across our OPMHS wards. Changes to shifts patterns, bed numbers and operating models are being piloted by the care group to mitigate this. The completed nursing establishment review was discussed and its recommendations endorsed by the Care Group at our Planning Performance People and Finance meeting and will now be escalated for consideration through the Health Boards approval process.
Advise	• The Care Group is reviewing the anti-ligature audits of all 15 MHLD wards and updating the Ligature Policy. This will be presented at the Care Groups QSRE meeting in June. • The Prison In Reach Team at HMP Parc have considerable capacity issues due to staffing issues which has led to a waiting list. Demand and capacity work is underway and as mitigation bank staff and overtime are being used to underpin the service while the Adult Community Directorate explore more permanent options to support the service. The Care Group is part of a multi-disciplinary Strategic Oversight group which is meeting in response to the recent unexpected deaths at HMP Parc. • Community Mental Health Services have noticed an increase in unexpected deaths particularly drug related deaths. It is not clear at present if this is statistically significant. The Lead Nurse in the Adult Community Directorate is working with the Head of Quality and Patient Safety and Harm Reduction Lead to better understand what is driving this and whether this is part of a national pattern. An update will be provided via the Adult Community highlight report to the Care Group's June QSRE meeting.

	• Llais conducted an unannounced visit to Seren Ward which is an OPMHS ward at RGH, no official feedback has been received as of yet.
Assure	• The number of complaints received by the Care group is higher than previous months but remains within the mean for past year.  Complaint closure compliance in the MHLD Care Group was 0% during this reporting period, however, the low volume of formal complaints (5 received in total in February and March and just 1 closed) can artificially skew the reporting and contributes to a perception of variation in closure compliance performance in the Care Group.  At the time of compiling this report at the end of April there are 5 open formal complaints (up from 2 in the last reporting period). • Datix incident reports remain at a consistent level. The HoN is working with the Business Intelligence Manager in the Patient Care and Safety team on the development of datix dashboards which will be the first to go live in the Health Board.



- There are 2 open NRIs (down from 4 since the last report) both of these are overdue but nearing completion.

  There were no new NRIs reported during this period. There was a NRI and Early Warning Notice (EWN) submitted in April following the death of a person under adult inpatient services.

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

Project overview

Project	No. audits	Current compliance	Improvement	Overdue actions
Health & Safety	2	98.5%		1
Health and Care Standards	1	96.3%		2
Infection Control	4	99.6%		3
Medicines Management	2	98.8%		0
Patient Safety	14	93.6%		14

There are 14 overdue actions in the Patient Safety category which are causing the amber grading, these all relate to Infection, Prevention & Control (IPC) and falls, mainly in OPMHS and have been escalated through the Lead Nurses to be addressed.

- The Care Group has completed a review of the historic Regulation 28 - Report to Prevention of Future Deaths issued by His Majesty's Coroner to ensure that the learning associated with these continues to be monitored. The learning from the Regulation 28s received by CTM UHB was presented at the MHLD National Quality, Safety and Learning Group where 3 historical action plans were re-opened, these will be monitored via the Care Group's QSRE meetings.

Inform	• The OPMHS inpatient team at Angelton clinic continue to work with Improvement Cymru on falls prevention and recently presented their work so far at the Safe Care Collaborative. The scale and spread of the project has been praised and early indications are that the project is reducing variation across the OPMHS directorate. • Recruitment to the MHLD Service Improvement team is progressing well, the Senior Nurse for Quality Assurance and Improvement is now in post and the senior Nurse for Professional Development out to advert. • The Care Group CDAT service have held an annual multi-agency service development day, to agree priorities and celebrate joint working. • HIW, Care Inspectorate Wales (CIW), and Estyn are conducting a joint national review on "How are healthcare, education, and children's services supporting the mental health needs of children and young people in Wales?". The Care Group has submitted a self-assessment and are awaiting to be informed if we will be 1 of the 3 HBs reviewed further. • The Child and Adolescent Mental Health Service (CAMHS) Schools In Reach team (SHINE) have produced and published a YouTube podcast aimed at parents about the importance of managing sleep and exam stress. More podcasts relating to the emotional wellbeing and mental health of Children and young people are due to be rolled out April 2024. • The Goal Attainment Scale (GAS) outcome measure is now in place at Angelton for all new admissions after consultation with patients and their families. A well-attended GAS workshop was facilitated by the Assistant Psychologist Assistant who is auditing the results of the first stage of implementation.
Appendices	None

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Ageing Well
	If more than one applies please list below: Growing Well Living Well Dying Well
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Enablers of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Learning, Improvement & Research
	If more than one applies please list below: If more than one applies please list below: Culture and valuing people Learning, improvement and Research Leadership
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Domains of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Effective
	If more than one applies please list below: Efficient Person centred Equitable Timely Safe
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	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:	If no, please include rationale below: Not applicable

Have you undertaken a Quality Impact Assessment Screening?		
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please include rationale below: Not applicable
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
5.2b

Quality & Safety Committee

Highlight Report from the from the Children & Families Care Group

Dyddiad y Cyfarfod / Date of Meeting	16/05/2024
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	
BFI	Baby Friendly Initiative
CTM	Cwm Taf Morgannwg
CYP	Children and Young People
EWN	Early Warning Notification

HIW	Health Inspectorate Wales
HPV	Human Papilloma Virus
HV	Health Visiting
IDM	International Day of the Midwife
ISH	Integrated Sexual Health
JICPA	Joint Inspectorate Review of Child Protection Arrangements
LA	Local Authority
MMR	Measles, Mumps & Rubella
PCH	Prince Charles Hospital
PMRT	Perinatal Mortality Review Tool
PROMPT	Practical Obstetric Multi-Professional Training
QSRE	Quality, Safety, Risk & Experience
RCM	Royal College of Midwives
RCPCH	Royal College of Paediatricians and Child Health
RCT	Rhondda Cynon Taff
SLA	Service Level Agreement
SSN	Special School Nursing
WG	Welsh Government
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 Children and Families Care Group at its meeting on 11th April 2024.

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 Children & Families Care Group Quality, Safety, Risk and Experience Meeting (QSRE) 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	• Industrial Action within Health Visiting (HV) services by UNITE members commenced 26.02.24 until 31.07.24. Regular meetings with Workforce, Care Group and Unite members continue to try to resolve. Subsequent discussions taking place with Rhondda Cynon Taff (RCT) Local Authority (LA) about the potential breach to the Service Level Agreement (SLA). Risk assessments and mitigation in place, Risk Register updated, Early Warning Notification (EWN) submitted. • Integrated Sexual Health (ISH), Gynaecology Outpatients and Obstetric Antenatal Clinic at Ysbyty Cwm Cynon (YCC) relocated to Primary Care Resource Centre on Friday 12th April 2024 to support Unscheduled and Planned Care Groups. • Essential work required to Labour Ward and Neonatal Unit at Princess of Wales Hospital. Paper presented to Executive Leadership Group on 22nd April 2024. Plans being developed. Risk assessment completed and added to Organisational Risk Register 18.4.24
Advise	• Health Inspectorate Wales (HIW) Unannounced Visit to Maternity Services at Prince Charles Hospital (PCH) January 2024, report due to be published 26th April 2024. Improvement Plans accepted by HIW, monitoring in place within the service group. • Health Inspectorate Wales (HIW) visit to Paediatric Ward at Princess of Wales (POW) – Immediate actions undertaken, medication room temperature regulation work still outstanding due to estates required. Risk Assessments and mitigation in place. Daily temperature monitoring continues. • Service level agreements for special school nursing have expired. There is inequity of service provision across CTM, recruitment & retention challenges of special school nurses (SSN). The Association of Special School Heads have raised concern across Wales to Welsh Government (WG) Local meetings are scheduled during April, in attempt to strengthen relationships with the LA. Benchmarking and model review in progress. • Theatre table in Labour Ward at POW replaced. Risk de-escalated and removed.

	• Clinical supervisors for midwives at Cwm Taf Morgannwg (CTM) supporting clinical supervision for Guernsey colleagues. • School Entry Hearing Service (SEHS) – Cwm Taf Morgannwg (CTM) in breach of their responsibility to implement direction from Welsh Government (WG) to handover the governance arrangements of the programme to audiology services. Discussions within Operational Management Board (OMB) and between Children & Families and Planned Care to seek solution.
Assure	• Bridgend health visiting service have been experiencing increased pressures: with caseloads subject to priority plan. Improved position in April: 3 new HVs recruited and 3 returning from long term absence. • Children's ward at Prince Charles Hospital (PCH) has 6.18 WTE vacancies & 3.6 Maternity Leave from May. Mitigation, scrutiny and oversight in place through use of Bank, Additional Hours, Overtime and Agency where necessary. • Measles, Mumps & Rubella (MMR): Pathways in place across Paediatric Assessment Units and wards. Staff vaccinations carried out across all service areas. Central vaccination team invited all primary and secondary aged children into the vaccination centres over Easter. School Nursing will vaccinate any outstanding secondary school pupils alongside Human Papillomavirus (HPV) programme • Children & Young People (CYP) Safeguarding Improvement Plan (following the Joint Inspectorate Review of Child Protection Arrangements (JICPA) in Bridgend) monitored within Safety & Effectiveness and Safeguarding Operational meetings. • Infertility clinics have been re-located to main out patients department at POW, to enhance the experience and avoid distress of an antenatal clinic location. Further work with outpatient colleagues being explored for remaining gynaecology out-patient clinics to be re-located. • Service-wide Perinatal Loss Forum commenced 26.1.24, monthly meetings to Quality Assure and finalise Perinatal Mortality Review Tool (PMRT) investigations. On target to complete 2023 cases by 31.5.24. • Practical Obstetric Multi-Professional Training (PROMPT) annual report received, all actions complete and compliance achieved.

- Breast Feeding Initiative (BFI) assessment undertaken for PCH maternity services 10-11th April 2024. Informal feedback shared an overall 'sound' result. Few outstanding actions to complete within six months to achieve full accreditation.

- Manual Handling risk within midwifery services de-escalated due to increased compliance.

Inform

Risk ID	Description	Score
2808	Waiting times for performance Neurodevelopmental team	15
5755 New risk added 18.4.24	Essential work required within Maternity and Neonatal Unit at PoW (Electrical UPS/IPS & Air Exchange)	20

- Notification received from Ty-Hafan informing Health Boards that access to the offer of pre-booked respite/ short breaks will no longer be available. Impact will be monitored within the service group, as potential risk of increased referrals for Continuing Care as a result

- Research & Development (R&D) have approved the "CTM Play in Hospital" scoping study, evaluating the play provision for inpatients in CTMUHB district general hospitals. There are plans to develop a CTM Play Strategy as the benefits to patient care and outcomes are recognised. This scoping study will support the development of a business case.

- Values and behaviours training with the 'Behaviours garage' arranged for Summer 2024 to equip staff to address dignity at work issues, improve culture and foster a positive and respectful approach to addressing inappropriate behaviours and promoting professionalism and trust.

- Senior Nurse Neonatology commences 6th May 2024.

- Children & Young People Directorate Manager commenced 2nd April 2024.

- Clinical Director Appointments made April in Children and Young People, Obstetrics, Gynaecology and ISH

- Maternity & Neonatal Safety Support Programme National (Phase 2) launch event 15th May 2024.

	• Celebration events planned for International Day of the Midwives (IDM) and International Nurses Day (May 2024) across the Care Group. • Two midwifery abstracts accepted for national Royal College of Midwives (RCM) Conference in Liverpool May 2024. • Formal letter received from the RCPCH congratulating the CTM Paediatric Epilepsy team for being a positive outlier in terms of Epilepsy Specialist Nurse input to children and their families
Appendices	• None Attached

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: • Living Well • Growing Well
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Enablers of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Whole-systems Perspective
	If more than one applies please list below: • Culture and Valuing People • Leadership • Learning, Improving and Research
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Domains of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Safe
	If more than one applies please list below: • Timely • Equitable • Efficient

	• Effective Person Centred
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* Quality *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not a policy / guideline
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please include rationale below: Not applicable
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
5.2c

Quality & Safety Committee

Highlight Report from the Diagnostics, Therapies, Pharmacy and Sciences Quality, Safety, Risk and Experience (QSRE) Meeting

Dyddiad y Cyfarfod / Date of Meeting	16/05/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Lisa Love-Gould- Clinical Director of AHPs
Cyflwynydd yr Adroddiad / Report Presenter	Lisa Love-Gould- Clinical Director of AHPs
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Lauren Edwards, Executive Director of Therapies & Health Science

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	
AHP	Allied Health Professionals
CDs	Controlled Drugs
DI	Designated Individual
DTPS	Diagnostics, Therapies, Pharmacy & Sciences
HIW	Healthcare Inspectorate Wales
HTA	Human Tissue Authority

IABT	Independent Authorisation of Blood Component Transfusion
INR	International Normalised Ratio
ISO	International Organisation for Standardisation
LHP	Llantrisant Health Park
OCP	Organisational Change Policy
OMB	Operational Management Board
PCH	Prince Charles Hospital
POW	Princess of Wales Hospital
QA	Quality Assurance
RGH	Royal Glamorgan Hospital
RSI	Repetitive Strain Injury
RTT	Referral to Treat Time
SLA	Service Level Agreement
UKAS	United Kingdom Accreditation Service
USC	Urgent Suspected Cancer
WLI	Waiting List Initiative
MCCD	Medical Certificate of Cause of Death
HMPPS	HM Prison & Probation Services
PHW	Public Health Wales

1. Introduction

1.1 This report had 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 22nd April 2024.

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

2. Purpose of the QSRE 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 and Safety 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.

3. Highlight Report

Alert / Escalate	<u>Radiology</u> <u>Radiopharmaceutical provision (Risk ID 5590) Risk score 20.</u> • Ongoing business interruption for Radiopharmaceuticals provision. Reduction in provision planned from 22/04/24 – 03/05/24 due to SBUHB needing to do some compliance work for maintaining their MHRA licence. All patients are being seen based on a clinical prioritisation basis during this period. The reduced level of production is likely to impact on non-urgent patient care. • Mitigations include, support from Bristol for additional vials. SLA drafted and sent to commissioning and Chief Pharmacist for sign off. Prioritising sentinel node biopsy injections to enable Breast Surgery lists to continue. Trialling Magtrace as an alternative to Isotope -will need funding to support this longer term. Urgent Suspected Cancer (USC) bone scans are impacted but will offer an alternative scan if appropriate. <u>No Health Board MRI Pacemaker Service (Risk ID 5730)</u> • Recent MHRA guidelines state that all Health Boards providing MRI pacemaker services should have access to a MR physicist and cardiac physiology to support service development and all necessary aspects of MR safety issues. CTM does not currently have an MRI Pacemaker service as we have access to physics but not cardiac physiology and so are not compliant with the latest statutory requirements. • Patients with cardiovascular implantable electronic devices (CIEDs) specifically pacemakers (PPMs) and defibrillators are disadvantaged because of poor access to MRI scans, leading to potential late and/or misdiagnosis particularly for cancer and neurological disease.

	• Risk escalated to Medical Director and Organisational Risk Register. • Funding has been found to start a small service to cover emergencies and some cancer cases where no alternative modality will answer the clinical question. Cardiac physiology are scoping how this can be done, with the next meeting on May 9th when we will plan rollout.
Advise	<u>Pharmacy and Medicines Management</u> Controlled Drugs liquids: incidents reported on multiple sites of volume discrepancies for Oxycodone. Team is looking into alternate ways of monitoring to ensure easier detection of spillage/wastage. This will mean a cost pressure for clinical areas; plan to be developed for next DTPS QRSE. Action continuing Homecare: All Wales supply restriction for biosimilar Hyrimoz (Adalimumab). Supplier served notice on current Welsh contract to end on 30.6.24. No new patients to be initiated. 250 pts currently established on Hyrimoz must switch to alternative brand of Adalimumab by 28.6.24. Pharmacy have developed a switching plan to ensure patients receive timely supplies of alternative biosimilar medication. This has been communicated to clinical teams. Financial risk to health board as alternative products is currently more expensive. Discussed at OMB and EQIA has been developed. Community Pharmacy: Ongoing concerns about pharmacies' lack of robust access to shared NHS email inboxes raised at Community Pharmacy Digital Applications Board. WG requested to explore potential solutions with DHCW as a matter of urgency Cross sector: Datix raised by raised by Community Health Wellbeing Team. Investigation completed by Meds Management. Themes include: • poor documentation in Primary and Secondary Care • unclear rationale for prescribing decisions • use of guidelines without considering individual's situation • poor communication between sectors. Actions include: • communication with pharmacy teams in primary and secondary care in relation to opioid and analgesic prescribing and documenting interventions to be developed and circulated • Ongoing development of education, training, and information around antibiotic and analgesic prescribing for teams in primary and secondary care.

- High dose opioid prescribing and frequent hospital admission: Ongoing liaison and support to GP. Work with POW pharmacy and medical teams on admission. Communication across the interface. Highlights lack of services for people with complex pain and high-risk medicines use, also risks to prescribers.

Radiology

Backlog in imaging (Risk ID 4152)

- Month on month increase in demand on CT in hours and OOH. Current demand outstripping capacity. Risk currently scored at 16.
- All patients are being seen based on clinical prioritisation. All USC are being scanned within 10-15 days.
- Waiting list profile growing and routine waits increasing.
- Business Case underway to request support for additional funding/resources to tackle CT demand.

Pathology

UKAS:

June 2024 will see the 4-year re-assessment, and also assessment against the recently revised ISO 15189:2022 standards. This will be an important assessment for Pathology. A gap analysis has already been undertaken and an action plan is being progressed to ensure compliance with the new standards.

HTA – Reportable Incident:

The Health Board is investigating an incident in relation to the outsourcing of tissue samples for histology. There have been 5 cases of retained tissue samples that have now been returned by an external provider. Learning is underway from a governance perspective on tracking of any external samples. The outsourcing company involved in this incident is no longer used by the Health Board. Relatives are being contacted and the sensitive disposal of any remaining samples is being undertaken.

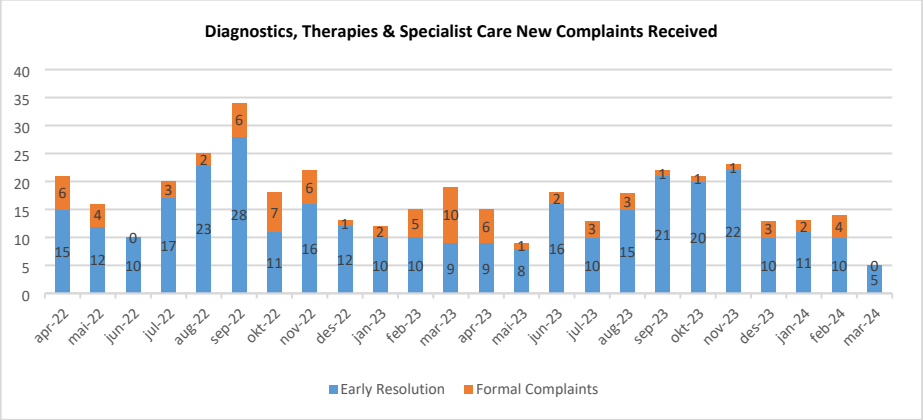
Haematology Harm Reviews:

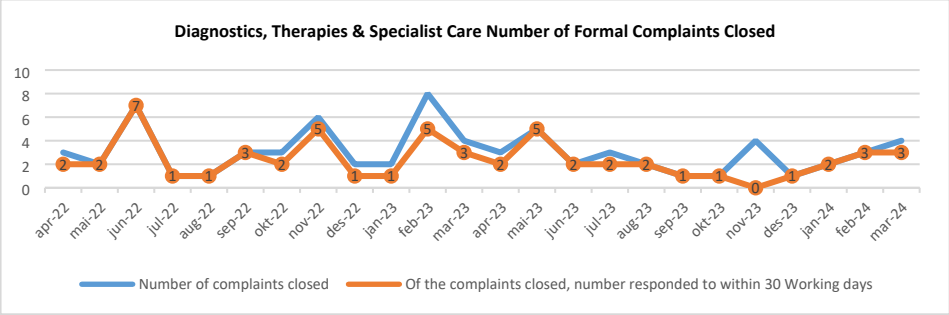
All Clinical Haematology harm reviews have now been closed on Datix, with a panel date of 28th March 2024. There is concern around 6 remaining harm reviews for patients that have attended POW. Clinical Haematology services for POW patients are provided by Swansea Bay under SLA. Swansea Bay has been notified of these outstanding reviews and this is noted on the Datix records. The reviews date back to March 2022.

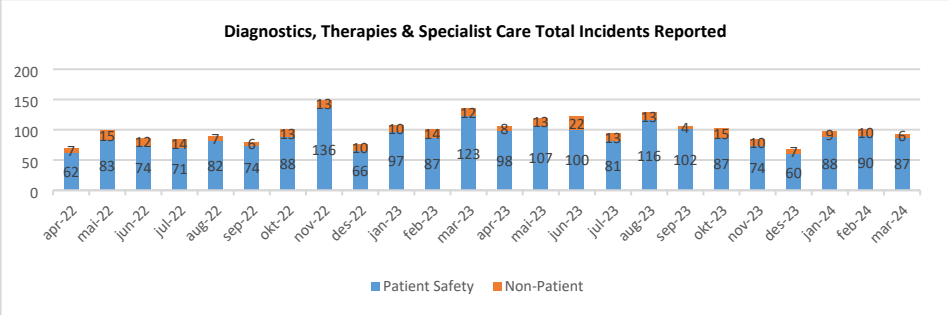
PCH Pathology Refurbishment:

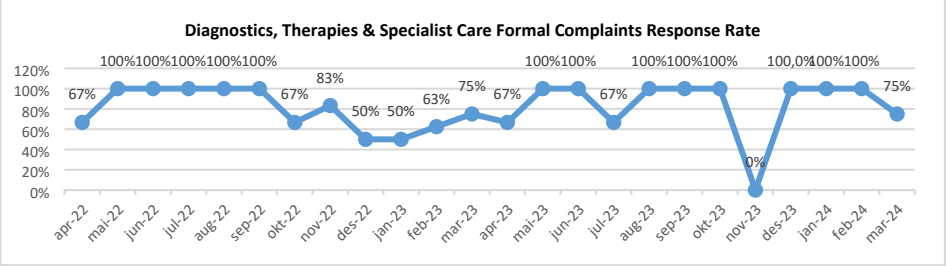
	The remaining sections of pathology are planning to move to the new build in September 2024. The move will include extensive validation/verification of existing and new equipment that will require considerable staff resource and time to complete. The team will try to minimise disruption to services during the move, however there is concern around the provision of the routine Biochemistry service during this time. Death certification reform and Medical Examiners: A legal framework for a statutory, unified system of independent Medical Examiners for all deaths in England & Wales will come into force 9th Sept 2024. All deaths will be independently reviewed by ME or Coroner. Introduction of new MCCD form to support the process.
Assure	<u>Pharmacy and Medicines Management</u> Recent internal audit conducted by NWSSP considered governance and control arrangements of the management of controlled drugs (CDs) process. This was undertaken in line with the 2023/24 Internal Audit Plan for Cwm Taf Morgannwg University Health Board. [Correction from previous report- an 'old' draft was provided to us by NWSSP] The assurance summary has found that all areas had 'reasonable' assurance. The overall report was 'reasonable': This means some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved. The matters that require attention are: • Reinforcement of some processes in place for the management of CDs, such as the maintenance of an up-to-date authorised CD signatory list and safekeeping of CD order book and register. Some CD cabinet keys were part of a bunch of other keys • A system in place to monitor and view the trends regarding the use of CDs distributed across the sites. An action plan has been agreed between Medicines Management and Central Patient Safety Team. <u>Death in custody in HMP Parc:</u> • 6 Deaths in Custody over a 3-week period. 4 suspected drug related Spice/Nitizine deaths, so considerable scrutiny within the establishment • Commitment to engage Pharmacy in rapid reviews • Naloxone now provided to G4S staff for administration within the establishment. 2 further deaths were prevented by the introduction of training and wider carrying of naloxone (as a reversing agent) by the G4S security team

	(training being coordinated by Dyfodol Training - De Cymru - South Wales - Drug Education) • Joint group now convened with G4S, HMPPS, CTMUHB, www.wedinos.org and PHW to consider how agencies can better work together • Need to consider how we can work more closely across CTM and improve lines of communication within establishment. Meeting planned with Nursing and Primary Care Radiology • Non-obstetric ultrasound (NOUS) backlog clearance delivered an improved trajectory as per performance scorecard. At 22/04/24 there are 413 patients waiting over 8 weeks on a continual improvement trajectory. • MRI backlog reduction actions underway. Mobile MR Unit is now operational on LHP site. Longest waiting routine patients are currently being booked. Pathology An incident occurred in August 2023 where the Biochemistry department discovered an issue with the automated haemolysis index for folate results. This could potentially have led to erroneously high folate results dating back to 2014. Since 2014 around 290,000 folate results have been issued, these results were reviewed using several biological/analytical parameters and complex calculations. The review has narrowed the number down to 109 living patients and 220 deceased patients where an erroneous folate result may have had clinical impacted patient care. A meeting was held on 24th April to discuss next steps for the patients identified. Guidance was provided and the incident has resulted in the Biochemistry service reviewing their haemolysis index value for the folate test, and there is now a more robust mechanism in place for detecting haemolysis in folate samples.
Inform	DTPS Complaints received and Compliance









Radiology

PDR/Core Mandatory Training Compliance

PDR Compliance - Jan 70.75%, Feb 75.08%, March 79.19%
Core Mandatory Training Compliance - 63.12% Jan, 69.65% Feb, March 71.27%
Manual Handling Update: currently have one trainer and have scheduled the 2 days training once a month throughout 2024, allowing for 6 members of staff to be trained a month.

There are plans for another trainer to increase to 12 trainees per month. Plans for train the trainer training availability in the next 2 months.
Future planning: train more workplace assessors to support maintaining compliance and audit.

Basic Life Support: the in-house RGH trainers have started delivering training.

Pharmacy and Medicines Management

Use of new medication in Parkinson disease: New SLA for ProDuodopa (foslevodopa/foscarbidopa) signed with Health Net. Patient is titrated on Medical Day Unit over a few hours
Our CTM consultant has registered the first patient to start treatment on 15th April. This is the first patient in Wales to receive this treatment.

Therapies

Triangulation of learning from incidents, concerns and compliments
Corporate reports list zero compliments for most profession within DTPS care group, leading to an inability to triangulate learning and a missed opportunity to acknowledge these. Discussion re this at DTPS QSRE. Action agreed to review how other Care Groups record compliments within DATIX.

Occupational Therapist (OT) within community Navigation Hub

Welsh Government funding to enhance AHP workforce in our community has enabled an Occupational Therapist to join the clinical team in the Navigation Hub. The service can now assess patients, especially frail elderly patients, in their own homes or residential/nursing homes from a MDT holistic perspective.

An initial GP and OT assessment:

- Ensures there is a holistic assessment to prevent future falls or deterioration/crises that would amount to repeated ambulance or A+E attendances,

	• Enables medical intervention to complement and synergise with social/functional implementations to provide the best potential outcome for a patient to succeed and thrive in the community, achieved without an ambulance attendance or A+E admission, which is remarkable in its own right. • Delivers system efficiencies: Initial MDT assessment saves both another GP visit and @Home initial assessment and/or allows the @home referral to be downgraded to less urgent given an initial MDT contact and assessment has already been achieved.
Appendices	• No 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
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Living Well
	If more than one applies please list below: 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))*	Data to Knowledge
	If more than one applies please list below: Whole systems perspective Leadership Learning, Improvement and Research
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: Person centred Timely, Safe, Equitable, Efficient
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 at this point
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please include rationale below: No policy so not undertaken
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	Yes (Include further detail below)	
	As outlined in the report. PLR issue in particular	
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.

[i]

[i] The HTARI item on page 5 was redacted post meeting of the Q&S Committee due to information of a sensitive nature being shared. Once investigations are complete the Committee will receive a full report on this matter.

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

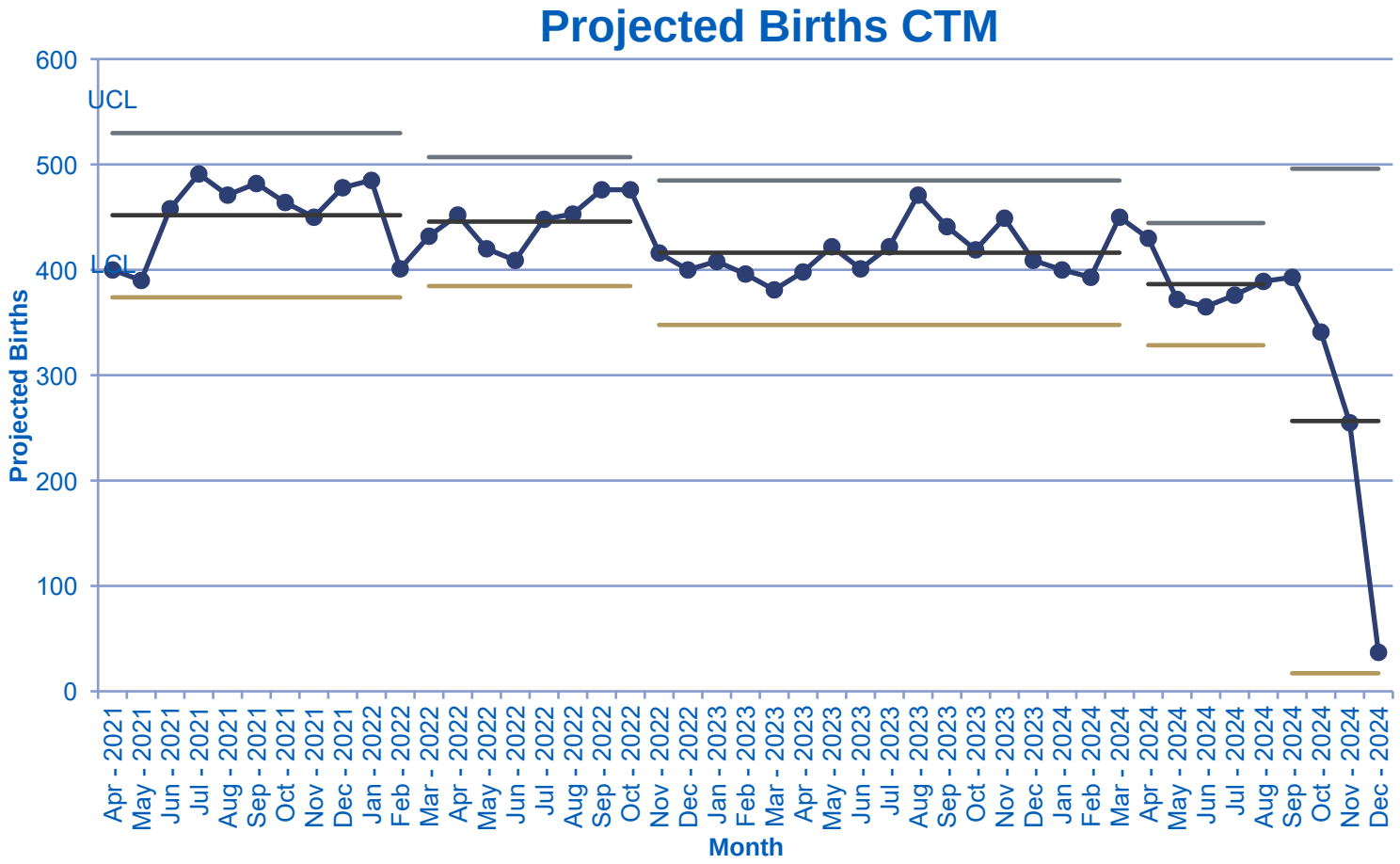
Maternity Metrics:

Clinical Dashboard & Quality Improvement Update

April 2024

Elinore Macgillivray, Consultant Midwife for QI and Population Health
Jodie Hodges, Perinatal Safety Support Champion

Projected Births CTM April 2021- Dec 2024

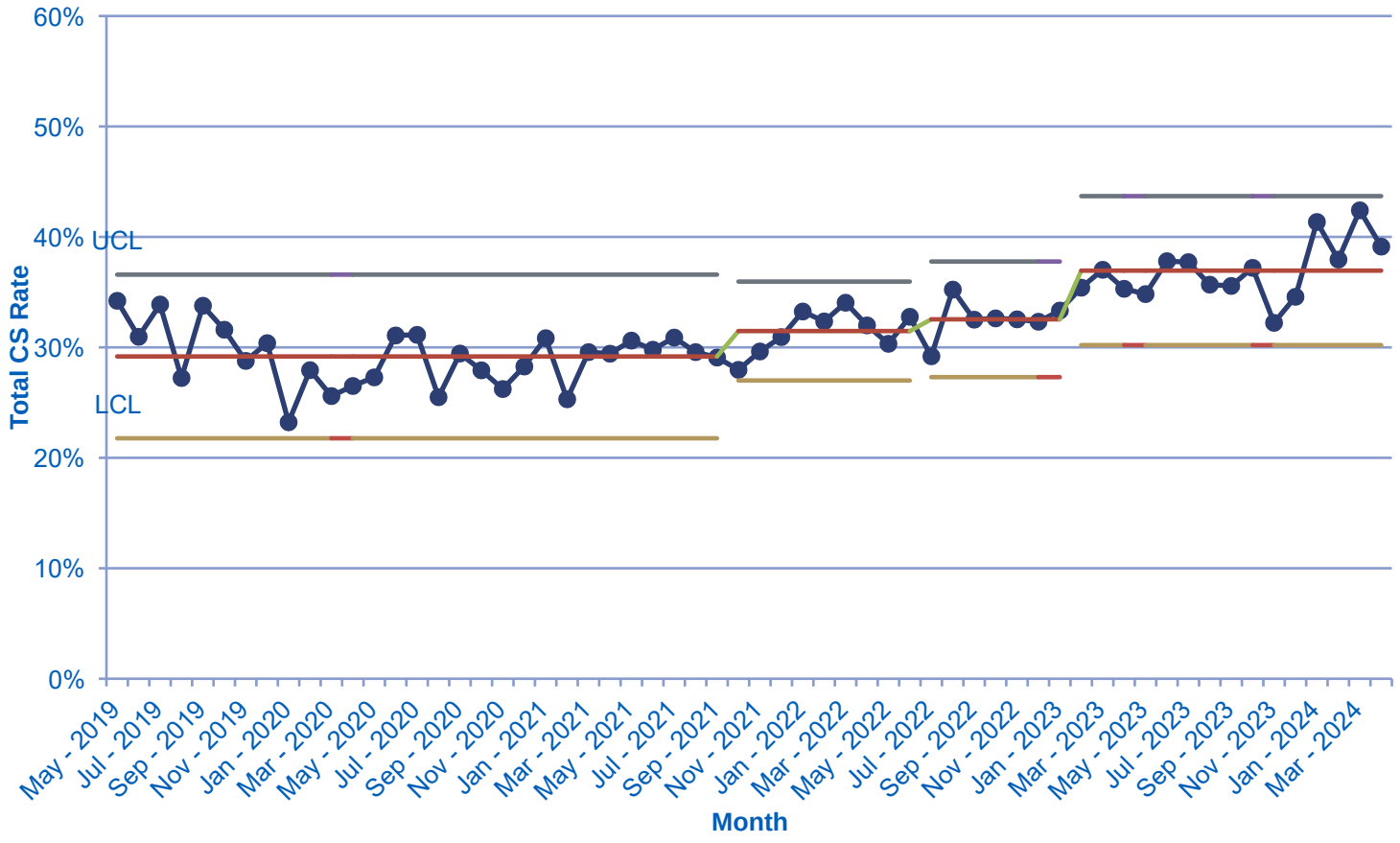


The median number of projected births was 445 per month until October 2022, when it decreased to 416.

The median number of projected births from May 2024 is 386.

From October 2024, the projections become less reliable as women with EDD's from that time on may not have been booked for maternity care as yet.

Caesarean Births: total rate for CTM May 2019- April 2024

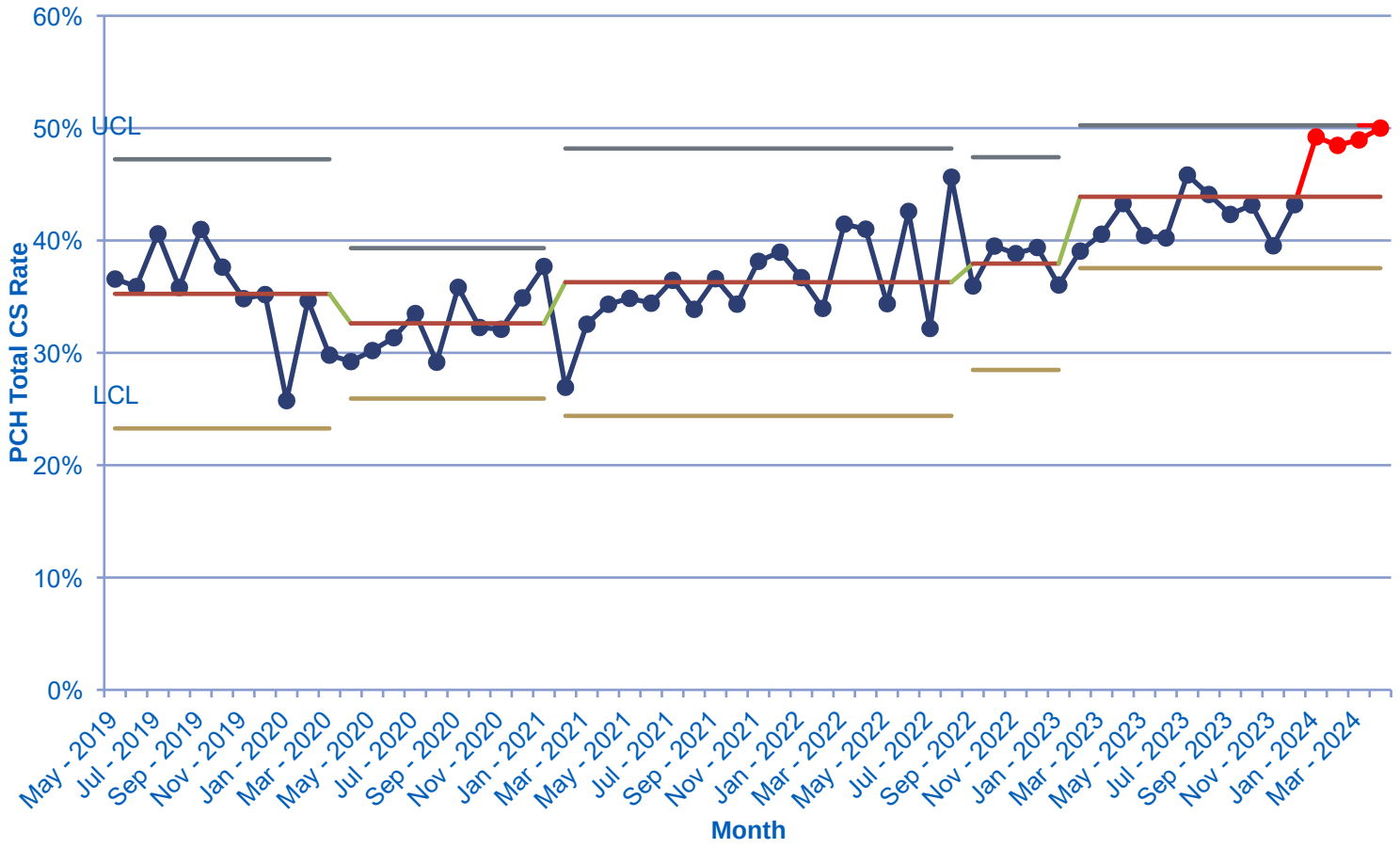


The total median CS rate has risen from 29% in 2019 to the current median of 37%.

Each month of 2024, there have been higher monthly CS rates than in any month in previous years.

The highest rate was in March 2024 at 42.4%.

Caesarean Births: total rate for PCH May 2019- April 2024

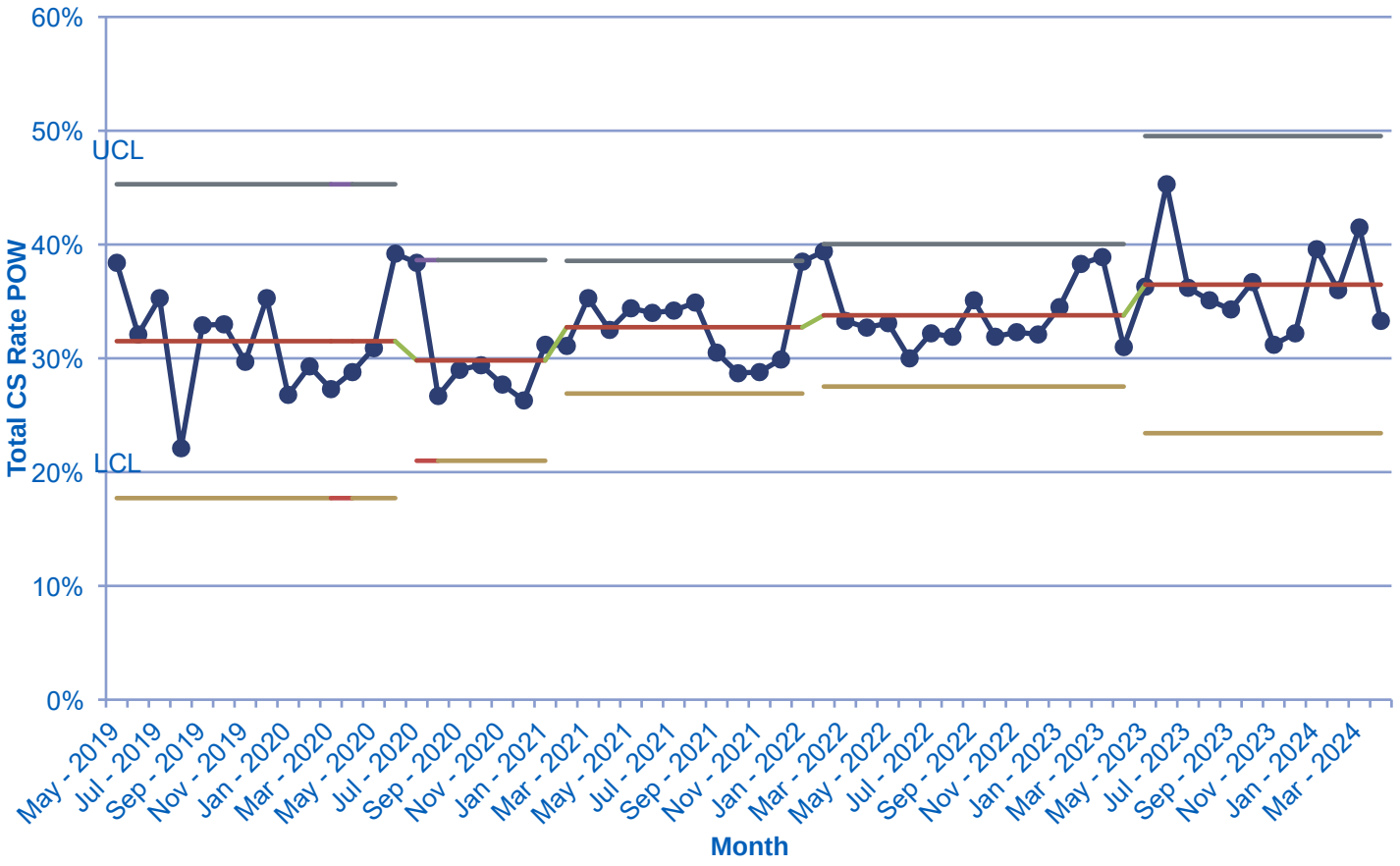


The total median CS rate at PCH rate was 35% in 2019. In April 2020, the rate decreased to 33%, then increased to 36% in January 2021.

The current median CS rate as of March 2023 is 44%.

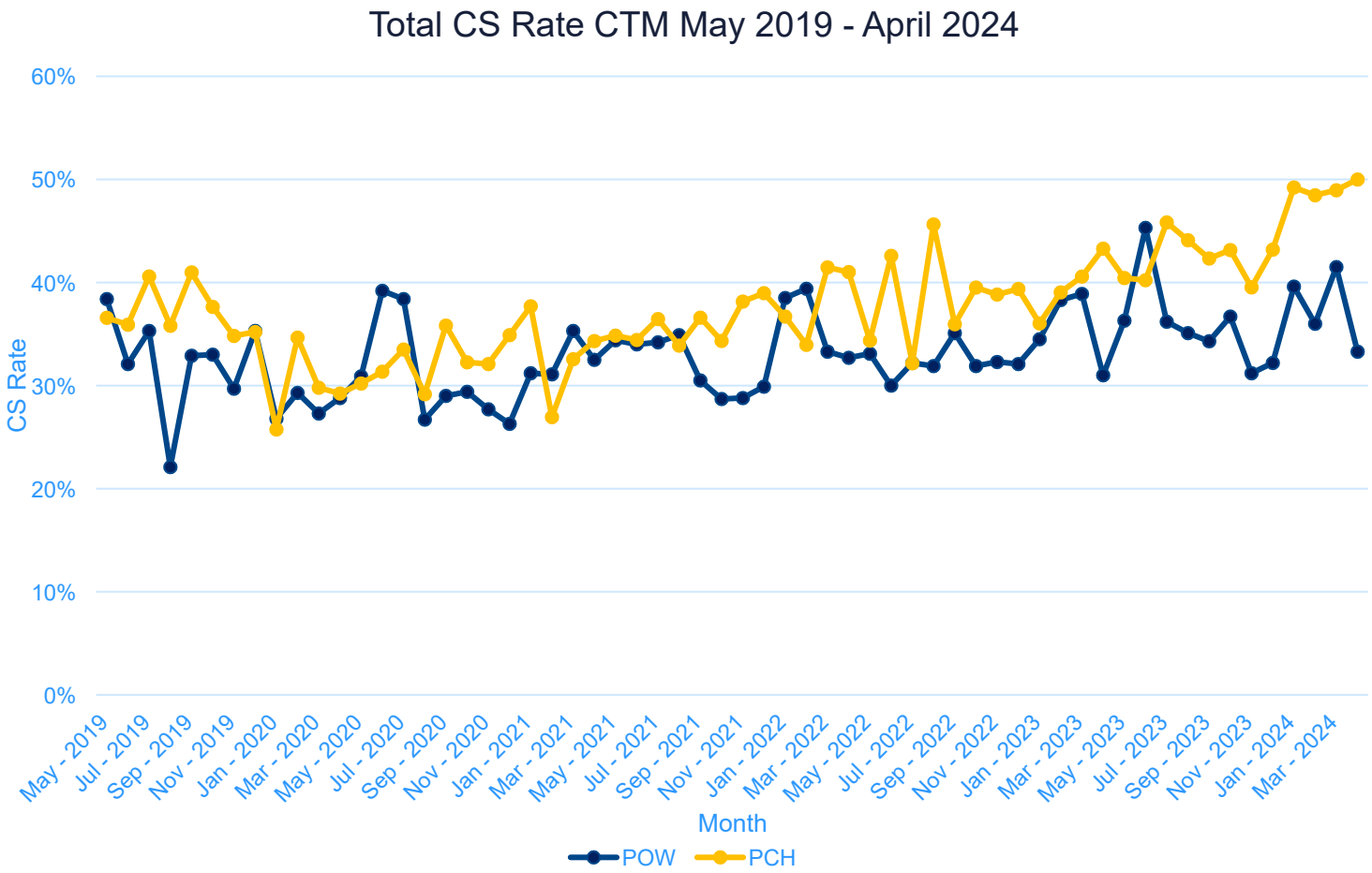
There has been a sharp rise since January 2024, with the total CS rate each month of between 48-50% of all births.

Caesarean Births: total rate for POW May 2019- April 2024



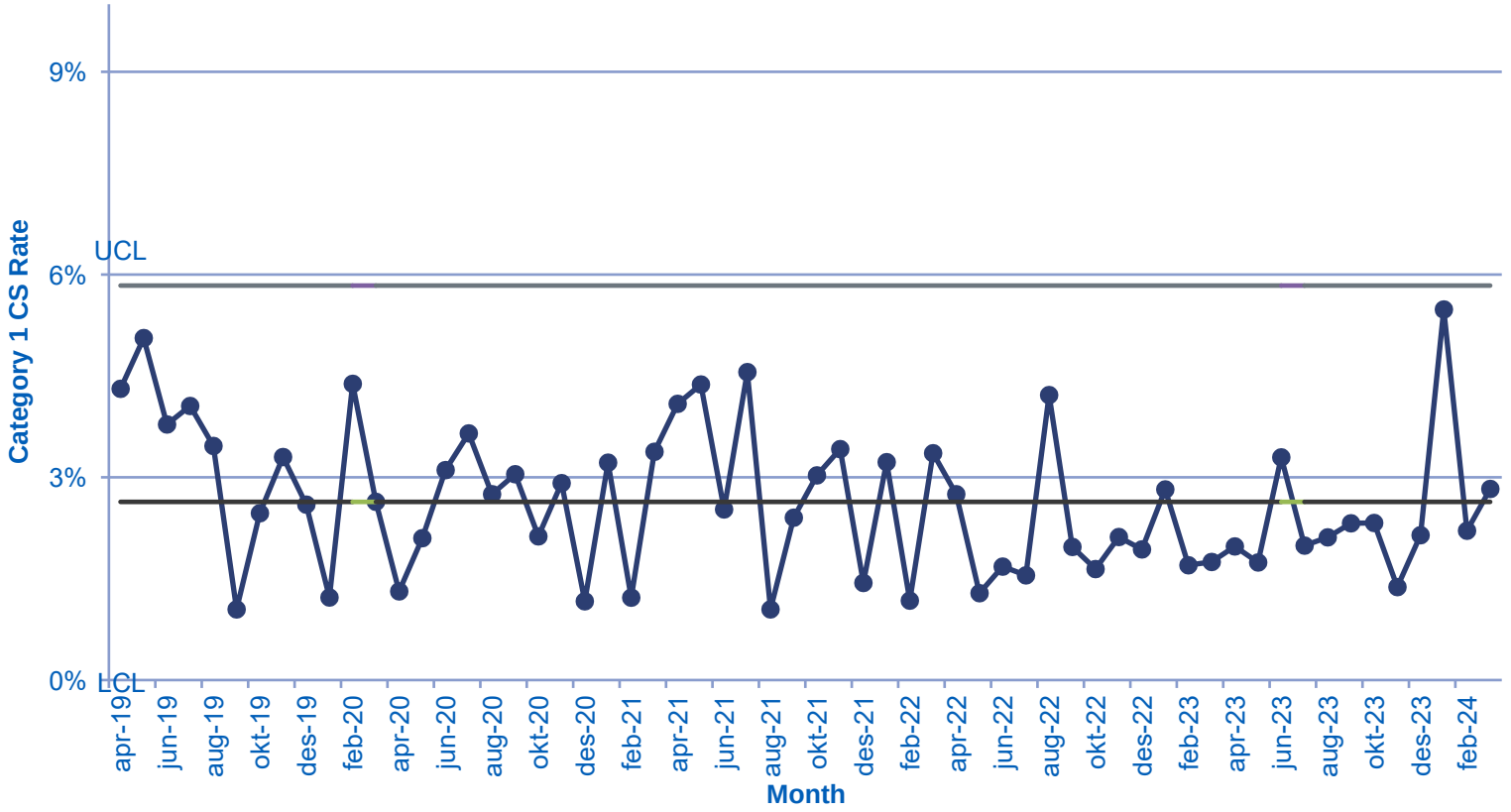
The total median CS rate at POW was 32% in 2019, then decreased slightly to 30% in July 2020. from February 2021, the rate was 33%, rose to 34% in January 2022 and is currently 37% (as of May 2023).

Caesarean Births: rate for POW and PCH May 2019- April 2024



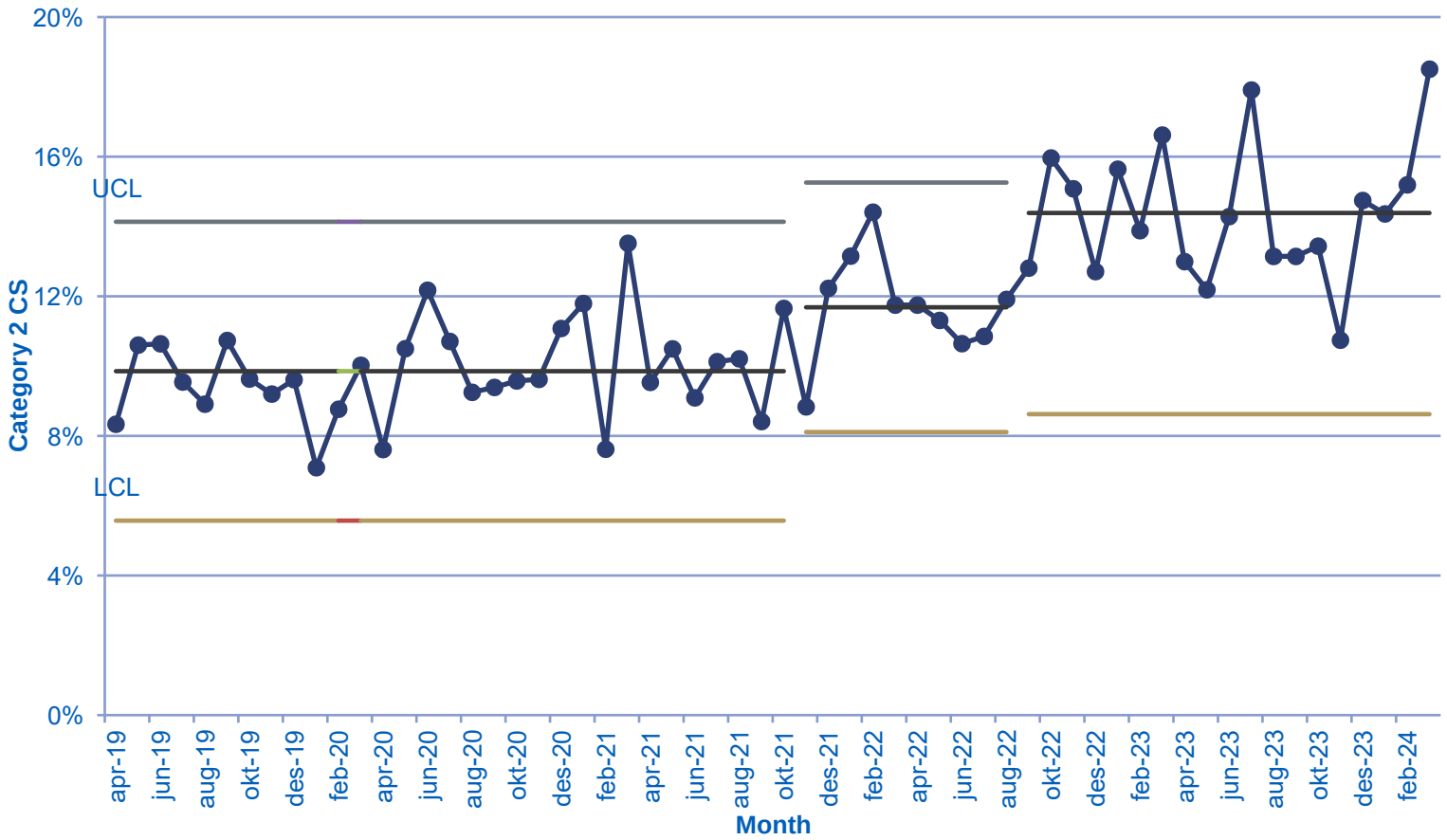
Whilst both sites have seen a rise in total CS rates over the past 5 years, the total CS rate at PCH is increasing significantly compared to that at POW over the past year.

Category 1 Caesarean Birth Rate April 2019- March 2024



The median category 1 caesarean birth rate has remained stable at 2.6% of all births.

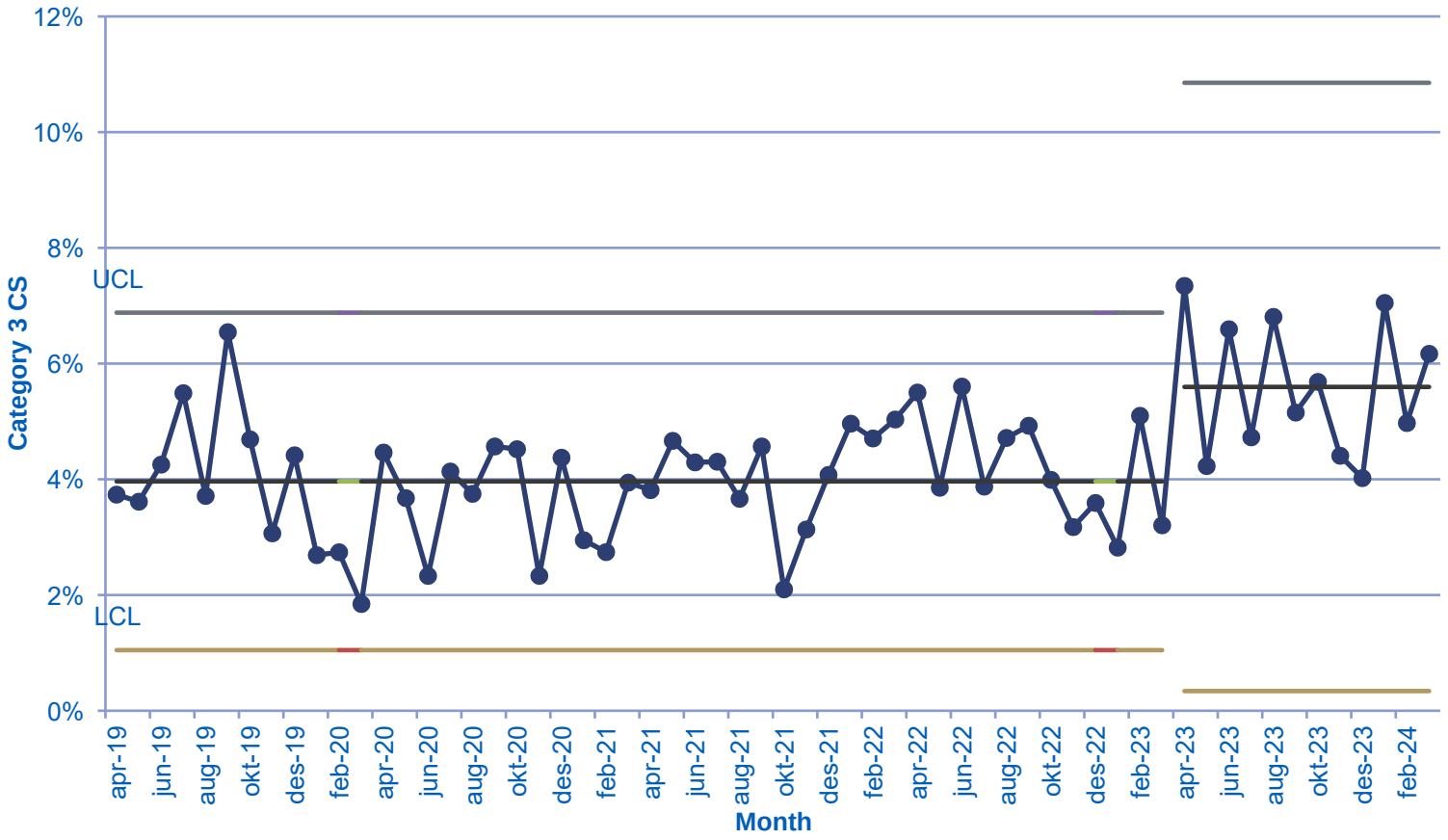
Category 2 Caesarean Birth Rate April 2019- March 2024



The median category 2 caesarean birth rate has increased from 9.8% to 11.6% to the current median of 14.4%.

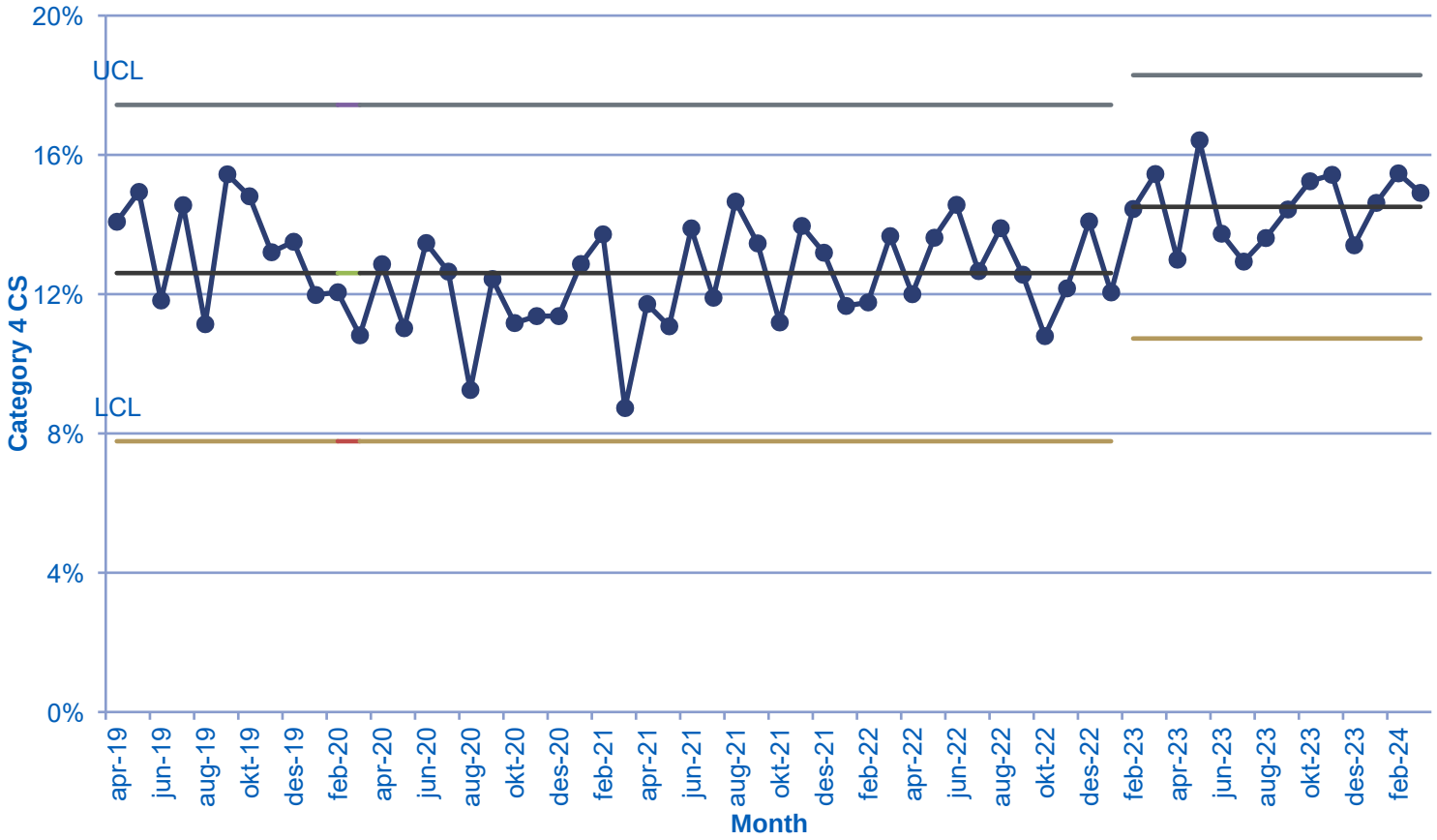
In March 2024, the rate was 18.5%.

Category 3 Caesarean Birth Rate April 2019- March 2024



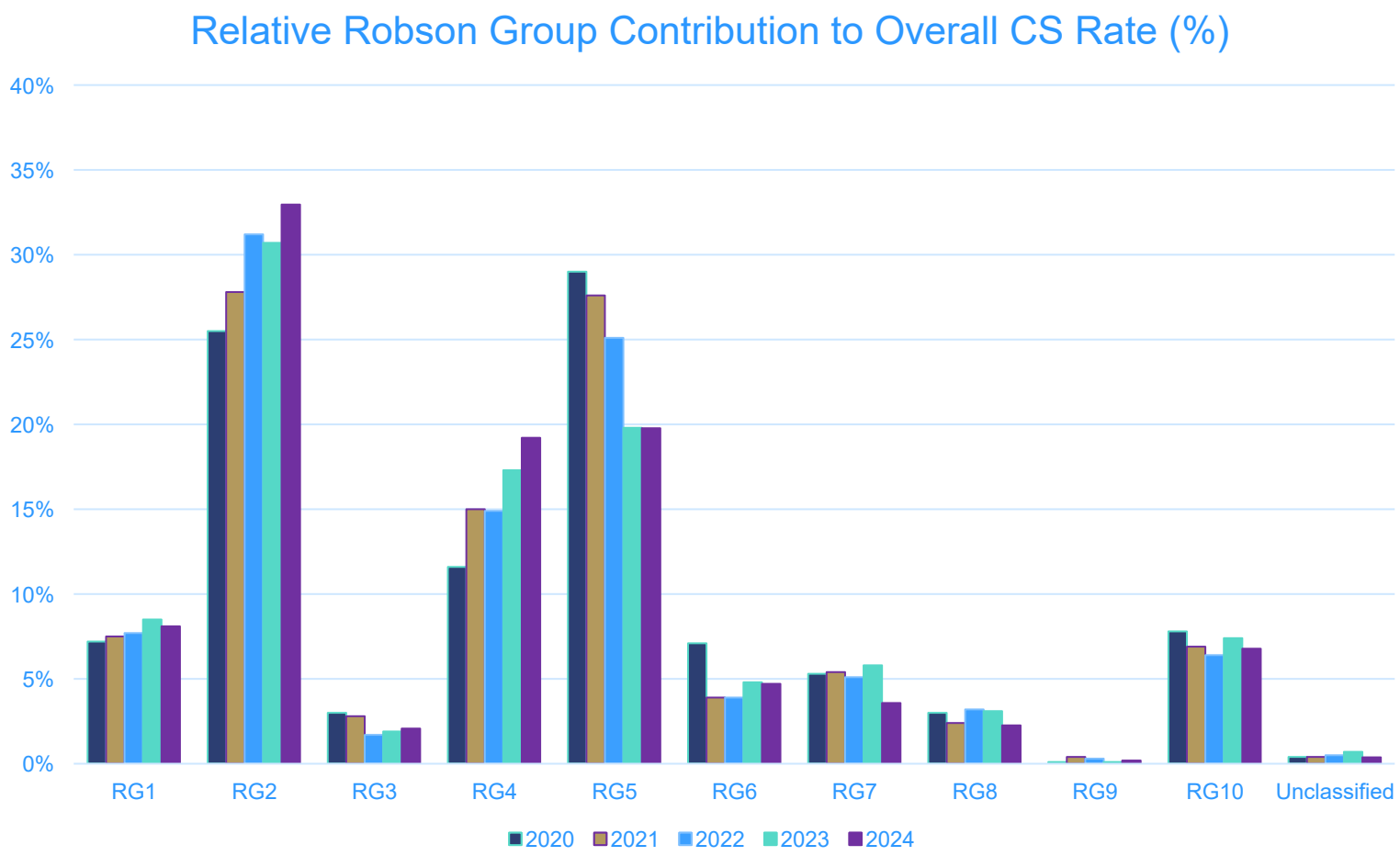
The median category 3 caesarean birth rate has increased from 4% to 5.5% as of April 2023.

Category 4 Caesarean Birth Rate April 2019- March 2024



The median category 4 caesarean birth rate increased from 12.6% to 14.5% as of February 2023.

Relative Robson Group Contribution to Overall CS Rate (%) 2020-2024



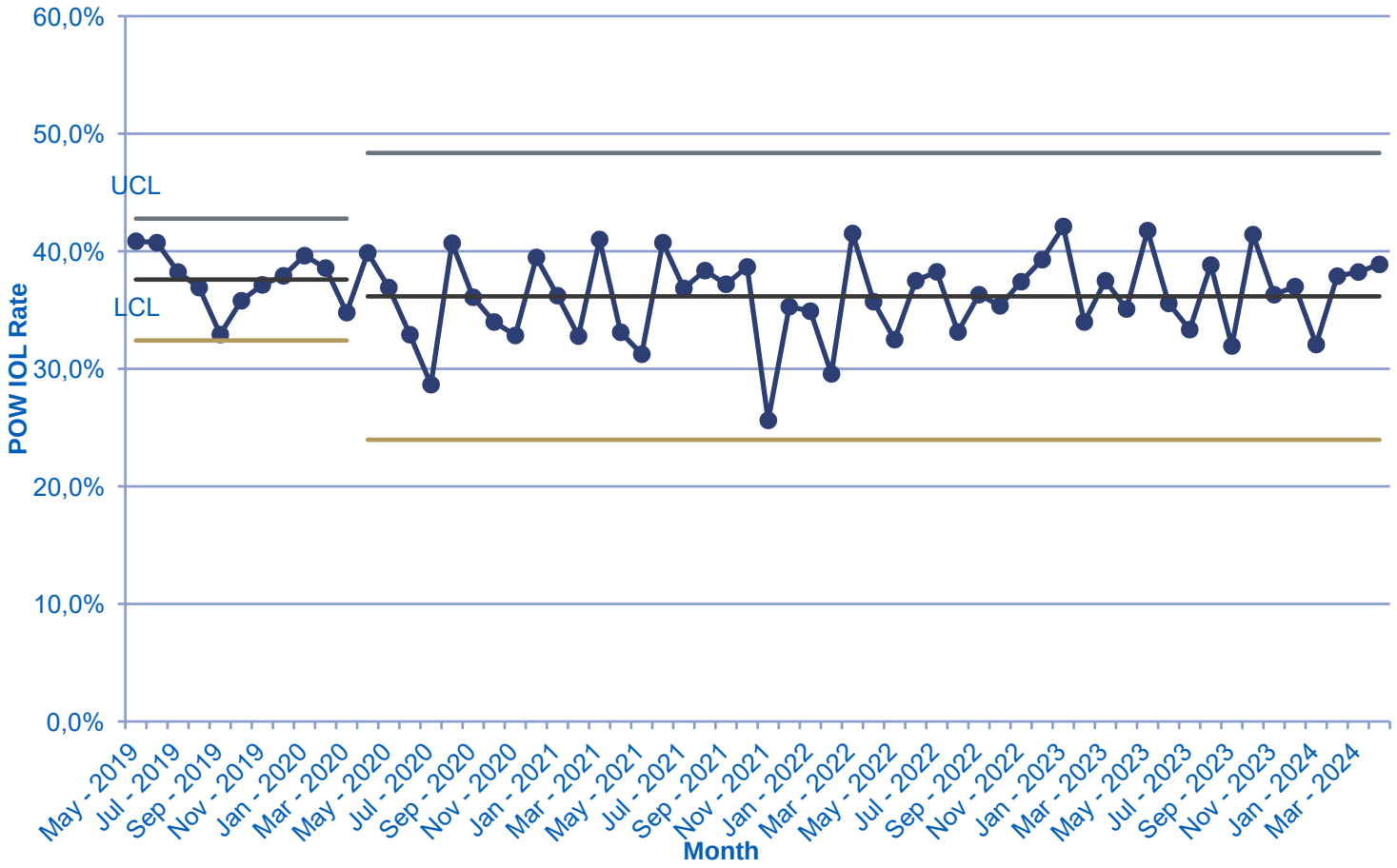
There are some notable changes to Robson Group contribution to overall CS rates from 2020 to 2024.

Group 2 contribution has *increased* somewhat consistently. Group 2 definition: nulliparous women with a single cephalic pregnancy ≥37 weeks gestation who has labour induced or had a CS before labour.

Group 4 contribution has *increased* each year since 2020. Group 4 definition: multiparous without a previous uterine scar, with singleton, cephalic pregnancy, ≥37 weeks' gestation, induced or caesarean section before labour.

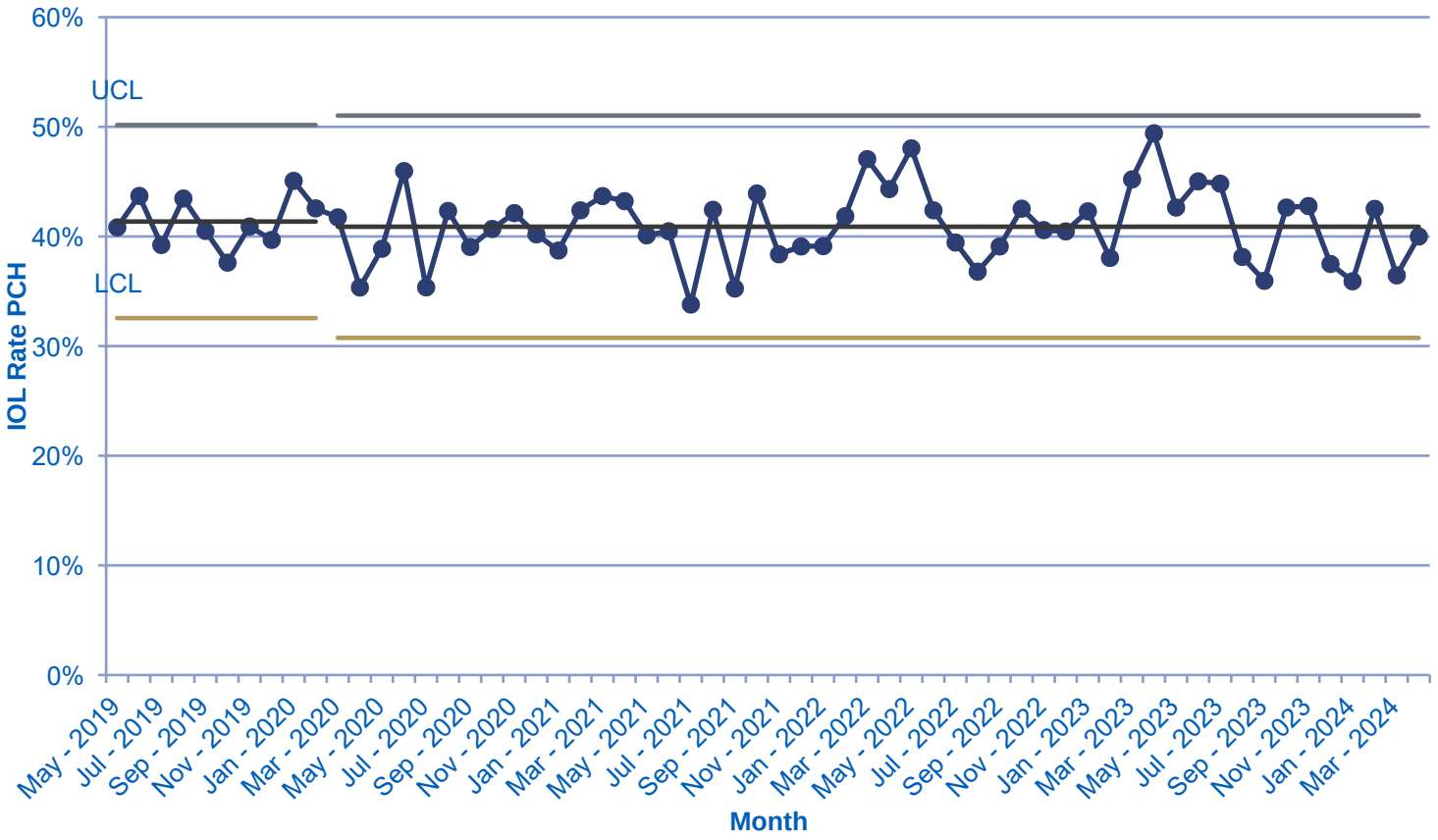
Group 5 contribution has *decreased* every year since 2020. Group 5 definition: Previous caesarean section, singleton, cephalic, ≥37 weeks' gestation.

POW Induction of Labour Rate May 2020- April 2024



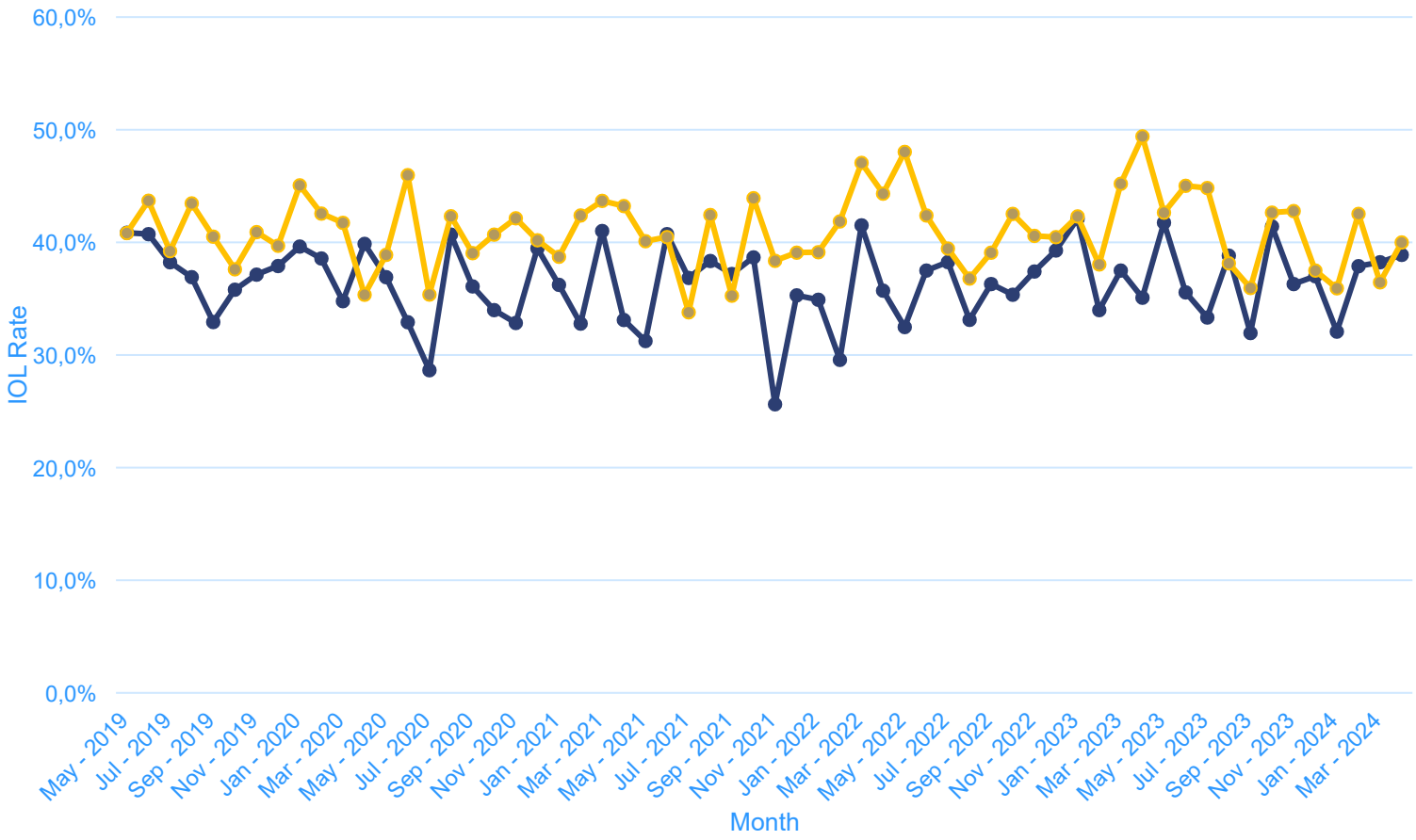
The median IOL rate at POW has remained unchanged for the past 5 years at 36%, so this is does not correlate with the rise in CS rates.

PCH Induction of Labour Rate May 2020- April 2024



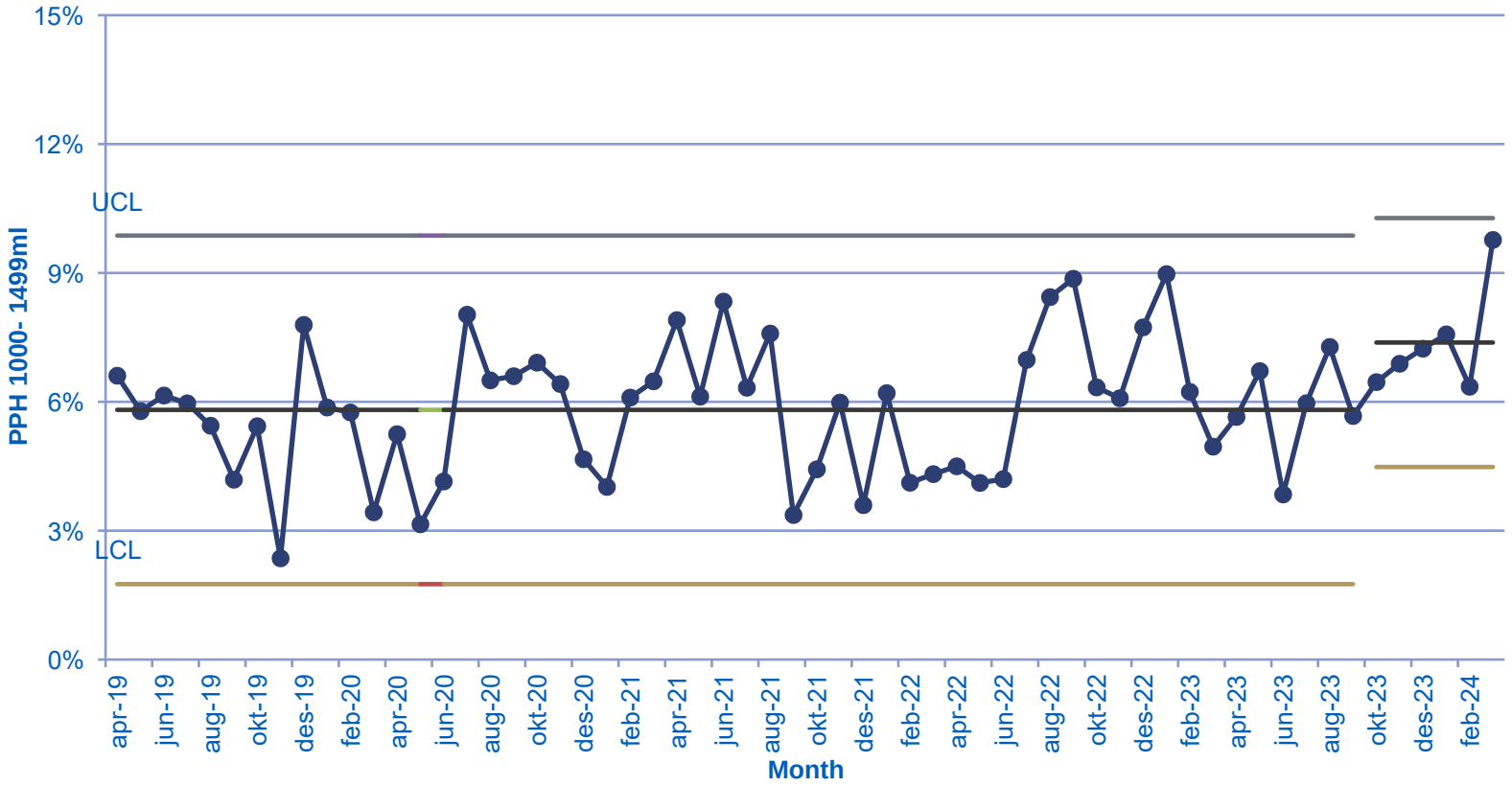
The median IOL rate at PCH has remained unchanged for the past 5 years at just under 40%, so this is does not correlate with the rise in CS rates.

PCH and POW Induction of Labour Rates May 2019- April 2024



The median IOL rate at PCH is consistently higher than at POW.

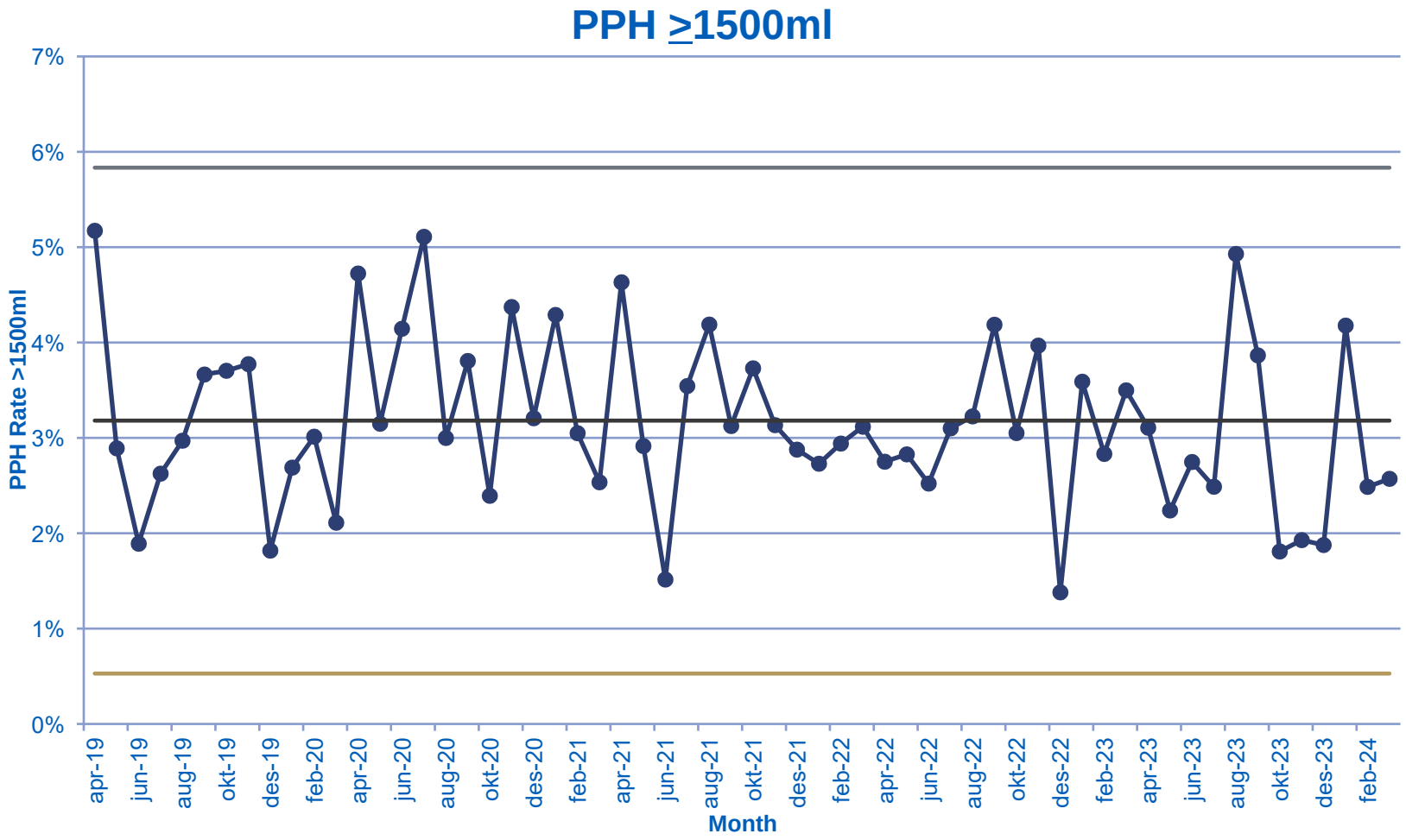
Postpartum Haemorrhage Rate CTM April 2019- March 2024



The median 1000-1499ml PPH rate has risen from 5.8% to 7.3% as of October 2023.

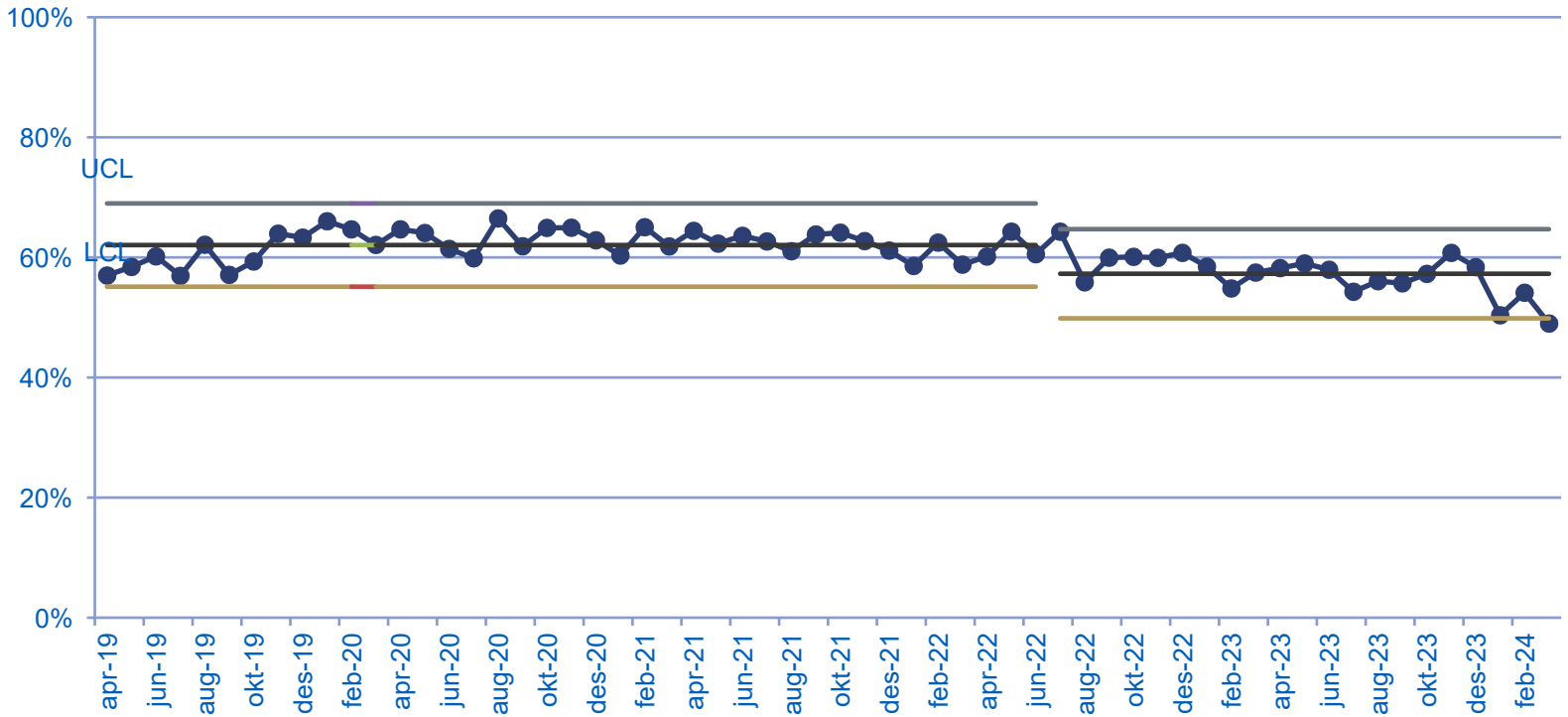
As women having caesarean births are more likely to experience PPH, this is not unexpected.

Major Obstetric Haemorrhage Rate CTM April 2019- March 2024



The increase in CS rates have not caused an increase in rates of major obstetric haemorrhage. The median rate has remained stable at 3.2% for the past 5 years. This rate is in line with the expected PPH rate.

Spontaneous Vaginal Birth Rate CTM April 2019- March 2024



In line with rising intervention, the median SVB rate has decreased from 62% to 57% as of July 2022. The rate in March 2024 was 49%.

In summary

The caesarean birth rate has been rising steadily over the past 5 years, but has risen more sharply at PCH this year.

There has been no change in the median rate of category 1 caesarean births.

The median category 2 caesarean birth rate has increased from 9.8% to 14.4%.

The median category 3 caesarean birth rate has increased from 4% to 5.5%.

The median category 4 caesarean birth rate has increased from 12.6% to 14.5%.

The median major obstetric haemorrhage rate has remained stable for 5 years.

The median induction of labour rate at both PCH and POW has been stable for the past 5 years, although is 4% higher at PCH than at POW.

In summary

Rising intervention rates are not associated with improvements in:

- Apgars of less than 7 at 5 minutes
- HIE grade II and III
- Term admissions to the neonatal unit

Plan:

- To share the data with senior midwifery and Obstetric colleagues via QPSE and Governance meetings
- to share the data nationally via SMLAG to understand the picture across Wales
- Continue with local QI work to improve women's experience of birth planning and decision making
- Identify an Obstetric colleague to undertake a deeper dive via audit, with any improvements to be based on the findings

Neonatal Data Metrics

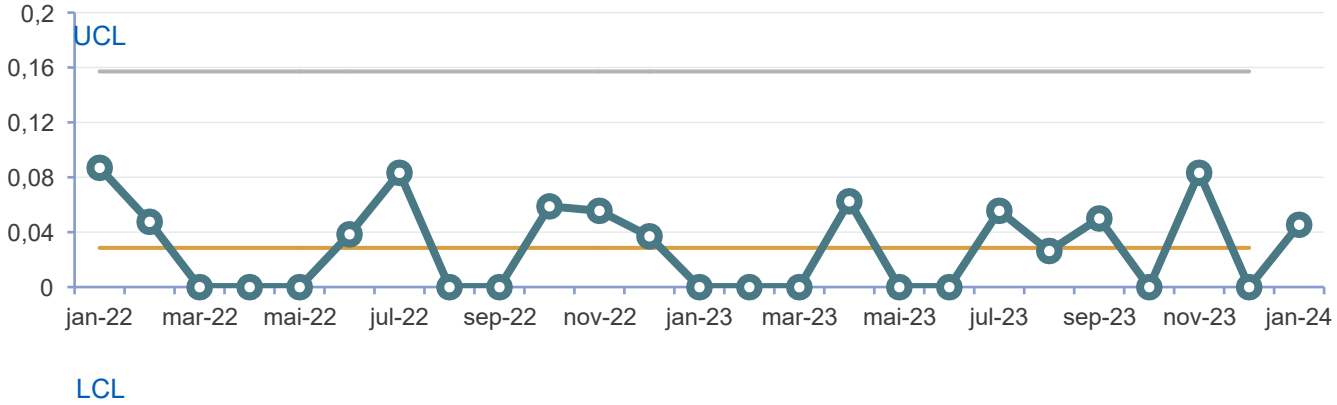
Exception Reportable Births
<32 week Singleton Births
&
Normothermia on Admission- Term Babies Admitted to the Neonatal Unit

Jodie Hodges
Local Perinatal Safety Champion (CTMUHB Mat/NeoSSP

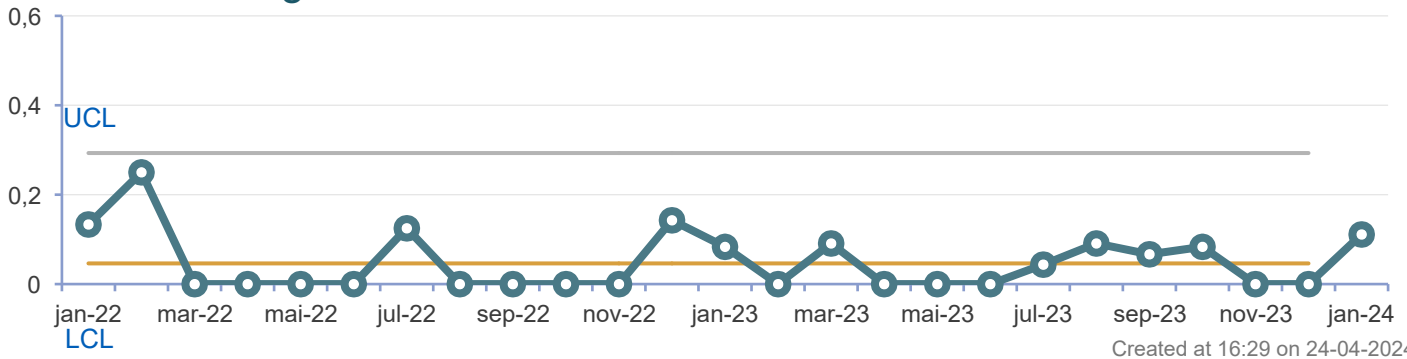
Exception Reportable Births- <32 week Singleton Births

Jan 2022- Jan 2024

<32 Week Singleton Births- PCH Neonatal Unit



<32 Week Singleton Births- POW Neonatal Unit



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Exception Reportable Births

- Rates have remain stable across the sites
- Rate remains lower in POW.

PeriPrem

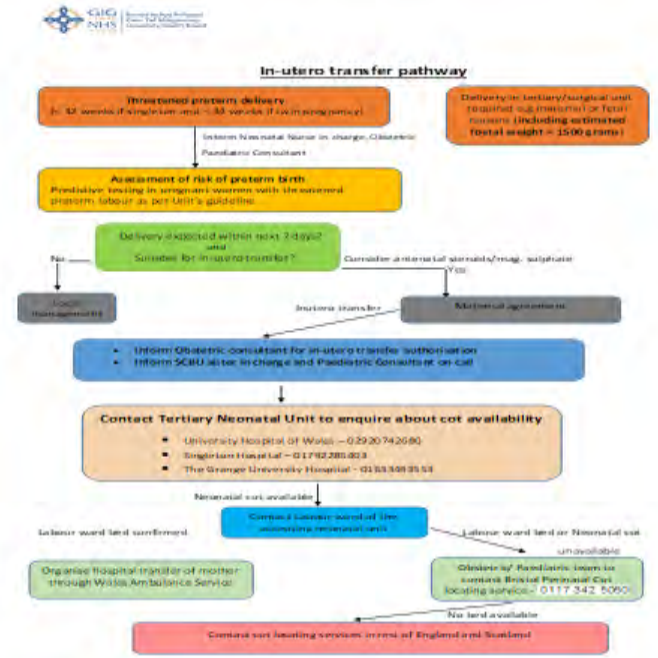
- Establishment of Local PeriPrem quad Team in April 2023.
- PeriPrem capture all exception reportable birth <34 weeks.
- Each case reviewed for optimisation if birth occurred in our unit and inutero transfer could not be facilitated.
- Neonatal QI project on going to purchase extra long oxygen tubing to facilitate prolonged cord clamping and skin to skin at birth.

Sustainability

Development of the IUT Pathway

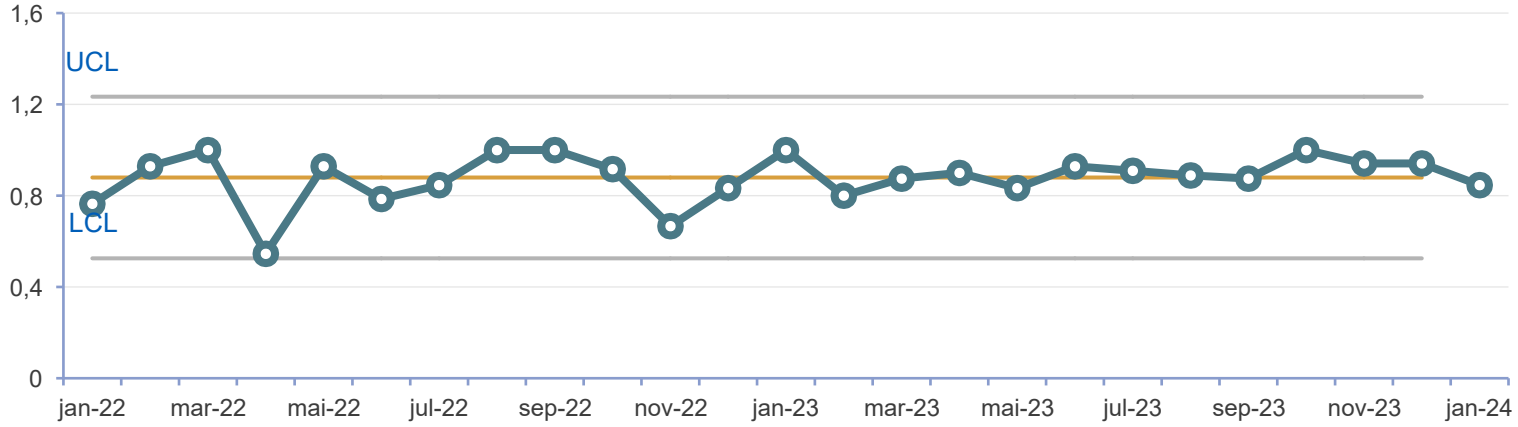
Ratification of the CTMUHB IUT Pathway. Aim to provide our women, birthing people and babies with the best care possible when experiencing threatened preterm labour.

- Work lead by Consultant Neonatologist and Intrapartum Lead
- Multiple MDT meetings held with representation from Maternity and Neonatal services to ensure effective collaborative working
- MDT approach throughout with consideration from each service valued by both parties
- The pathway is now ratified and is the best it could possibly be because of the success of cross service collaboration.

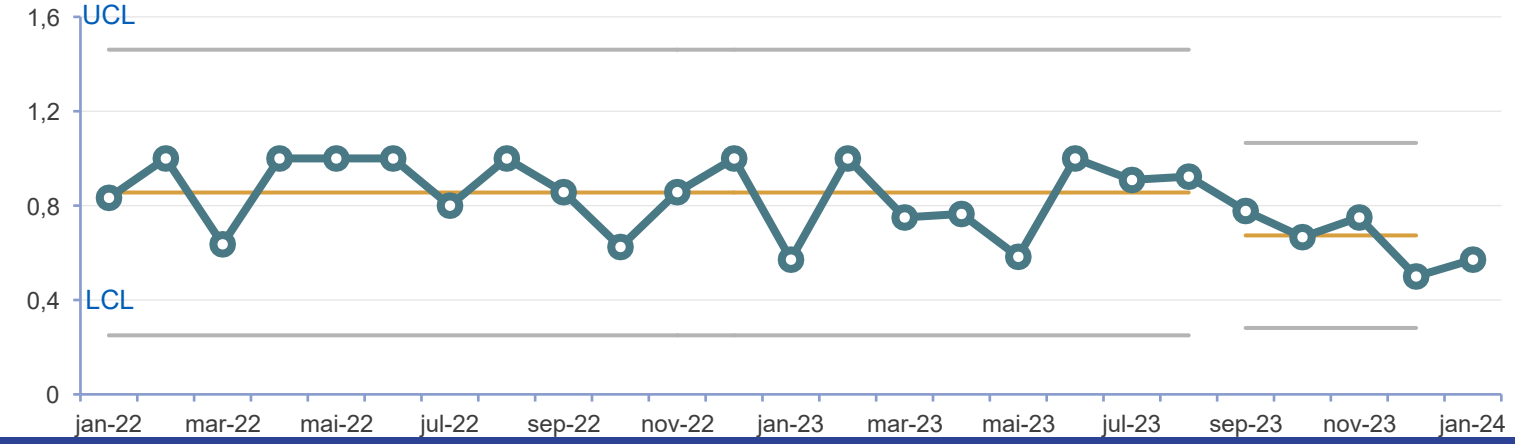


Neonatal Thermoregulation- Temperature on Admission to the Neonatal unit. Jan 2022-Jan 2024

% of Term Babies Normothermic on Admission- PCH NNU



% of Term Babies Normotheric On Admission to the NNU- POW



Normothermia- Term Infants Admitted to the Neonatal Unit.

- Defined as a temperature between 36.5-37.5'c.
- National programme underway to look at thermoregulation in term neonates.
- Rates have remained stable on the PCH site.
- Slight tailing of normal admission temperature in term babies on the POW site at during the last 5 months of 2023.
- Learning to be shared in joint newsletter.

Mat/NeoSSP- Care of the Newborn Term Infants

Baby Care Bundle-
A National Mat/NeoSSP Initiative

Ensuring equitable care for every term baby born in Wales

Aim

To reduce deterioration and time away from parent for term babies across Wales

Bundle

First Two hours of life bundle 4 Safety Steps (4SS)

- Skin 2 Skin (ensure normothermia is maintained)
- Monitor and record temperature
- Has feeding choice commenced?
- Identify Risk Factors

Measures

- **How many babies have the 4 Safety Steps (4SS) in their notes for the first 2 hours.**

- *How many identified at further risk*
- *Of these, how many commenced NEWTT 2 chart*
- *First point of escalation is placing babe on NEWWT 2 chart or local newborn observation chart*
- *Percentage of bundle completeness*

Local Data Collection Underway

Monitoring Metrics and Transparency

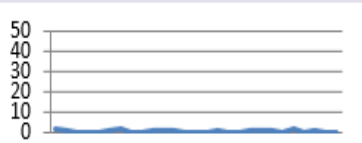
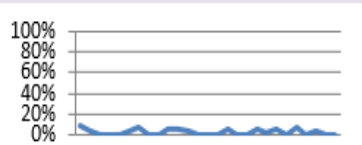
Neonatal Dashboard

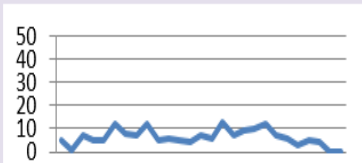
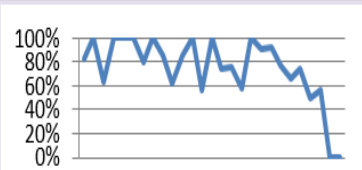
- Metrics include *(not limited to):*
- ✓ Exception reportable Births
- ✓ Term admission- reason for admission
- ✓ Admission rates
- ✓ Neonatal care days

- Easily monitor data over time

- Implement further tests of change and monitor progress.

- Transparency- dashboard can be viewed by all staff and will facilitate focused future QI projects to help form service improvements

Measure	Measure Definition	Source	Trend
Singleton birth admissions at <=31+6 weeks gestation	Total number of singleton babies admitted at <=31+6 weeks gestation	Badgernet	
% Singleton birth admissions at <=31+6 weeks gestation	Percentage of singleton babies admitted at <=31+6 weeks gestation	Badgernet	

Measure	Measure Definition	Source	Trend
Term Babies with Admission Temperature between 36.5 and 37.5 >=37 gestation	Total number of Term babies admitted to the LNU with an admission temperature of between 36.5 and 37.5 (Normothermic)	Badgernet	
% Term Babies with Admission Temperature between 36.5 and 37.5 >=37 gestation	Percentage of Term babies admitted to the LNU with an admission temperature of between 36.5 and 37.5 (Normothermic)	Badgernet	

Agenda Item
5.2d

Quality & Safety Committee

Highlight Report from the Unscheduled Care Group

Dyddiad y Cyfarfod / Date of Meeting	16/05/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Emma James, Unscheduled Care Nurse Director Alex Brown, Unscheduled care Medical Director & Victoria Healey, Head Of Quality & Patient Safety
Cyflwynydd yr Adroddiad / Report Presenter	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 Committee	17/04/2024	

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf Morgannwg University Health Board
PCH	Prince Charles Hospital
RGH	Royal Glamorgan Hospital
POW	Princess of Wales Hospital
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
AL	Annual Leave
ENP	Emergency Nurse Practitioner
YCC	Ysbyty Cwm Cynon
RCDU	Regional Cardiac Day Unit
TOE	Transesophageal echocardiogram
DCCV	Direct Current Cardio Version
PALS	Patient Advice and Liaison Service
ADH	Additional Duty Hours
ACSP	Acute clinical Service Plan
TARN	Trauma Audit and Research Network
NMTR	National Major Trauma Registry
NAIF	National Audit of Inpatient Falls

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 at its meeting on 17th April 2024.

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 (Q&S) Committee on the provision of safe and high quality patient care and experience to the population we serve.

The Unscheduled Care Quality, Safety, Risk & Experience Group (QSRE) will embed the six characteristics of quality, being worked towards in Wales, in the care provided ensuring care is:

- Safe - avoid harm;
- Effective - evidence based and appropriate;
- Patient-centred - respectful and responsive to individual needs and wishes;
- Timely – at the right time;

- Efficient - avoid waste; and
- Equitable – an equal chance of the same outcome regardless of geography, socioeconomic status etc.

The Unscheduled Care QSRE Group will:

- Put the needs of patients, carers and the public at the centre of all its business.
- Ensure appropriate arrangements are in place to support workplace health & safety.
- 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 care group in relation to the Localities 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.
- Support and bolster Clinical Service Group ownership of assurance of all quality and patient safety activity within their service group.
- Ensure patient feedback/experience received is acted on and supports service improvement and change.

The Unscheduled Care QSRE Group will embed the CTMUHB Quality Framework and provide assurance to the CTMUHB Quality and Safety Committee for the services for which the care group are responsible, including services on a CTM wide basis.

3. Highlight Report

Alert / Escalate	The Emergency Nurse Practitioners (ENP) have returned to the Minor Injury Unit at YCC, this allows them to provide high quality care to our patients in a safe purpose built unit. The team are very pleased and are very grateful to the other care groups for the support provided. The Cardiology team in Princess of Wales Hospital are going to trial a 'perfect week' approach to their elective and non-elective intake. This will mean a protection of the Regional Cardiac Day Unit (RCDU) from use as a surge area. The Cardiologists, the Advanced Nurse Practitioners, Cardiac Physiology, Heart Failure Team, Cardiac Catheter Lab Team and Ward 4 inpatient team will then be able to support: -discharge from the front door (ED/AMU) with a return to RCDU for bloods/medication up-titration instead of remaining as an inpatient -Urgent reviews following GP referral -Urgent review post discharge (HF patients)

	-Early ward discharge with follow up through RCDU for bloods, medication, diagnostic tests -Ability to see and treat following clinic/diagnostic test red flag for pacemaker/loop implant -RCDU can be utilised for TOE/DCCV recovery for inpatients Data will be gathered to analyse all throughput through RCDU to demonstrate elective and non-elective activity and how protection of RDCU can provide proactive support for the front door and admission prevention.
Advise	Complaints have been transferred to a central quality governance team within the organisation. This has ensured that we maintain equity, consistency and strengthen resilience. USC compliance with the 30 day target has slightly decreased in March 2024 from 100% to 93%. This is due to the doctor strikes which had a negative impact on response times. Currently there are 33 open complaints and 5 over the 30 day compliance. 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 which has resulted in a significant improvement. AMaT A high- level report has been produced to give an oversight of the outstanding actions on AMaT allowing the Directors to drill down specific areas. Available on request is the compliance for all areas within the USC care group to highlight areas which require improvement. Following review of the AMaT actions for USC, it was noted that Ward 20 and ED at RGH have a downward trajectory in their compliance. The following mitigation and improvement plan has been developed for each of the respective areas. Ward 20 ➢ Neighbouring Band 7 Ward Manager to provide support. ➢ Delegation so that not only one member of staff completes actions (to maintain compliance during Safe to Start and AL).

	➢ Feedback has been provided to the wider team that when actions are completed they change RAG rating and close. ➢ Senior Nurse to provide oversight, monitor compliance and provide assurance that actions are completed timely. ➢ Local refresher training has been arranged. ED ➢ ED audits to be completed first week of the month to allow sufficient time for relevant actions to be completed in timely manner. ➢ Local refresher training has been arranged. ➢ ED and Outreach Senior Nurse meeting 29th April to review audit process. ➢ New ED pharmacist starting end of April whom will complete monthly controlled drug audit. ➢ Allocation of a fluid balance champion. ➢ Senior Nurse to sanitise audit requirements to ensure bespoke for ED. ➢ Senior Nurse to provide oversight, monitor compliance and provide assurance that actions are completed timely. Junior doctor strikes have continued to have an impact. The majority of the impact was felt on outpatient services, where a large number of clinics were cancelled in order to provide consultant cover to the inpatient wards and front door cover. Through the strikes staffing was maintained, mostly by consultants and SAS doctors. There were occasions where this staffing fell below the usual level of what would be considered 'safe', but not at the level where derogations would be considered and actions were taken to ensure site safety. No patient harm has been identified as a result of junior doctor strikes to date.
Assure	The Emergency Department (ED) national continues to have excellent service user engagement, providing a monthly report via CIVICA. This patient feedback is reviewed by the department leads and actions are undertaken accordingly. RGH are currently in the process of developing a patient feedback board to display in the ED waiting room, to highlight “you said” and “we did”. This in turn will encourage more feedback and evidence of listening and actions undertaken. The Nurse Director, for USC is working with the patient experience lead and other sites to implement the same process. This will allow us to develop themes and trends, with an action plan for learning.

	The re -introduction of the Patient Advice and Liaison Service (PALS) team within our acute settings across the organisation and has had a positive impact within the Emergency Departments across the 3 acute sites. PALS enquires have raised from 42 in September 2023 to 103 in March 2024. This is enabling our services users to have enquires dealt with in a timely manner.
Inform	Following the ALERT escalation re: neurology at the last Quality and Safety meeting in March 2024, CTMUHB has engaged with the directorate management team for Specialist Medicine as well as the neurology team and is now working on a project with two separate priorities: 1. To explore the creation of liaison neurology posts who would also contribute to a stroke on call - the majority of this to be funded through existing funding streams including reduction in Additional Duty Hours (ADH) spend on two vacant slots in the stroke on call rota. 2. To develop a long term and sustainable plan for neurology services in CTM in line with the Acute Clinical Service Plan (ACSP) and a vision for CTM 2030. Latest stroke guidelines include an increasing thrombolysis window (the maximum time from onset of symptoms that 'clot-busting' medications can be given). There is also a likely increase in access to thrombectomy services in the coming months. Initially CTM is planning to deliver thrombolysis within the extended time window primarily in hours when the stroke consultants are present on site - primarily as this requires perfusion CT scanning. This is being developed to be able to be delivered out of hours with collaboration with radiology. In the medium and longer term, increasing patient access to thrombolysis and thrombectomy will require an increase in resource available to diagnose and treat stroke at the front door. The stroke directorate team are working with the unscheduled care group senior management team to work through options - both through local resource and regional options. Some of the team members from the Emergency Department at RGH, have joined the National Quality Improvement project for time critical medication, and are currently within the first phase of the project. This involves supporting the service to improve patients, receiving their time critical medication in a much timelier manner. Posters have been displayed in the ED waiting

	room and there is an electronic patient board to prompt staff to remind patients that have been diagnosed with a cognitive impairment the importance of bringing their medication into hospital with them. In addition, when patient's report to the reception desk, the reception team will ask if they have Parkinson's, diabetes or epilepsy. If they confirm one of these illnesses, the reception team will provide the patient relative with a form and will be asked to provide details of the medication. This will then be given to the triage nurse, who will add to the ED card and ensure a visual prompt in the form of a sticker will be applied to the notes. The Trauma Audit and Research Network (TARN) is now replaced with National Major Trauma Registry (NMTR) and Dr Biswas, Consultant Physician has been newly appointed Clinical Lead for the National Audit of Inpatient Falls (NAIF).
Appendices	Not applicable.

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: Improving care Sustaining our Future
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Living Well
	If more than one applies please list below: 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))*	Learning, Improvement & Research
	If more than one applies please list below: Duty of Quality

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 Time Safe Person centred
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	Yes - Recycle
	If more than one applies please list below:

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

5. Recommendation

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

Agenda Item
5.2e

Quality & Safety Committee

Highlight Report from the Primary Care and Communities Care Group

Dyddiad y Cyfarfod / Date of Meeting	26/04/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Lucie Williams, Head of Nursing Primary Care and Communities
Cyflwynydd yr Adroddiad / Report Presenter	Ana Llewelyn, Nurse Director for Primary Care and Communities and Mental Health and Learning Disabilities Care Groups.
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
DN	District Nursing
GDS	General Dental Service
GP OOH	GP Out of Hours
HB	Health Board
HIW	Health Inspectorate Wales
HMP	His Majesty's Prison
HMPPS	His Majesty Prison and Probation Service

IPC	Infection Prevention Control
ODTC	Ophthalmic Diagnostic Treatment Centre
PIFU	Patient follow up
POWH	Princess of Wales Hospital
TVN	Tissue Viability Service
YBN	Y Bwthyn Newydd
YCC	Ysbyty Cwm Cynon
YCR	Ysbyty Cwm Rhondda

1. Introduction

1.1 This report had been prepared to provide the Committee with details of the key issues considered by the Primary Care and Communities Care Group at its meeting on the 29th April 2023.

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.

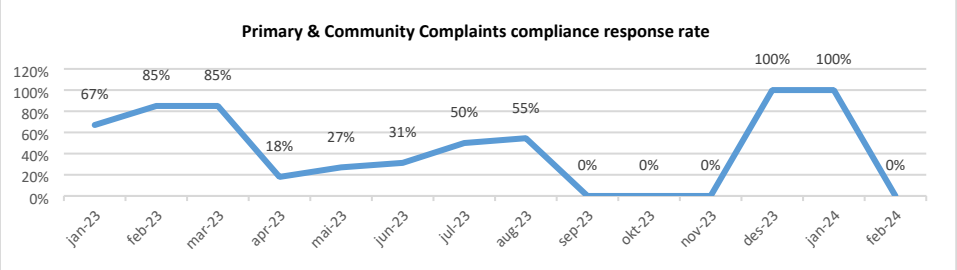
3. Highlight Report

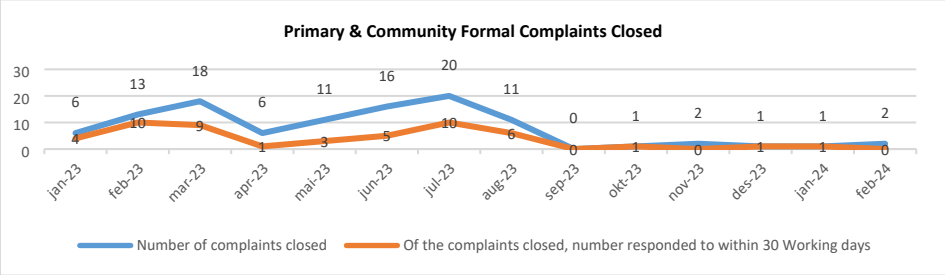
Alert / Escalate	GP OOH – due to Measles update across CTM, OOH is identified as a high risk area and currently there is no fit test training available to HB staff. Discussions have been held with the Health and Safety Team and the IPC team, we are awaiting fit testing dates. Also added to the risk register. Dental Service Paediatric General Anaesthetic (GA) Lists. Remains on the risk register. Additional GA lists required. As an interim measure a validation of the list has been undertaken and alternative treatments being provided. Special Care Dentistry General Anaesthetic Lists. There is a waiting list due to complex needs the current backlog is 9 patients but only 1 patient has GA per month due to complexity of care. There are ongoing discussions with secondary care regarding use of weekend capacity and cancellations.
Advise	HMP Parc high number of deaths between 26.02.24 to 19.03.2024. Joint meetings in place with G4S and HMPPS, initial findings no immediate learning required by healthcare. Lymphoedema Service - All patients known to the service have now been reviewed. There are ongoing plans for the service to ensure they provide a service in line with other HB's and have an ongoing sustainable service. • PIFU total: 260 (32%) • Appointment total: 548 (67%) a percentage of these will also be PIFU • Patients passed away: 9 (1%) TVN-Increase in referrals to the team with requests to provide training to Care homes across CTM. At present only one day is available to care homes due to capacity but is not sufficient therefore a plan needs to be generated to review how training can be delivered bespoke to care homes. Wound Clinics service review to be undertaken due to inconsistencies identified. This will allow the opportunity to strengthen the referral pathways to GP. Meetings to be arranged April 24. DN Transcribing – transcribing of insulin now in place, further work being undertaken for all medications to be able to be transcribed by the DN service.

	Community Nursing specification – update submitted to WG, some work done to boost weekend capacity in line with milestones. Vacancies out to advert. HIW visit to Ward B2, YCR action plan in place and work ongoing. DN night service redesign – action plan in place to support amalgamation of overnight DN service YBN POWH Ongoing Legionnaires and pseudomonas. The service was relocated for 3 weeks whilst Estates work undertaken. Two bedrooms remain out of use while further Estates work is undertaken. Pseudomonas work ongoing in YBN POWH – 2 beds remain closed. Awaiting review of water samples on 15th April. GDS: HIW INSPECTION: Currently HIW are not able to provide a 5 year inspection visiting programme. The Dental team are undertaking 'HIW support visits' to practices for assurance on compliance with legislation & guidance. Identified issues/practices are flagged and an action plan is put in place.
Assure	HMP Parc DIC action plans in place and in compliance to achieve by completion date. IPC audits being devised for HMP Parc. The team are liaising with the infection control team to develop infection control audits using AMaT. HMP Parc – governance lead post recruited into which will be based at Parc and provide assurance. HMP Parc work being undertaken to review current staffing model against service needs. BLS training compliance lower than average in YCR, YCC and Ward 21, POWH due to training availability – plans in place for ANP on site to provide the training for all staff to attend and to improve compliance over next 3 months. HMP Parc ongoing service improvements • CTM Bereavement clinical lead supporting services offered to patients • Introduction of sexual health testing strips/in admissions • Task & finish group set up to support transfers from HMP Parc to ED in POW.

	• Palliative care rooms in place in Parc for patients that require end of life care. • Ongoing work with Clinical System Implementation Manager to adapt audits for HMP Parc environment @Home Service profile now established on intranet/Informatics poster cascaded through primary/ secondary care Glaucoma Service development/Refinement scheme by June 2024 (provisional date) Optometrists suspecting glaucoma can refer to an ODTC for review prior to any hospital onward referral, optimising the numbers referred into ophthalmology outpatients. OOH: meeting planned to discuss re-tendering exercise for PCH/Bridgend weekend model and proposed Prison Out of Hours, etc. CTM LOCAL GENDER TEAM: repatriation due temporary measure in place until September 2024 GP practice Pont Newydd will continue to provide this service and a longer term solution is being discussed.
Inform	Lymphoedema Change of contract for collection of LYMPROM-new provider now confirmed planned to go live may 24 Parkinson service – Senior Nurse featured in Parkinson UK Nurse Appeal, leaflet created and will be involved in filming in May 24. @Home staff member HCSW flexi route to RGN has been selected as a finalist for “most inspiring student 2024” award Staff development forums – being undertaken in various areas across the care group to develop staff. This is being led by Senior Nurses. PCH CNS team have delivered training on Care Decisions Tool to teams at PCH with good feedback. Palliative care workshop has been delivered to Bridgend District Nurse Team leaders to review pathways, Care Decisions tool and symptom management.

Concerns





Amat

Project	Number of audits	Current compliance	Improvement	Overdue actions
Health & Safety	1	G 98.1%	▼	1
Health and Care Standards	1	G 99.1%	▶	2
Infection Control	4	G 97.4%	▶	4
Medicines Management	3	G 95.8%	▼	1
Patient Safety	14	G 97.1%	▶	37

Appendices	Not applicable.

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: Ageing well Dying Well Growing Well
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Enablers of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Learning, Improvement & Research
	If more than one applies please list below: Culture and valuing people Learning, improvement and Research Leadership
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Domains of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Effective
	If more than one applies please list below: Efficient Person centred Equitable Timely Safe
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* Quality *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not required for individual sections detailed above
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please include rationale below: Not applicable for the purpose of this report
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

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

Agenda Item
5.2f

Quality & Safety Committee

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

Dyddiad y Cyfarfod / Date of Meeting	16/05/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Sharon O'Brien, Nurse Director, Planned Care
Cyflwynydd yr Adroddiad / Report Presenter	Sharon O'Brien, Nurse Director, Planned Care
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Not applicable		

Acronyms / Glossary of Terms	
ED	Emergency Department
SAU	Surgical Assessment Unit
GAU	Gynae Assessment Unit
TAU	Trauma Assessment Unit
DoC	Duty of Candour

1. Introduction

1.1 This report had been prepared to provide the Quality & Safety Committee with details of the key issues considered by the Planned Care Group, Quality, Safety, Risk & Experience Group at its meeting on 22nd April 2024.

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

2. Purpose of this Meeting

2.1 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 (Q&S) 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. Highlight Report

Alert / Escalate	Princess of Wales (POW) Hospital • While Ward Controlled Access is currently not implemented on inpatient wards at Princess of Wales (POW) Hospital, the CTM UHB Task & Finish (T&F) group initiated corrective actions in their first meeting on November 23. Enhanced care monitoring and risk identification measures have been reinforced during this period, demonstrating an ongoing commitment to patient safety as the group addresses the issues. Urology • Remains a key focus of Targeted Intervention for Cancer. The Urology Sustainability Programme has been revised with additional focus on key actions, with weekly review of demand and capacity. • Review of medical, nursing and CNS workforce and job plans has commenced with Urology Transformation Group meeting on 5th June 2024 with wider Urology medical and nursing teams.

Advise	Blood Glucose Monitoring

The current Blood Glucose Monitoring Meters contract expires July 24. Changing to new Nova Meters but only for PCH and RGH only. Training dates have been arranged.

Boarding into escalation spaces on wards

The criteria for the use of additional, escalation spaces on wards within the acute hospitals is being updated. This includes improved guidance on the procedure and process in and out of hours and detailed patient criteria. This will form part of the overarching CTM Escalation Policy

Incidents – Care Group Overview (March 2024)

Incidents	PCH	POW	RGH
Total Number of Incidents Reported	70	105	67
Total Patient Safety	64	85	61
Total Non-Patient	4	14	6
Total Organisational Incidents	2	6	0
Total Number of Incidents Closed this month	72	101	85
Total Number of Open Incidents on Datix Cymru	138	491	311
New Incident	102	263	223
Management review/Make it safe plus	5	30	8
Under Investigation	19	170	65
Awaiting Closure	12	28	15
Number of Nationally Reportable Incidents	2	0	5
Number of Never Events reported	0	0	0
Number of Open Nationally Reportable Incidents	4	5	6

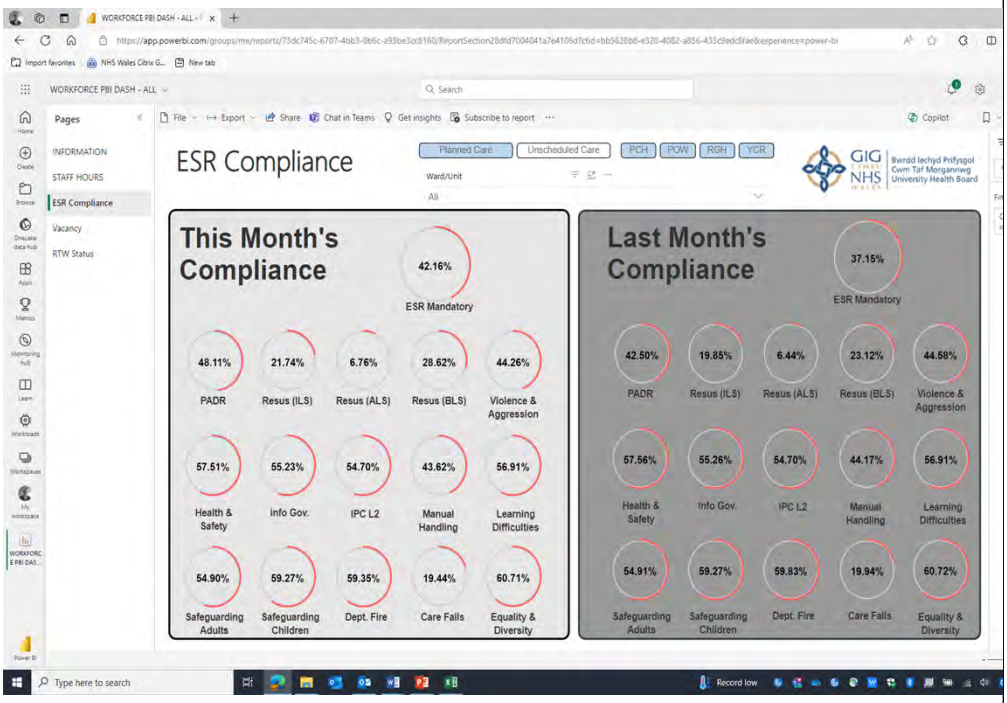
Nationally Reported Incidents – Planned Care
NRI's reported to NHS Wales Exec during February & March 2024 – 8 in total:-

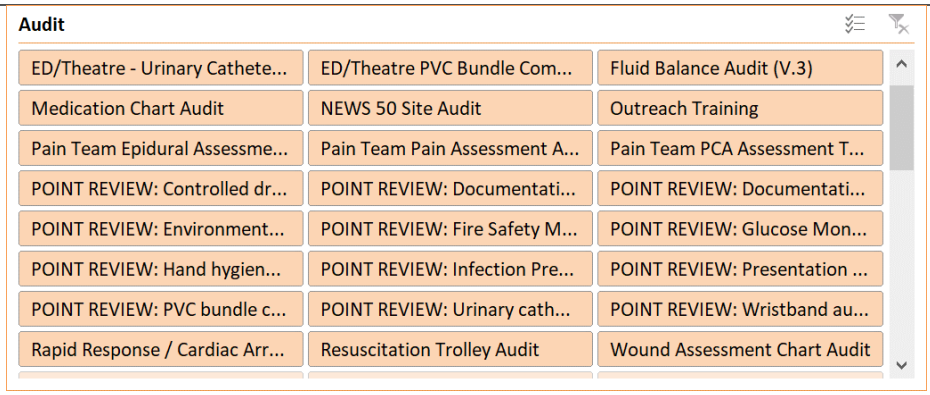
- 3 x Avoidable pressure damage (RGH)
- 1 x Severe Fall (RGH)
- 2 x Delay in treatment (PCH)
- 2 x Ophthalmology - delays in treatment following harm review

All the above triggered DoC
TOTAL NRI's Open for Planned Care = 38

- Scrutiny Panels have been renamed as Assurance Panels to avoid punitive language and the Terms of Reference and SOP's for Falls and Pressure Panel have been updated and ratified and are awaiting wider circulation.

	• Ophthalmology – dedicated governance resource for historic cases has been implemented. All new cases will continue to be managed under Specialist Services Directorate within Planned Care. • Plans created to reduce the amount of open incidents on datix across the 3 sites, with a focus on RGH and PoW. Large number of open incidents relating to ophthalmology & cancer harm review outcomes.
Assure	PCH Actions from Concerns and Incidents remain generally unchanged, although improvements noted. Plan is to continue with focus training sessions for: NEWS monitoring, Sepsis Management, Fluid Balance Chart Monitoring, Escalation by use of the JUMP policy (MDT), Equality/Diversity Learning Disability, Pressure Area management, Clexane prescription and administration errors-alert developed and circulated. • Training days/Work Stations arranged April 24 • Implementation of Bespoke Manual Handling training (supported by the Theatre staff, MH trainers) • No Avoidable Pressure Damage this Quarter • Over the past 6 months-medium transfer time from ED to GAU reduced to 1.5 hours, transfer to SAU and TAU 3.5 hours. Improvement in patient experience and performance. • Aim to create GAU emergency pathways from ED to a GAU on the PoW site. RGH • Additional theatre (was old Tirion) refurbished and opened end of April. This is a dedicated theatre for patients requiring breast surgery. Creating an improved patient experience, which has also provided additional theatre capacity in the main theatres department for additional orthopaedic planned surgery. • Reduction in pressure damage in April following increased training of Purpose T documentation post incidents in March. • Trialing in-patient Diabetic Foot Assessment Tool on Ward 8. PoW • Additional surgical ward in PoW is now fully commissioned ward with agreed funded establishment. • Shared learning from incidents continue via their Professional Nursing Forums • Focus on reviewing open incidents

Inform	Phase 2 Operating Model New appointments in April into Lead Nurse for General Surgery & Gastrointestinal Service and Lead Nurse for Anaesthetics, Critical Care, Theatres, Trauma & Orthopaedics ESR compliance Dashboard – Planned Care (March & April 2024  Next Steps • Newly created dashboard. First reviewed at the Planned & USC Nursing Workforce Meeting in April 24 • Data is reviewed and actions for improvement and monitoring will be agreed at each meeting. • Ability to drill down into each ward/dept which enabled a more detailed narrative with senior nursing teams regarding challenges and opportunities. It also provides opportunities for shared learning from areas that are achieving Mandatory & Statutory training compliance AmaT – Ward Assurance. Percentage of compliance against the ward assurance audits listed below (Feb/March 2024)


Audit
ED/Theatre - Urinary Cathete...
ED/Theatre PVC Bundle Com...
Fluid Balance Audit (V.3)
Medication Chart Audit
NEWS 50 Site Audit
Outreach Training
Pain Team Epidural Assessme...
Pain Team Pain Assessment A...
Pain Team PCA Assessment T...
POINT REVIEW: Controlled dr...
POINT REVIEW: Documentati...
POINT REVIEW: Documentati...
POINT REVIEW: Environment...
POINT REVIEW: Fire Safety M...
POINT REVIEW: Glucose Mon...
POINT REVIEW: Hand hygien...
POINT REVIEW: Infection Pre...
POINT REVIEW: Presentation ...
POINT REVIEW: PVC bundle c...
POINT REVIEW: Urinary cath...
POINT REVIEW: Wristband au...
Rapid Response / Cardiac Arr...
Resuscitation Trolley Audit
Wound Assessment Chart Audit

	Feb	Mar
PCH Anaesthetics Department	N/A	N/A
PCH Critical Care Outreach	N/A	N/A
PCH Day Surgical Unit	98.93%	100.00%
PCH Endoscopy Unit	93.85%	95.70%
PCH ITU	96.13%	97.13%
PCH Pre Assessment Clinic	99.15%	99.15%
PCH Theatre Department	98.65%	95.10%
PCH Ward 05	90.55%	93.15%
PCH Ward 06	95.15%	97.28%
PCH Ward 07 (formerly ward 3)	83.73%	93.30%
PCH Ward 08	95.01%	97.39%
PWH Anaesthetics Department	N/A	N/A
PWH Day Surgery Unit	98.87%	98.03%
PWH Endoscopy Unit	99.24%	99.51%
PWH ITU	98.40%	99.07%
PWH Theatre Department	90.84%	81.99%
PWH Ward 07	93.96%	94.76%
PWH Ward 08	98.73%	98.31%
PWH Ward 09	91.36%	92.95%
RGH Anaesthetics Department	100.00%	100.00%
RGH Critical Care Outreach	N/A	N/A
RGH Day Surgical Unit	100.00%	100.00%
RGH Endoscopy Unit	100.00%	100.00%
RGH Hummingbird Centre	98.87%	98.87%
RGH ITU/HDU	100.00%	100.00%
RGH Outpatients Department - Main	100.00%	99.10%
RGH Snowdrop Breast Unit	99.03%	98.20%
RGH Theatre Department	98.58%	99.64%
RGH Ward 02	97.78%	97.90%
RGH Ward 03	96.84%	96.80%
RGH Ward 07 ITU	100.00%	100.00%
RGH Ward 08	94.43%	90.61%
RGH Ward 09	95.48%	95.49%
RGH Ward 10	95.89%	98.57%
RGH Ward 15	100.00%	99.74%
Average	**96.09%**	**96.47%**

All wards/depts. across Planned Care need to focus on reviewing and closing outstanding AMaT actions following monthly 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))*	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 Timely Equitable Person centred Safe
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* Quality *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☒	No: ☐
	Outcome:	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☒	No: ☐
	Outcome for Equality (delete as appropriate): POSITIVE	If no, please include rationale below:

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

5. Recommendation

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

Agenda Item
6.1

Quality & Safety Committee

Organisational Risk Register

Dyddiad y Cyfarfod / Date of Meeting	16/05/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
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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	April / May 2024	RISKS REVIEWED
Operational Management Board / Offline via email	April 2024	ENDORSED RISKS WHERE APPLICABLE FOR ELG
Executive Leadership Group	13th May 2024	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 taking into account feedback received from Members in relation to scoring, actions with associated timeframes and ensuring timely reviews. This will be a continuous improvement area that Members will hopefully note will evolve and improve over the next 12 months.

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 3rd May 2024. Where review dates have passed and updates were not available these have been followed up and a request to update sent. Reviews received after this date will be reflected in the next iteration.

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.

2.5 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

2.5 To date 627 members of staff trained to date since training commenced in 2021.

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

2.7 Feedback on the training continues to be positive, please see below:

- 40 attendees have provided formal feedback (using the URL Code for the Evaluation Form, which was introduced in November 2023).
    - 78% (31/40) provided a score of 5/5 in terms of content of the session
    - 20% (8/40) provided a score of 4/5 in terms of content of the session
    - 3% (1/40) provided a score of 3/5 in terms of content of the session
- 100% of the 40 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.
- 98% of the 40 attendees providing formal feedback said they felt more confident to escalate a risk through the organisation.
- Some of the recent comments received through evaluation have been included below:

  From the session on the 2nd May 2024.
    - *"Clear guidance on what risks are how to score and actions."*
    - *"Clear explanations with good examples"*
    - *"All new info (to me), well presented. Thank you"*
    - *"Great insight clearly explained and would advise my team to attend".*
    - *Really good session. Friendly and informative."*

3. Key Risks / Matters for Escalation

3.1 NEW RISKS

Children and Family Care Group

- Datix Risk ID 5755 - Princess of Wales Air handling unit and electrical infrastructure for Labour ward and Neonatal Unit - New risk escalated to the Organisational Risk Register in May 2024. Risk score of 20.

Medical Directorate and Digital & Data Directorate

- Datix ID 5761 - Cross Health Board Data Sharing - New risk escalated to the Organisational Risk Register in May 2024. Risk score of 16.

3.2 CHANGES TO RISKS

Unscheduled Care (USC) – Care Group

- Datix Risk ID 1133 - Long term sustainability and staffing of the Emergency Department (ED) at the Royal Glamorgan Hospital. (RGH). Risk score reduced from a 20 to a 12 in May 2024. USC Senior Management Team risk reviewed, nurse establishment invest to save paper under development unitising the RCN BEST tool (same tool used to review the Prince Charles Hospital nursing workforce 2021). In order to mitigate this risk, the increase staffing level requested has been maintained by the care group at financial risk, by utilising bank and agency staff.

- Datix Risk ID 4732 - Lack of orthogeriatrician as NICE guidance and KPI1 NHFD. The USC SMT reviewed. Awaiting alignment of budgets, post phase 2 OCP. This forms part of the investment cycle for the financial period 24/25 and therefore risk has been de-escalated to a risk score of 12.

3.3 CLOSED RISKS FROM THE ORGANISATIONAL RISK REGISTER

Nil as assigned to this Committee.

3.4 Organisational Risk Register - Visual Heat Map by Datix Risk ID (Risks rated 15 and above):

Consequence						
	5			3337 3993 4080	5276 5755	
	4				4906 3131 4908 5404 5579 5658 5417 4152 3133 5254 4907 5646 2713 5761	4491 4071 4103 3826 5590 5640 4632 5462
	3					4650 2808 4691
	2					
	1					
CxL		1	2	3	4	5
		Likelihood				

3.5 Emerging risks

- The Diagnostics, Therapies, Pharmacy and Sciences Care Group have indicated that the following risks, which have a current risk score of 15 and above, will

be considered at the next Operational Management Board for consideration in terms of escalation to the Organisational Risk Register:
  - o Datix Risk ID 5730 – No Health Board MRI Pacemaker Service
  - o Datix Risk ID 5726 – Public Health Funding for Microbiology.

- The Patient, Care and Safety Team have indicated that they are currently reviewing the following risk to consider escalation to the Organisational Risk Register:
  - o Investigation of post-April 2022 patient safety incidents of nosocomial COVID-19.

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	Scoring Trajectory *(since the last report received by the Board)*
1.	Sufficient capacity to meet emergency and elective demand Click Here for Risk 1	Improving Care	Chief Operating Officer / Executive Director of Strategy and Transformation	Quality and Safety; Planning, Performance and Finance	16 (C4xL4)	No change as at May 2024 ⟷
2.	Ability to deliver improvements which transform care and enhance outcomes Click Here for Risk 2	Improving Care	Executive Dir. Of Nursing, Midwifery / Executive Medical Director	Quality and Safety	16 (C4xL4)	No change as at May 2024 ⟷

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:
	A Resilient Wales

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

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd?* / Quality *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not required for the organisational Risk Register. Individual risks may have been subject to QIA.
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg?* / Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: Not required for the organisational Risk Register. Individual risks may have been subject to an Impact Assessment.
Cyfreithiol / Legal	Yes (Include further detail below)	
	See detail captured for each risk	
Enw da / Reputational	Yes (Include further detail below)	
	See detail captured for each risk	
Effaith Adnoddau	Yes (Include further detail below)	

(Pobl /Ariannol) / Resource Impact *(People / Financial)*	See detail captured for each risk

5. Recommendation

5.1 The Committee are asked to:

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

6. Next Steps

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

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
2	5755	Chief Operating Officer	Children and Families Care Group	Service Director - Children and Family Care Group	Improving Care	Environment /Estate/ Infrastructure	Princess of Wales (POW) Air handling unit and electrical infrastructure for Labour ward and Neonatal Unit	**If** the Air handling unit or the electrical system backups fail for the labour ward and neonatal unit template in POW. **Then** we do not have assurance that our backup systems will maintain critical equipment including ventilators, anaesthetic machines, pumps etc. and key life preserving equipment during clinical procedures. **Resulting in** harm to patients and potential for life changing consequences for mothers and babies.	All equipment is being assessed for battery backup. Emergency scenario planning will be arranged with Strategy team as a priority.	Capital resource has been approved and allocated to support the infrastructure work from Welsh Government during this financial year. Plans are being drafted for the temporary decant of services for the period of estates work.	Planning, Performance & Finance Committee Quality & Safety Committee	20	C5xL4	C3xL2	New risk escalated to the organisational risk register in May 2024	18.04.2024	18.04.2024	24.05.2024
3	5590	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Radiology Service Manager	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 April 2024 - Swansea Bay University Health Board who supply CTMUHB's radioisotopes have instigated a brief firebreak in order to scale up their production. This would have had an impact on breast cancer surgery, however, the team have been able to use an alternative technique for this period, which has been used previously in Neath Port Talbot Hospital when part of the service was based there.	Quality & Safety Committee	20	C4xL5	4 C4xL1	↔	23.10.2023	15.04.2024	20.05.2024
4	5276	Director of Digital	Central Support Function - Digital and Data	Assistant director of therapies and health science	Sustaining Our Future	Business Objectives - Operational Patient safety Digital Healthcare Wales interdependencies	Failure to deliver replacement Laboratory Information Management System, LINC Programme, by summer 2025,	**IF:** the new Laboratory Information Management System (LIMS) service is not fully deployed before the contract for the current LIMS expires in June 2025. **THEN:** operational delivery of pathology services may be severely impacted. **RESULTING IN** potential delays in treatments, affecting the quality and safety of a broad spectrum of clinical services and the potential for financial and workforce impact.	Currently LINC Programme reports progress against timeline to LINC Programme Board and Chief Executive Group. Business continuity options are being explored including extending the contract for the current LIMS to cover any short term gap in provisions. An expert stock take review of the LINC programme has been completed with findings presented to Collaborative Executive Group (CEG) to inform next steps.	Update May 2024 - CTMUHB have appointed internally into the 2 x fixed term band 7 clinical systems support roles for Pathology - once these posts have been backfilled these posts will be able to fully support LIMS implementation. The 1 x 8a fixed term clinical systems manager for Pathology has just gone out to advert, hoping to recruit externally - this post will provide project oversight and co-ordination. These posts will bring CTM in line with other Health Board's in terms of dedicated pathology IT support, however, Health Boards across Wales are looking for extra support in addition to this. Pathology continues to hold monthly LIMS deployment meetings with Digital Health Care Wales (DHCW) to facilitate progress.	Digital & Data Committee Quality & Safety Committee	20	C5xL4	5 (C5xL1)	↔	26.10.2022	3.5.2024	31.05.2024
5	4491	Chief Operating Officer	Deputy Chief Operating Officer - Acute Services.	Deputy Chief Operating Officer - Acute Services.	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to meet the demand for patient care at all points of the patient journey	**IF:** The Health Board is unable to meet the demand upon its services at all stages of the patient journey. **Then:** the Health Board's ability to provide high quality care will be reduced. **Resulting in:** Potential avoidable harm to patients	Controls are in place and include: • Technical list management processes as follows: - Speciality specific plans are in place to ensure patients requiring clinical review are assessed. - All patients identified will be clinically reviewed which will include an assessment of avoidable harm which will be reported and acted upon accordingly. - A process has been implemented to ensure no new sub specialty codes can be added to an unreported list, this will be refined over the coming months. - All unreported lists that appear to require reporting have been added to the RTT reported lists - All unreported lists that are to remain unreported (as they do not form part of the RTT criteria) are being reviewed and will be visible and monitored going forward. • Patients prioritised on clinical need using nationally defined categories • Demand and Capacity Planning being refined in the UHB to assist with longer term planning. • Outsourcing is a fundamental part of the Health Board's plan going forward. • The Health Board will continue to work towards improved capacity for Day Surgery and 23:59 case load. • A Harm Review process is being piloted within Ophthalmology – it will be rolled out to other areas. • The Health Board has taken advice from outside agencies especially the DU when the potential for improvement is found. • Appropriate monitoring at ILG and Health Board levels via scheduled and formal performance meetings with additional audits undertaken when areas of concern are identified Planned Care board established. - The Health Board is exploring working with neighbouring HBs in order to utilise their estate for operating.	Update April 2024 - to align with the review of the Strategic Risk on the Board Assurance Framework, Planned Care and Unscheduled Care Group Service Directors have been asked to review this risk with a view to splitting it out to accurately reflect the performance and risk trajectories in each of these areas so they can be more clearly articulated. In terms of the management of flow CTMUHB is looking to transform the flow function across CTM to scope a flow hub 7 day week model of working (Currently in the early stages). Within Planned Care 6-4-2 embedded across the acute sites to support the maximum utilisation of theatres and outpatients, this is reflected in the current performance and reduction in waiting times in line with Welsh Government targets. The Navigation Hub is hugely successful and is constantly refining its ability to manage activity away from the Emergency Department. No change to risk score due to the review shortly to be undertaken.	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4xL5	12 C4 x L3	↔	13.7.2023	01.05.2024	30.06.2024
6	4071	Chief Operating Officer Planned Care - Care Group	Planned Care Group	Interim Planned Care Service Group Director	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 recommencing 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 May 2024 - Risk unchanged. Sustained reduction in 104 day backlog. Improved percentage of patients informed that they do not have cancer <28 days. Reduction in USC and BSW endoscopy waiting times and now achieving 4 week standard for screening colonoscopy.	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4 x L5	12 (C4 x L3)	↔	01/04/2014	26.04.2024	3.6.2024
7	4103	Chief Operating Officer	Planned Care Group	Interim Planned Care Service Group Director	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 enactioned. 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 April 2024 Previous high risk areas of the injection/macular clinic and the diabetic retinopathy service are now in a much better position with significant delays mostly eliminated. They remain vulnerable and work is ongoing to try and make them more robust and sustainable. CTMUH B did not have a substantive glaucoma consultant from 2017 to 2023. The glaucoma service is top of the list of services to fix but in the process of fixing it, we are going to come across many, many cases of avoidable vision loss. Aside from the human cost of avoidable blindness, there is a large financial and reputational risk to the HB. The glaucoma service is currently at score of 25 on risk matrix - catastrophic consequences (blindness in high volume of patients) (5) x almost certain to occur (5). This needs to be the highest priority area in ophthalmology for the HB. Cataracts and eye casualty are ongoing problem areas but are less urgent clinically than the risks outlined below. Major risks in ophthalmology at present 1) Glaucoma – glaucoma causes irreversible vision loss due to damage to the optic nerve. a. high volumes of long waiting patients. Many not seen for several years. Increasing Sis with severe harm as long-waiters finally being seen b. Large numbers of stage 4 glaucoma patients awaiting surgery, some for > 1 year. This is the highest risk glaucoma population. Patients are generally listed for surgery when medical treatment does not work – these patients are at high risk of vision loss with such long delays. Mitigating factors – we have 2 substantive glaucoma consultants, 1 locum consultant. Community glaucoma scheme and WGOS4 will allow some low risk patients to be monitored in the community Immediate actions: meeting next week to formulate plan for stage 4 patients Need decision on funding for diagnostic hub to increase capacity in glaucoma service 2) Medical retina a. Long delay for new appt. Few dedicated medical retina appointments. 3) Inappropriate discharge by outsourcing company in April 2019. a. ~3000 patients discharged after notes review by outsource company in April 2019. b. Was noted that many of these patients had sight-threatening disease and should not have been discharged. Some patients with ocular cancer received a discharge letter. c. Sample of 350 records reviewed in 2021: ~50% were appropriate discharge. 22% not appropriate. 23% uncertain. d. Initial plan was to review all notes of all discharged patients to ascertain if discharge was safe – this work still outstanding	Quality & Safety Committee	20	C4 x L5	12 C4 x L3	↔	01/04/2014	26.04.2024	3.6.2024

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
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8	4632	Executive Director of Therapies and Health Sciences.	Unscheduled Care Group	Head of Strategic Planning and Commissioning	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Provision of an effective and comprehensive stroke service across CTM (encompassing prevention, early intervention, acute care and rehabilitation)	**IF:** changes are not made to improve and align stroke prevention initiatives, early intervention campaigns, and acute and rehabilitation stroke care pathways across CTM **THEN:** avoidable strokes may not be prevented, patients who suffer a stroke may miss the time-window for specialist treatments (thrombolysis, thrombectomy), and patients may not receive timely, high-quality, evidence-based stroke care **RESULTING In:** higher than necessary demand for stroke services, poorer patient outcomes/increased disability, increased length of stay, and poor patient/carer experience. Impact will extend to the need for increased packages of care, increased demand for community health services, and increased carer burden when discharged to the community.	• Executive-led Stroke Strategy Group in place, with targeted task and finish under development. Membership updated to reflect senior Ops changes. • ToR and membership of Strategy Group updated. • Close working amongst executive team to escalate and address operational and clinical issues in relation to stroke pathway • Board briefing to ensure all sighted to challenges • Quarterly briefings to Quality and Safety Committee • Performance data regularly presented to Performance, Planning and Finance Committee • Strong CTM input to regional and national Stroke Programme Boards • Unified, evidence-based pathway developed for thrombolysis • Preparations progressing to prepare for 24/7 thrombectomy service at Bristol and updated RCP guidance on thrombolysis and thrombectomy • Designated senior operational lead for performance and improvement leadership for stroke pathway	Update April 2024 - USC Care Group continue with new governance arrangements to give a greater level of focus and assurance in relation to an organisational approach relating to Stroke: • Operational Performance Group and Stroke Programme board now fully established to focus on the performance and actions for improvement. • Consultant recruitment still remains challenged, no applicants when the job has been advertised. • On the 18th December the Brainomix AI Software (reporting for CTs and CT angiograms to minimise delays in referral for thrombectomy) was implemented and a report on its early stages was presented at February's Programme Board. It reported that whilst the access to view CT scans was much improved that the current stage of development of the AI was not sufficiently reliable for the reporting of scans. • The South Central Regional Stroke Programme continues in developing options towards a regional solution for stroke services. • Consultant vacancy - discussions are underway to explore opportunities for a Regional approach with Cardiff and Vale to support the Service. • In order to improve the performance of our Stroke service across both PCH and POW a proposal has been developed that would increase the CNS cover up to 12/7, due to limited number of strokes coming within the night. Operation proposal in progress, if approved and implemented this should contribute to improving the % of patients admitted to a stroke ward within 4 hours and the number of eligible patients thrombolysed door to needle time of >45mins. • A proposal has been made to expand the remit of the Stroke Data co-ordinator role at PCH to incorporate POW to achieve consistency of process and data collection and robustness across both sites. In addition to this it is inclusive of the operation proposal. • The Early Support Discharge Service has been extended to Bridgend to improve equity across the Health Board. • There are challenges to meet demand at the front door at both sites and achieve effective discharge pathways, this is impacting flow across the system, which is an issue in relation to the ring-fencing of Stroke beds, CT scans and conveyancing of self-presenting patients at RGH to PCH. This is not however a CTM only issue as reflected in the National Review of the impact of Flow on Stroke services. An improvement plan is in place to address the national recommendations. Risk rating to remain the same, 20. Next review date 30/06/24.	Quality & Safety Committee	20	C4 x L5	12 (C4 x L3)	↔	11.05.2021	03.05.2024	30.06.2024
9	5462	Executive Director of Public Health Executive Director of Therapies & Health Science	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Care Group Service Director	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.	People are offered the lowest intervention required in line with the Health Weight Healthy Wales pathways. Those that are waiting are being supported with 'waiting well' signposting. Digital opportunities are being explored to maximise efficiencies within pathways as well as maintaining communication with patients to manage expectations on waiting list times. Existing services, both within the Health Board and with community partners are being maximised and integrated within pathways.	Update April 2024 - Demand & Capacity continues to be reviewed each quarter. Q4, March 2024 showed a waiting List of 1500 patients, an increase from 1300 at Q3. Group education evaluation is positive, showing it is a suitable service model for 75% of patients requiring a level 3 service. This has increased service capacity by 50% compared to original service specification, however referral rates continue to exceed service capacity. Prescribing capacity for high-cost medications and implications for demand exceeding current funding has been agreed in collaboration with Medicines Management. Next rv 20.5.24	Quality & Safety Committee People & Culture Committee Population Health & Partnership Committee	20	C4xL5	8 - (C4xL2)	↔	07.06.2023	29.04.2024	20.05.2024
11	3826 Linked to 4839 and 4841 in Bridgend Linked to 4462	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director - Unscheduled Care.	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Emergency Department (ED) Overcrowding	**If:** As a result of exit block due to hospital capacity and process issues patients spend excess amounts of time within the Emergency Department. This is manifested by, but not limited, to significant 12 hour breaches currently in excess of 400 per month. There are also large numbers of patients spending longer than 24hrs and 48hrs within the ED (please see attached information). **Then:** patients are therefore placed in non-clinical areas. **Resulting In:** Failure to deliver Emergency Department Metrics, Poor patient experience, compromising dignity, confidentiality and quality of care. The ability for timely ambulance handover with extensive delays for patients requiring assessment and treatment. Filling assessment spaces compromised the ability to provide timely rapid assessment of majors cases; ambulance arrivals and self presenters. Filling the last resus space compromises the ability to manage an immediate life threatening emergency. Clinicians taking increasing personal risk in management of clinical cases. Environmental issues e.g. limited toilet facilities, limited paediatric space and lack of dedicated space to assess mental health patients. Some of the resulting impact such as limited space has been exacerbated by the impact of the Covid-19 pandemic and the need to ensure appropriate social distancing.	Increased number of nursing staff being rostered over and above establishment. Additional repose mattresses have been purchased with associated equipment. Additional catering and supplies. Incidents generated and attached to this risk. Weekly report highlighting level of above risk being generated. All patients are triaged, assessed and treatment started while waiting to offload. - Escalation of delays to site manager and Director of Operations to support actions to allow ambulance crews to be released. - Rapid test capacity in the POW hot lab has recently increased with a reduction in swab turnaround times. - Expansion of the bed capacity in YS to mitigate against the loss of bed capacity in the care home sector and Maesteg community hospital. - Daily site wide safety meeting to ensure flow and site safety is maintained. - There is now a daily WAST led call (including weekends) with a senior identified leader from the Health Board representing CTM and talking daily through the plans to reduce offload delays across the 3 DGH sites. -Twice weekly meetings with BCBC colleagues to ensure that any delays in discharge are escalated at a senior level to maximise the use of limited care packages/ care home capacity. -Appointment of Clinical Lead and Lead Nurse for Flow appointed Feb 21 - Operational Performance is now monitored through the monthly performance review. Performance review process has been restructured to bring more rigour with a focus on specific operational improvements. - Programme improvement is monitored through the monthly Unscheduled Care Improvement Board, which reports into Management Board.	Update April 2024 - The USC Senior Management Team (SMT) reviewed current ambulatory pathways and the site based clinical teams are in the process of developing an Standard Operating Procedure (SOP) relating to fit2sit. The USC SMT continue to explore the potential to expand ambulatory footprint at the Princess of Wales site. Following the successful bid for Welsh Government funding for Royal Glamorgan Hospital nurse call bell and emergency call system within Ambulatory Emergency Care Unit (AECU), Prince Charles Hospital Ambulatory plans are in place to complete this work however there is a slight delay with this at present. This will improve patient experience within these departments. Work has commenced to create an action plan, linked to the quality statement for care in the emergency departments. 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. This 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, risk rating to remain at 20. C4, likely hood 5. New review date 30/06/2024.	Quality & Safety Committee Planning & Performance Committee	20	C4xL5	12 (C4xL3)	↔	24.09.2019	3.5.2024	30.06.2024
12	5761	Executive Medical Director	Medical Directorate Function	Medical Directorate Manager	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Cross Health Board Data Sharing	If: Digital services across Wales are unable to resolve an ongoing issue with the ability to share patient data in both directions across health boards/trusts Then: Clinical staff across CTM will be unable to provide the safe and effective care to patients using transparent, available data Resulting in: Potential harm to the patients of CTM due to the lack of clinical information available to clinicians when making clinical assessments	For CTM, this is a particular issue in Prince Charles Hospital as there is a lot of patient cross over at the boundary of Aneurin Bevan Health Board. As a health board we continue to raise this as a serious patient safety issue and will continue to press for a solution with Digital Health Care Wales. CTMUHB have asked for alternate options for a quicker solution and timescales to be aligned with these. This has been added as an agenda item for discussion at the next All Wales Medical Director meeting.	Digital Health Care Wales have been working on the ability to share data in both directions so data flows in the Health Board systems – this has been an issue for some time. ABUHB have allocated some project resource to scope, map and plan the work needed, however, resources will need to be allocated by C&V and AB to get the work done. There was a strong commitment from Pan-South East Wales Regional Digital to work closer together and link into a wider regional programme board, this was repeated at the regional planning meeting. As of March 2024, the update from DHCW is that they working on delivering the open architecture to support sharing documents and diagnostic results.	Quality & Safety Committee Digital & Data Committee	16	C4xL4	8 C4xL2	New risk escalated to the organisational risk register in May 2024	26.04.2024	26.04.2024	31.05.2024
15	5417	Chief Operating Officer	Primary Care and Community Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Paediatric Dentistry - General Anaesthetic (GA) theatre list	**If...** Regular additional GA theatre lists (necessary to meet current and future demand) are not made available to the Community Dental Service team for paediatric GA. **Then...** the number of children waiting list for assessment and treatment will continue to increase beyond 1000 by March 2024. **Resulting in..** 1. children waiting increased times for assessment/treatment who have high levels of dental caries and painful teeth requiring extraction, 2. a further increase in the number of children requiring GA, due to long waits for assessment more children need GA when assessed, conversion rate has jumped form 48% to 80%. Children can only wait 8 wks form assessment to treatment therefore there is a large backlog of assessments due to limited GA lists to provide treatment.	Current theatre lists are run on Monday mornings and Friday afternoons and are likely to be cancelled due to bank holidays. This impacts the running of the service, no additional lists are available when lists are missed. There are currently 800+ patients waiting for appointments, with some already waiting for 17 months. Patients are advised to return to their General Dental Practitioner (GDP) if they experience pain, some children are being prescribed multiple courses of antibiotics to ease dental infections that can only be alleviated by tooth extraction. There is a risk these patients will require the removal of more teeth/more require GA when assessed/children will present as an urgent case in Accident and Emergency if left untreated.	Update April 2024 - The Care Group have explored the mitigating action required to manage and reduce this risk and identified that the main mitigation will be the allocation of the adhoc additional lists by secondary care, however, these additional sessions are not yet confirmed. Until these sessions are confirmed this risk remains high. The Care Group are working through a plan around demand and capacity with the Planned Care – Care Group for additional theatre sessions but as indicated this has not yet confirmed. Once additional sessions are secured the risk will be reduced and be mitigated through to the backlog being resolved.	Quality & Safety Committee	16	C4xL4	9 C3xL3	↔	20.04.2023	18.04.2024	31.05.2024
16	5658	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Care Group Service Director	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 April 2024 - SBAR completed, meeting held on 10.4.24 between Head of Dietetics, Clinical Director for AHPs, Clinical Director for Critical Care and Clinical Service Group Manager . Next steps are to explore funding for proposed workforce via planned care board and Operational Management board. Next rv date 23.5.24.	Quality & Safety Committee. People & Culture Committee - Workforce aspect	16	C4xL4	8 (C4xL2)	↔	19.12.2023	29.04.2024	23.05.2024
18	5646	Chief Operating Officer	Mental Health Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	The impact of "Right Care Right Person" approach.	**If:** South Wales Police (SWP) implement Right Care Right Person **Then:** In some circumstances the Health Board will not be able to routinely call upon SWP to assist with people in mental health crisis or with social care issues, for example, missing patients, welfare checks and supervising people who are detained on S136 Mental Health Act. **Resulting in**: Increased risks to our staff and the people who use our services.	Multi-agency planning meetings have been arranged to review policies. This is an emerging picture and one which the Health Board are developing a fuller mitigation against, it is also a picture which has a gradual phased roll out over the next year. Nurse Director for the Care Group will be drafting a report for Operational Management Board later in the month but timelines have not allowed for this at submission to the Organisational Risk Register.	The Health Board will gather and analyse available data to further understand the issues and impact The Health Board will explore options to manage the need in a different way. Risk likelihood assessment: Initial data gathering suggests that the likelihood is more likely to be weekly and not daily. Update March 2024 - Phase 1 of RCRP commenced 26/02/2024. Head of Nursing for MHLD Care Group is tactical lead. Awareness sessions attended by over 250 staff. Health Board wide planning meeting continues to meet. Daily troubleshooting Multi-agency meetings with South Wales Police continue. Update April 2024 - progress remains as captured in March 2024 and the next review date of this risk is scheduled for the end of May. No change to mitigation and risk score at this time.	Quality & Safety Committee Mental Health Act Monitoring Committee	16	C4xL4	12 (C3XL4)	↔	08.12.2023	06.03.2024	31.05.2024

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
19	2713	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Radiology Service Manager	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Backlog of Reporting Radiology Examinations	**IF** there is consistent backlog of Radiology reports **THEN** there will a delay in patient diagnosis and treatment, which could lead to poorer patient outcomes **RESULTING IN** deterioration of health and potential death. All radiological examinations should be reported in a timely manner. There is a risk of delay in diagnosis of patient condition and any additional interventions/treatment that may be required following diagnosis due to an excessive backlog and increasing demand in imaging services. There is also a risk of damage to the reputation of the Organisation due to the failure to meet performance targets. The reporting backlog has been compounded by; Reduced effective Radiologist workforce due to retirements, sickness, secondment, maternity leave and limited available Radiologist workforce. RadIS merger which caused problems for outsourcing as prior imaging has not been available as it previously has been. National Cyber attack, computer & RadIS patches which caused two weeks downtime for reporting. Colon CT - All barium enema examinations are now scanned in CT which has increased the specialist reporting significantly with no increase in Radiologist support. Long term inability to recruit Radiologists as there are insufficient numbers trained in the UK. There is also risk of work related stress due to pressure placed on existing Radiologist workforce to meet the demands of the service.	Radiologists performing extra reporting sessions in addition to their normal working hours. Radiographers trained to report accident & emergency images. Up to date job plans for all Radiologists. Datix incident and concerns procedures in place. Data tracked weekly.	Update April 2024 - Review monitoring of additional funding. Vacancies.	Quality & Safety Committee Planning Performance & Finance Committee	16	C4xL4	4 C4xL1	↔	08.02.2017	15.04.2024	20.05.2024
20	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 Impact on the safety – Physical and/or Psychological harm	Rising childhood obesity rates resulting in an increase in obesity related conditions and poorer health outcomes.	**If** there is no children and young person's weight management service **Then** the Health Board will be unable to support children and young people to manage their overweight and obesity **Resulting in** non-compliance with national standards and pathways, significant risk to patients with increase in childhood obesity rates, obesity related conditions, healthcare costs and no improvement in the health of the most disadvantaged.	Some Level 1 weight management service exist across the Health Board, namely PIPYN (3-7yrs Merthyr only) and Henry (0-5 CTM wide), these programmes are currently fixed term funded until end March 24. There is no level 2 - multicomponent service or level 3 - specialist MDT service. An option appraisal for the introduction of a children and families weight management service has been undertaken.	Update April 2024 - - Risk descriptor changed on this risk review. Business case finalised, and presented to Creating Health Steering Group 18.04.24. Proposal endorsed and the agreed next steps are to identify sources of funding. Next rv 25.7.24.	Population Health & Partnerships Committee Quality & Safety Committee	16	C4xL4	8 C4xL2	↔	13.10.2023	29.04.2024	25.07.2024
21	4907	Executive Nurse Director / Deputy Chief Executive	Central Support Function - Quality Governance (Concerns & Claims)	Assistant Director of Concerns and Claims	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 May 2024 - Overtime work continues on redress backlog. New invest to save bid is to be updated with estimate of any potential change to thresholds from £25k to £50k (as per proposed Putting Things Right consultation). The demand versus capacity report has provided a snapshot of current position and has prompted a review of all case files. A review and reallocation of all redress cases will take place in May 2024. Redress is an area of high risk and will need some funding if the threshold changes from £25k to £50k as proposed in the Putting Things Right changes.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	02.11.2021	22.04.2024	01.06.2024
22	4908	Executive Nurse Director / Deputy Chief Executive	Central Function - Patient, Care and Safety	Assistant Director Quality & Safety	Improving Care	Statutory Duty, Regulation, Mandatory Requirements	Failure to manage Legal cases efficiently and effectively	**If:** The Health Board was unable to sustain ongoing funding for the two temporary Legal Services Officers **Then:** the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. **Resulting in:** Risk to quality and safety of patient care, resulting from lack of capacity to management cases in a efficient and effective manner, which could result in failure to comply with the WRP procedures resulting in financial penalties	The Health Board are developing an action plan in response to the Welsh Risk Pool review, which includes the reviewing structures and workloads New operating model in respect of quality, safety and governance almost fully implemented. New systems and processes, including escalation, implemented to assist to effectively manage cases. The Assistant Director of Concerns & Claims, Head of Legal Services and Legal Services Manager are all carrying case loads to help mitigate this risk. The team are having to apply an objective triage approach across the portfolio of redress, LFERs and Inquests to support the mitigation of this risk.	Update May 2024 - New reports are required for the Care Groups. Inquests continue to be graded to identify high risk inquests (Red, Amber and Green). In April 2024, a data reconciliation took place with HM Coroner's Office, which allowed just over 50 cases to be closed and any outstanding information was highlighted. Communication channels remain open between CTMUHB and HM Coroner's Office. The demand versus capacity report has provided a snapshot of current position and has prompted a review of all case files. A review and reallocation of all Inquest cases will take place in June and July 2024. Care Group Governance meetings continue to be managed in a locality format therefore Legal Services team do not have capacity to attend all meetings. A new report is being devised by the BI team to support Care Groups.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	02.11.2021	22.04.2024	01.06.2024
23	5404	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Care Group Service Director	Improving Care	Statutory Duty, Regulation, Mandatory Requirements	Post Mortem Backlogs in Mortuary	**IF:** the Coronial service fails to ensure consultant Pathologist capacity to undertake post mortems to meet the increasing demand across the Health Board region. **THEN:** There will be delays in performing and reporting autopsies. **RESULTING IN:** * Mortuary capacity breaches * Inability to store deceased appropriately including long term freezer storage of which the Health Board only has 8 spaces. *deterioration of deceased due to length of stay leading to poor experience for the bereaved and complaints *Failure of the Health Board to provide a quality Bereavement service to the population. * Families not being able to view loved ones due deteriorating condition of the deceased due to prolonged storage *Non-compliance with HTA regulatory requirements and current WG bereavement framework principles *Reputational damage *Reliance on additional contingency storage creating financial risk for the Health Board	Additional contingency storage in place. Weekly situation meetings with Coroner's Office to assess current situation. Short term use of Locum pathologist by service provider commissioned by the Coroner's Office using our current supporting APT resource whilst Pathologist on leave.	Update April 2024 - Backlogs have improved with the use of medi-link. A bank APT has left however so we are short 1 APT, we are using a locum APT 1 day per week to support the Forensic service whilst UHW is undergoing re-furbishment.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	13.04.2023	08.04.2024	08.05.2024
24	3131	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Mortuary Capacity	**IF:** There is insufficient Mortuary capacity across the Health Board, including bariatric capacity **THEN**: the Health Board will be unable to accommodate any increases in deaths (due to seasonal pressures, pandemics, general increases in service demand), and may exceed capacity in the event of Mortuary closure or refrigeration failure, or funeral directors/undertakers being unable to collect bodies or move bodies between sites due to adverse weather. **RESULTING IN:** bodies not being placed in storage that is in compliance with HTA licencing standards, No capacity for bariatric bodies, leading to HTA reportable incidents, complaints and reputational damage.	Mortuary capacity log is in operation and informs the pathology scorecard for monthly reporting (average, max and min). Business continuity plan is in place to move bodies around the sites to ensure capacity is maintained within the HB. This relies on the Health Boards contracted funeral director to move the bodies in an appropriate and dignified manner. Mortuary staff are trained to complete the mortuary capacity log on a daily basis and to ensure the business continuity plan is executed in the event of likely capacity issues. Nutwell units in use at Royal Glamorgan Hospital (RGH) and Prince Charles Hospital (PCH) "Real time" capacity white board installed in both mortuaries so porters/APTs can visualise quickly capacity issues. Private ambulance with a dedicated driver, now in use between sites. 4X4 vehicle so can be used during inclement weather (within reason). Can transport up to 4 deceased per journey, in a dignified manner.	Update April 2024 - Mortuary staff resource is currently unstable due to some bank staff leaving making it difficult to efficiently move bodies. We are currently at 67% occupancy however this is including Nutwells contingency storage. Could potentially be de-escalated from the organisational risk register, however approval and further information will be required from the service manager prior to any de-escalation.	Quality & Safety Committee	16	C4xL4	C4xL2	↔	05.03.2018	08.04.2024	08.05.2024
25	5254	Executive Nurse Director / Deputy Chief Executive	Centre Support Function - Quality Governance - Concerns and Claims	Assistant Director of Concerns and Claims	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to manage Redress cases efficiently and effectively in respect of Duty of Candour	**If**: The Health Board is unable to meet the increased work demand in respect of the implementation of Duty of Candour **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: * New incident framework developed * Engagement with the All Wales Duty of Candour Network to discuss implementation of the Duty * Reports run on predicted case numbers * Request to the All Wales Duty of Candour Network that an impact assessment is undertaken	Update May 2024 - Overtime continues to reduce the backlog of redress cases. Redress remains a risk area, particularly if the threshold increases from £25k to £50k following the PTR consultation. The demand versus capacity report has provided a snapshot of current position and has prompted a review of all case files. A review and reallocation of all redress cases will take place in May 2024.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	07.10.2022	22.04.2024	01.06.2024

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1	Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
27	3133	Executive Director of Nursing / Deputy Chief Executive	Patient Care and Safety	Head of Clinical Education	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Poor compliance with Medical Gas Safety Training .	**If:** Staff are not able to attend Medical Gas Safety training or courses are being continuously rescheduled. **Then:** Staff are not being trained in safe storage and flow of cylinders (e.g. oxygen). **Resulting In:** Failure to adequately and safely obtain and continue flow of cylinders (e.g. oxygen), potentially causing harm to patients.	PSN041 Patient Safety Notice and local safety alert disseminated to all staff. Posters developed and displayed in areas to encourage attendance. New staff trained at induction. TNA has been undertaken. Refresher training is undertaken, however current attendance levels by clinical staff for Medical Gas Safety training is poor, hence the current risk score. Medical Gas Cylinder Policy developed with training section completed by Medical Device Trainer, referencing the mandatory requirement for training by all users. Completed To make it a key requirement that staff can be released to attend training to re-enforce safety and operating guidelines of medical gas cylinders. Completed. Medical Device Trainer has put in place a B4 role who is undertaking a rolling programme for Medical Gas Training, with two sessions, twice a month, at each ILG every month. However, although training has been undertaken for Porters and graduate nurses, nursing staff currently in post are still not attending and attendance continues to be poor due to current circumstances with Covid-19 and due to not being able to be released for the 2 hours of training. Medical Device Trainer and Assistant Director of Facilities to request again for the Executive Director of Nursing Midwifery and Patient Care to review nursing attendance and make the necessary arrangements to allow nursing staff to attend training and also to look at the possibility of introducing a 'training day' that will allow nursing staff to be released to attend those courses that are struggling with attendance levels. Meeting held and COO has requested for Facilities to work on a monthly Medical Device Training Compliance report template that can be presented to both COO and ILG Director leads to inform current compliance position and actions to improve attendance and compliance for all courses including Medical Gas Training. Medical Device Trainer has stated that the current report template needs to be reconfigured to account for the change of wards and Directorates for the new ILG structure and to deal with the pandemic, this will take time to complete, hence the change in action implementation date to account for this.	Update March 2024 - New module of training and education related to medical gases has been introduced in collaboration with Learning & Development and All Wales ESR Team to improve compliance and flexibility for all relevant staff to undertake training. Risk score to remain unchanged until training embedded. Update May 2024 - Learning and Development function have supported the sourcing and roll out of an e-learning module for medical gas testing. The risk has remained at this score subject to assessment of the impact and uptake of the e-learning module.	Quality & Safety Committee. People & Culture Committee.	16	C4 x L4	8 (C4xL2)	↔	01/05/2018	07.05.2024	31.05.2024
28	4152	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Sciences Care Group	Care Group Service Director.	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Back log for Imaging in all modalities / areas and reduced capacity	**If:** there is a backlog of imaging and reduced capacity **Then:** waiting lists will continue to increase. **Resulting in** delay and diagnosis and treatment. Due to the Covid-19 outbreak, all routine imaging has stopped and there is reduced capacity for imaging of USC sand Urgent patients.	Due to the Covid-19 outbreak, all routine imaging was curtailed in line with recommendation for the lockdown periods, resulting in reduced capacity for imaging of Urgent Suspected Cancer (USC) and Urgent patients. It is likely to take many months or even years to get back to a pre-Covid state without additional planned care recovery financial support. However, the Welsh Government (WG) target is to return within the 8-week standard for all patients by March 2024. Cancer waits have been prioritised and are now being undertaken within around 2 weeks with the exception of CT scans which are still around 4 weeks at present.	Update April 2024 - -MRI van operational 22.4.24 Non Obstetric Ultrasound, decreased waiting list. 3865 CT increased demand 3021 Van to be cited at PCH (to cover building work) - explore costs to extended with and without staff. Out of hours staffing an issue across all sites.	Quality & Safety Committee	16	C4 x L4	4	↔	01/06/2020	15.04.2024	20.05.2024
31	4906	Executive Nurse Director / Deputy Chief Executive	Central Support Function - Quality Governance (Concerns & Claims)	Assistant Director of Concerns and Claims	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to provide evidence of learning from events (Incidents and Complaints)	**If:** The Health Board is unable to produce evidence of learning from events. **Then:** the Health Board will be unable to recoup any costs from Welsh Risk Pool for personal injury or clinical negligence claims made against the Health Board. **Resulting in**: Risk to quality and patient safety with potential for further claims as learning and improvement will not have taken place. Financial impact to the Health Board	Controls are in place and include: * Monitored and reported through the weekly Executive Quality & Safety meeting. * Regular engagement and meetings with the Executive team to assist in gathering of learning. Improvement plan implemented by WRP with monthly targets to submit the backlog. * Learning From Event Report (LFER) Standard Operating Procedure devised and disseminated * LFER 'How to Guide' devised and disseminated * Ad-hoc training available on request. * Internal targeted monitoring in place.	Update April 2024 - LFER status is regularly monitored in: Q&S Business meeting, Weekly Executive Patient Safety Meeting and Quality & Safety Committee. New systems and processes have been in place for some time in respect of the management of LFERs. One penalty received in respect of one outstanding deferred LFER. Regular review and liaison with the Heads of Quality & Safety. Linking with the WRP Safety Learning advisor for any problematic LFERs. Proactive management of LFERs is proving beneficial. Proactive management and monitoring will continue. Updated May 2024 - LFERs continue to be monitored in: Q&S Team Business meeting, and Weekly Executive Patient Safety Meeting and Quality & Safety Committee.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	02.11.2021	22.04.2024	01.06.2024
34	4080	Executive Medical Director Executive Director of People	Central Support Function - Medical Directorate & People Directorate	Assistant Medical Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to recruit sufficient medical and dental staff	**If:** the CTMUHB fails to recruit sufficient medical and dental staff. **Then:** the CTMUHB's ability to provide high quality care may be reduced. **Resulting in:** a reliance on agency staff, disrupting the continuity of care for patients and potentially effecting team communication. This may effect patient safety and patient experience. It also can impact on staff wellbeing and staff experience.	• Associate Medical Director for workforce appointed July 2020 • Recruitment strategy for CTMUHB being drafted • Establishment of medical workforce productivity programme • Work to understand workforce establishment vs need • Development of 'medical bank' • Developing and supporting other roles including physicians' associates, ANPs -Improving induction and development of new doctors	Update March 2024 - led by the Change Hub Programme Team, in collaboration with the Care Group leads and Chief Operating Officer, the Medical Workforce Productivity Programme (MWPP) has now been reformed to focus its efforts on workforce performance across the health board. There are now two accountability groups that meet monthly (Performance and Escalation Group & Workforce Framework Group) - these feed in to the MWPP, Value and Efficiency, and then Transformation Board. No change to risk score. Update April 2024 - risk mitigation remains as reported in March 2024. No Change to risk score.	Quality & Safety Committee People & Culture Committee	15	C5 x L3	10 (C5xL2)	↔	01.08.2013	04.03.2024	31.05.2024
35	2808	Chief Operating Officer	Children and Families Care Group	Clinical Service Group Manager	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Waiting Times/Performance: ND Team	IF: The Neurodevelopment service does not have capacity to achieve the WG assessment target (80% of assessments to commence within 26 weeks of referral) and to follow up patients in a timely way, due to demand exceeding capacity Then: Patients will wait excessive periods to reach a diagnosis and children on medication that require titration and monitoring may not be able to be seen within the appropriate timeframes Resulting in: Delays in appropriate treatments being commenced, delays in accessing support e.g. in school following a diagnosis, delay in being effectively titrated, risks associated with delays in medication monitoring	3.5 wte AHP/Nurses successfully appointed, starting June/July 2024 Demand and capacity modelling completed. Merging of Community and ND waiting lists to enhance capacity has taken place. Capacity available should meet demand following 3.5 wte commencing in post. However, this does not account for the average 20% increase in referrals accepted each year. This also doesn't address the backlog of patients already on W/L. (SBAR developed and presented at OMB seeking 2.0 wte B7 AHP for 2 years to clear backlog. SBAR also submitted for PCR monies) NDIP funding for 24/25 awaiting final agreement (funds to include WLI clinics, additional overtime for A4C staff, medicine costs and ADOS training).	Update May 2024 -Consideration required for further investment in service to address backlog of longest waiters. Funding for 2024-2025 from WG still on hold - funding from this will help address backlog but not provide the required capacity.	Quality & Safety Committee	15	C3 x L5	9 (C3xL3)	↔	14.07.2017	08.05.2024	08.07.2024
36	3993	Executive Director of Strategy & Transformation	Central Function - Planning Project Risk	Head of Capital, Strategic and Operational Planning	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 2024 - A request was made to South Wales Fire & Rescue Service (SWF&RS) to extend the Fire Enforcement Notice by a period of 2 years to enable the remedial scheme to be implemented. SWF&RS have initially agreed an extension of 12 months, with the agreement the Health Board could apply for a further extension if necessary. The current Notice is now due to expire on 1st January 2025. There is documentation on this available on request from the Assistant Director of Health, Safety & Fire. Update May 2024 - status of the Fire Enforcement Notice remains as outlined in January 2024. Business Case is in development for Welsh Government Funding and is due to be submitted by October 2024.	Quality & Safety Committee Health, Safety & Fire Committee	15	C5xL3	8	↔	31.01.2020	03.05.2024	30.06.2024

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
39	3337 Linked to RTE Risk 4813 and M&C 4817. Also linked to 4804.	Chief Operating Officer Director of Primary Care and Mental Health Services	Central Support Function: Digital & Data Mental Health Care Group	Lead Infrastructure Architect Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services	Creating Health	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Use of Welsh Community Care Information System (WCCIS) in Mental Health Services	**If:** Mental Health Services do not have a single integrated clinical information system that captures all patients details. **Then:** Clinical staff may make a decision based on limited patient information available that could cause harm. **Resulting In**: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace.	Control measures updated September 2023. 1. A PID has been developed which outlines the processes, resources and timelines sought - this to be discussed in September Programme Board. 2. The Business Case to be refreshed on the back of the PID once approved. It will need to identify additional staff resource required to progress the disaggregation process to bring all CTMUHB staff who currently use WCCIS via local authority over to CTMUHB WCCIS platform. Requires Programme Board approval. 3. Business case to be progressed following Board approval. 4. A new MHLD Care Group risk will be developed relating to the operational mitigations required in the interim to support safe communication and this will be held by the High Quality Clinical Record group, part of the Inpatient Improvement Programme	Update March 2024 - There is still no confirmation of national replacement system as yet. The Health Board and Care Group are exploring alternative interim digital systems and there are 2 events in March to look at the suitability of the PARSI and RIO systems. The mitigation and risk score remains unchanged. Update April 2024 - as at March 2024. During the review of risks it was identified that there were 7 WCCIS related risks registered for the MHLD Care Group, the other 6 have been closed to leave this as the main cross covering entry. The other risks were (4613, 4786, 4804, 4813, 4991, 4996).	Quality & Safety Committee	15	C5xL3	6	↔	07/11/2018	21.03.2024	31.07.2024
40	4691 Linked to RTE Risks 4803, 4799, 3273 and 3019.	Chief Operating Officer	Mental Health Care Group	Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services	Sustaining Our Future	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	New Mental Health Unit	**IF**: Mental health inpatient environments fall short of the expected design and standards. **Then**: Care delivered may be constrained by the environment, which is critical to reducing patient frustration and incidents as well as presenting more direct risk as a result of compromised observations. **Resulting in**: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace and extended lengths of stay.	A Quality Improvement programme in relation to inpatient care has started and a work stream in relation to Safe and Therapeutic Environments has been established with the aim of optimising the patient experience. Inaugural workshop took place on the 26th April. Assistant Director of Strategic Transformation – Mental Health has commenced in post. This new role will lead a range of strategic programmes including recommencing a capital business case for a new Mental Health Unit. Annual revisiting of all patient ligature risks and completion of Statement of Needs via capital process for any ligature risks assessed as needing resolution. All anti ligature works planned for 2022 – 2023 have now been completed. A scoping document case is to be prepared and submitted to WG. Inpatient Improvement Programme established April 2023	Update March 2024 - 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. Update May 2024 - risk mitigation remains as reported in March 2024. No change to risk score. Next review date set for the 01.07.2024.	Quality & Safety Committee	15	15 (C3xL5)	6 (C3xL2)	↔	15.06.2021	29.02.2024	01.07.2024

Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Rating (Target)	De-escalation Rationale
5640	Medical Directorate Manager	Sustaining Our Future	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Potential Junior Doctors Industrial Action	**If...**the NHS Wales Junior Doctors take industrial action related to a dispute over pay erosion between 21st-23rd February 2024 and as expected monthly going forward **Then...**there will be significant disruption on clinical services and planned and unscheduled care provision will likely be impacted. **Resulting in...**the quality of the care and services provided to patients and service users being affected in terms of access to services and compliance with performance and delivery objectives. This includes an impact on waiting list times for surgery and outpatients increasing, and patients being unable to access some health care services.	This is a national issue and decisions on any pay increases are out of CTM's control. A decision on strike action has been confirmed for 15th-18th January 2024 and 25th-29th March. There will be no derogation agreed ahead of the proposed strike unless the health board has offered BMA agreed rates to the doctors Consultants/SAS doctors in some cases will be asked and negotiated with to cover gaps in service. National group in place which includes group of senior colleagues who are agreeing process around pay rates for "acting down"	Process to be agreed with BMA for derogation decisions on day of strike with clear info on the information UHB's will have to provide. BMA have stated they will turn these around in 30-60 minutes CTM working group taking place regularly HB can switch pre-existing locum hours around with agreement, however, locums have already cancelled their shifts Planning and preparation with contingency plans for all affected service will be taken. With these measures in place the consequence score will reduce to 3, with a target score of 15. Update March 2024 - Medical Directorate undertaken a review of this risk and no changes made to mitigation or risk score on this review.	Planning, Performance & Finance Committee Quality & Safety Committee People & Culture Committee	12 Decreased from a risk score of 20 in May 2024	9 C3xL3	Risk Score reduced to a 12 in May 2024. Negotiations with UK Government is currently underway. This means that there is unlikely to be a strike until July/August at the earliest, and this is if there is no agreement made between Government and the BMA. Risk also reduced due to experience from the last 2 strikes and the ability to manage the impact on the Health Board. Risk will need to be reviewed if there are discussions/confirmation around another strike in the summer, based on pressures and staffing levels at the time. Risk will be monitored by the Medical Directorate function.
1133 Linked to risk 3826	Chief Operating Officer	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Long term sustainability and staffing of the Emergency Department (ED) at the Royal Glamorgan Hospital. (RGH).	**If:** the Clinical Service Group (CSG) is unable to deliver a sustainable staffing model for the Emergency Department (ED) at the RGH; **Then:** the Health Board will be unable to deliver safe, high quality services for the local population; **Resulting in:** compromised safety of the patients and staff and possible harm.	ED sustainable workforce plan developed and being implemented (May 2021). Option 1 funded so risks around sustainability remain particularly in respect of the consultant workforce. Financial position remains a challenge as locum and agency staff still used. No agreed plan to align staffing to benchmarking standards and the staffing levels on other sites within CTM. Boundary change and challenges across CTM continue to have a significant impact on the RGH site.	Update April 2024 - USC Senior Management Team risk reviewed, nurse establishment invest to save paper under development unitising the RCN BEST tool (same tool used to review the Prince Charles Hospital nursing workforce 2021). In order to mitigate this risk, the increase staffing level requested has been maintained by the care group at financial risk, by utilising bank and agency staff. Risk rating reduced C4 & L3, risk score 12. Target score 9. Review date 30/06/2024.	Quality & Safety Committee. People & Culture Committee - Workforce aspect	12 Decreased from a risk score of 20 in May 2024	9 C3xL3	In order to mitigate this risk, the increase staffing level requested has been maintained by the care group at financial risk, by utilising bank and agency staff. Risk rating reduced C4 & L3, risk score 12. Risk will be monitored by the USC Care Group.
4732	Chief Operating Officer	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Lack of orthogeriatrician as NICE guidance and KPI1 NHFD	IF: If we do not have this specialist service THEN: our patients will receive suboptimal care than others in the UK and across Wales with potential for non achievement of KPIs set by the Welsh Government, increased length of stay, increased complications such as delirium and pressure ulcers and increased mortality. RESULTING IN: The inability to achieve good outcomes and care appropriately for our patients has a detrimental effect on staff wellbeing too.	The already stretched on call medical team are contacted for ad hoc advice. There is no Care of The Elderly (CoTE) service and no specialist advice available	Unscheduled Care Group will hold responsibility for Consultant orthogeriatrician to be working with the wider Care of the Elderly Team on each site. Awaiting disestablishment of posts in planned care in order to fund. Update March 2024 - Previous update remains, Orthogeriatrician service model is being reviewed in CTM as part of the trauma and orthopaedic reconfiguration of service. SMT reviewed and has requested that this risk is transferred to planned care Directors for management. Update April 2024 - USC SMT reviewed, Awaiting alignment of budgets, post phase 2 OCP. This forms part of the investment cycle for the financial period 24/25 and therefore risk has been de-escalated to a risk score of 12.	Quality & Safety Committee	12 Decreased from a risk score of 15 in May 2024	4 (C2xL2)	Update April 2024 - USC SMT reviewed, Awaiting alignment of budgets, post phase 2 OCP. This forms part of the investment cycle for the financial period 24/25 and therefore risk has been de-escalated to a risk score of 12. Risk will be monitored by the USC Care Group.

	A	B	C	D	E	F	G	H	I	J	K
1	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
2	Nil as assigned to this Committee.										

Agenda Item
6.2

Quality & Safety Committee

Highlight Report from the Infection Prevention Control Committee Meeting – End of Year Report

Dyddiad y Cyfarfod / Date of Meeting	16/05/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Sarah Morgan Deputy Lead Infection Prevention Control Nurse and Decontamination Officer
Cyflwynydd yr Adroddiad / Report Presenter	Greg Padmore-Dix Executive Director of Nursing, Midwifery & Patient 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
Infection Prevention Control Committee	16/04/2024	Agreed

Acronyms / Glossary of Terms	
FMT	Faecal microbiota transplant
SSI	Surgical site infection
IPCC	Infection Prevention Control Committee

CTM	Cwm Taf Morgannwg
JAG	Joint Advisory Group
IPC	Infection Prevention Control
Spp	Species
MSSA	Methicillin sensitive Staphylococcus aureus
MRSA	Methicillin resistant Staphylococcus aureus
POU	Point of use
HCAI	Health Care Associated Infections
CAI	Community Acquired Infection
POW	Princess of Wales
PCH	Prince Charles Hospital
IPCN	Infection Prevention Control Nurse
IV	Intravenous
C. Section	Caesarean Section
ANTT	Aseptic Non Touch Technique

1. Introduction

1.1 This report had been prepared to provide the Quality and Safety Committee with details of the key issues considered by the Infection Prevention Control Committee at its meeting on 16th April 2024.

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

2. Purpose of this Meeting

2.1 The purpose of the Infection Prevention Control Committee (IPCC) meeting is to provide assurance to the board via the Quality and Safety Committee in relation to the organisations arrangements for minimising all avoidable healthcare associated infections in accordance with its agreed objectives, and to meet the requirements and standards determined for the NHS in Wales.

2.2 The IPCC will:

- Provide leadership and direction to the Care Groups to ensure that appropriate arrangements are in place to monitor and minimise health care associated infections across CTM.
- Ensure the implementation of IPC strategic objectives for the Organisation and ensure effective reporting and monitoring.
- Ensure that infection prevention and control is a key priority for all staff.
- Set out the training education programs for IPC to ensure it meets identified needs, priorities and mandatory requirements scrutinising the implementation of the training plan.
- Regularly review the processes and systems for communication regarding HCAIs across the Organisation to ensure they are effective between the board to the point of care.

- Ensure that the Organisation is implementing up-to-date, evidence-based infection prevention control practice across the Organisation.
- Monitor the action plans and reports relating to local and national plans and targets are progressing on time and on target.
- Monitor the Organisation's compliance with the National Standards for Cleaning in NHS Wales and take corrective action.
- Ensure effective systems are in place to identify, eliminate, minimise or manage all risks related to IPC and decontamination.

3. Highlight Report

Alert / Escalate	• CTM only achieved one out of five healthcare associated improvement goals; Pseudomonas aeruginosa. There has been a reduction in MSSA and E.coli bacteraemia compared to the same period in 2022/23. The vast majority of mandatory surveillance organisms reported were community acquired infections. There is a strategic review planned to determine the direction of IPC across the CTM footprint. The aim is for the IPC team to provide an integrated service across primary, community and secondary care services. More emphasis must be placed on making improvements in primary care to improve patient care and safety and influence a reduction in C.difficile infection, S. aureus and gram-negative bacteraemia. • CTM has the second lowest healthcare associated infection rates in Wales. • There has been an increase in catheter associated urinary tract infections compared to the same period in 2022/23. The IPC team are planning to roll out the all-Wales urinary catheter passports in secondary care to aid communication between primary and secondary care services. The IPC team are working with the bladder and bowel health service to provide urinary catheter management training for all staff groups in CTM. • Local improvement goals will be calculated for each of the Care Groups for 2024/25. • Legionella spp. continues to be detected in the water at Dewi Sant Health Park. Monies have been approved for major capital work to replace and reconfigure the pipework. The tender documents have been prepared with the aim to complete the work by May 2024. POU filters have been fitted to the affected outlets and only outlets with POU filters in place should be used.

	• JAG accreditation has been deferred for a six-month period. A task and finish group has been set up to progress the short/medium term plan for endoscope decontamination in POW. The service users need to develop a purchase specification for the mobile decontamination unit.
Advise	C.difficile The reduction expectation for 2023/24 is 25 cases per 100,000 population, which equates to no more than 112 cases per year. 126 cases have been reported, which is 12 more cases compared to the same period in 2022/23. • 44% of the cases are considered healthcare associated infections. • 49% of the samples were sent from GP practices. • 7% of the cases were identified as a recurrent infection. FMT needs to be provided as a treatment option for all patients across the CTM footprint. Staph aureus bacteraemia The reduction expectation for 2023/24 is a combined target (MRSA and methicillin sensitive S. aureus) of 20 cases per 100,000 population, which equates to no more than 90 cases per year. MRSA bacteraemia 9 cases have been reported, which is 5 more cases compared to the same period in 2022/23. • 22% of the cases are considered healthcare associated infections. • There is one preventable source for a community acquired case. MSSA bacteraemia 129 cases have been reported, this is 14 fewer cases compared to the same period in 2022/23. • 24% of the cases are considered healthcare associated infections. • 76% of the cases are community acquired infections. • 12% are associated with an IV device. E.coli bacteraemia The reduction expectation for 2023/24 is 67 cases per 100,000, which equates to no more than 301 cases per year. 378 cases have been reported, which is 4 fewer cases compared to the same period in 2022/23. • 22% of the cases are considered healthcare associated infections. • 78% of the cases are community acquired. • 10% of the cases are associated with a urinary catheter (28 HCAI and 8 CAI).

	Klebsiella sp. bacteraemia CTM is expected to achieve a 10% reduction based on 2017/18 numbers, which equates to no more than 63 cases in 2023/24. 118 cases have been reported, which is 33 more cases than the equivalent period in 2022/23. • 32% of the cases are considered healthcare associated infections. • 68% of the cases are community acquired infections. • 10% of the cases are associated with a urinary catheter (5 HCAI and 7 CAI). Pseudomonas aeruginosa CTM is expected to achieve a 10% reduction based on 2017/18 numbers, which equates to no more than 24 cases in 2023/24. 21 cases have been reported, which is 19 fewer cases than the equivalent period in 2022/23. • 33% of the cases are considered healthcare associated infections. • 67% of the cases are considered community acquired infections. • 14% of the cases are associated with a urinary catheter (2 HCAI and 1 CAI). • Clinical engagement required from multi-disciplinary colleagues to improve compliance with IPC practices to enhance patient care and safety. • Support is required to restart the IV steering group to provide a steer for IV device management across CTM.
Assure	• PHW are in the process of validating the number of C.section SSIs reported to HARP between July and September 2023. PHW have commenced the process in PCH and there appears to be an element of overreporting. PHW will circulate a report once completed and mirror the process in POW. • A Measles pathway has been developed for CTM in line with national guidance and the Health Board approved Measles policy (IPC25). Vaccination is key and healthcare staff have been encouraged to update the MMR vaccines (two doses) if they have no documented evidence of vaccination status. Health and Safety are supporting with additional FFP3 fit test training for frontline staff. • The IPC team achieved 53% of the annual audit program. There are 6 inpatient areas and a number of outpatient areas outstanding as a result of staff shortages within the IPC team. These areas will be prioritised in the 2024/25 audit program.

Inform	• The Lead Infection Prevention Control Nurse for CTM has stepped down from her position. A new Head of Nursing for IPC has been appointed and their start date has been confirmed as July 15th 2024. The IPC team would like to thank the Lead IPCN for her compassionate, authentic leadership and welcome her back to the team as a Senior IPCN. • Preventable MSSA bacteraemia is now considered a moderate risk. The Patient Care and Safety team arrange a rapid review meeting to discuss the preventable infection and determine whether the duties of candour and quality have been breached. The outcome/learning is discussed at the site IPC meetings. • Y Bwthyn Newydd was reopened at the start of March 2024 following extensive remedial works. One bedroom remains out of use as the outlet continues to detect Pseudomonas aeruginosa. There are plans to replace the wash hand basin and resample the outlet. • ANTT has been temporarily "unmandated" whilst work is ongoing to review the ANTT requirements on ESR and update roles which need an ANTT competency attached. The IPC team continue to deliver ANTT training sessions across CTM. • The IPC strategy has been updated by the Deputy Executive Director of Nursing and will be approved in the upcoming Q&S Committee meeting.
Appendices	• Nil to note.

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: Improving care 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: Living well Growing well
	A Healthier Wales

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)*	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Enablers of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Culture and Valuing People
	If more than one applies please list below: Data to knowledge Whole system perspective Learning, improvement and research
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Domains of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Safe
	If more than one applies please list below: Timely Effective Efficient Equitable Person-centred
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd?* / Quality *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: No change to service.
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: Language assessment not required.

Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.
Enw da / Reputational	Yes (Include further detail below)
	Sharing infection rates.
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 Committee is asked to NOTE the highlights outlined in section 3 of this report.

Agenda Item
6.3

Quality & Safety Committee

CTM INFECTION, PREVENTION AND CONTROL STRATEGY 2024/27

Dyddiad y Cyfarfod / Date of Meeting	16/05/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Richard Hughes, Deputy Executive Director of Nursing
Cyflwynydd yr Adroddiad / Report Presenter	Richard Hughes, Deputy Executive Director of Nursing
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	Endorse for Board Approval

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Structured interviews with colleagues and stakeholders.	June 2023-Feburary 2024	Information to inform the strategy development.
Presentation to CTM IPC Committee	16/04/2024	Approved with agreed adjustments.

Acronyms / Glossary of Terms	
	(Referred to in the body of the paper)

1. Situation /Background

The quality of care and the safety of our patients and staff is paramount to the Health Board and integral to our CTM2030; 'Our Health, Our Future' strategic vision. The provision of a robust infection prevention strategy is an essential element in contributing to and achieving this vision, whilst in ensuring compliance to the Duty of Quality Statutory Guidance and to national, regional and local targets. With specific targeted interventions to reduce microbial related infections such as Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia, surgical site infections and Clostridioids difficile (C. difficile) infection. In support of our teams providing clinical care directly in our hospitals and the community, our Infection Prevention and Control team in partnership with our Public Health team and other key stakeholders, will build on the work underpinned by the aforementioned quality and safety drivers and continue to actively promote a culture of zero tolerance to avoidable healthcare associated infections (HCAIs).

2. Specific Matters for Consideration /

The development of the CTM IPC Strategy 2024/27 has been a collaborative endeavour, undertaken in consultation with key stakeholders since June 2023. From the outset, inclusivity and transparency were paramount. We engaged a diverse range of stakeholders, including internal departments, external partners, experts, and material provided by regulatory bodies. Through interviews and group discussions, we gathered valuable insights, ensuring a holistic perspective and enriching the strategy with varied expertise.

Needs assessments and goal-setting exercises formed the foundation of our process. We analysed data and evaluated trends to understand stakeholder concerns and aspirations regarding the future of the service and organisational focus. Interviews provided avenues for stakeholders to express their expectations, aligning the strategy with organisational and key clinical objectives.

Central to our approach were collaborative sessions, where stakeholders shared their expertise and contributed ideas. These interactive forums, facilitated by the Deputy Executive Director of Nursing, sought to enable creativity, consensus-building, and synergy among contributors. Through structured interviews and scenario planning, we explored strategic options, evaluating their feasibility, impact, and alignment with organisational values.

The drafting phase saw the synthesis of insights gathered from stakeholder engagement activities. We crafted an initial draft of the CTM IPC Strategy 2024/27, which served as a starting point for refinement. Circulating the draft among stakeholders for feedback, we encouraged candid input and suggestions for improvement. Iterative revisions and collaborative dialogue honed the strategy to address emerging challenges and reflect the collective vision of stakeholders.

Throughout the process, alignment with organisational goals and national policy remained paramount. Regular check-ins with senior leadership and a presentation to the IPC Executive Group ensured ongoing alignment, providing opportunities for feedback and course correction. This iterative process culminated in the

finalisation of the CTM IPC Strategy 2024/27, ready for presentation to the board for approval.

In conclusion, the development of the CTM IPC Strategy 2024/27 exemplifies our commitment to inclusive, collaborative decision-making. Through interviews, group discussions, and iterative refinement, we have crafted a strategic roadmap that reflects the collective wisdom of our diverse stakeholder community. As we embark on implementation, we remain dedicated to collaboration, agility, and continuous improvement, ensuring the successful execution of our strategic objectives in the dynamic landscape of intellectual property and commercialization.

3. Key Risks / Matters for Escalation

3.1 Patient Safety and Quality of Care: Any changes or initiatives introduced through the CTM IPC Strategy must prioritise patient safety and the delivery of high-quality care. Risks related to medical errors, adverse events, or compromised patient outcomes must be carefully assessed and mitigated.

3.2 Regulatory Compliance: Compliance with regulatory requirements and healthcare standards is paramount within the NHS in Wales. Risks associated with non-compliance, regulatory changes, or audits could result in penalties, legal consequences, or reputational damage to the organisation.

3.3 Clinical Governance: Ensuring effective clinical governance processes is essential to maintain accountability, transparency, and quality improvement in healthcare delivery. Risks related to clinical effectiveness, risk management, and patient experience will be carefully monitored and addressed.

3.4 Workforce Challenges: The NHS workforce faces various challenges, including staffing shortages, workload pressures, and retention issues. Risks associated with workforce capacity, skill mix, and staff morale could impact the successful implementation of the strategy and the delivery of patient care. The implementation phase will seek to work with workforce experts to ensure we continually seek to attract professionals into the field of infection prevention. Furthermore, working with care groups and public health colleagues, we will ensure that the strategic output for workforce arrangements reflect the the new structure and works to provide the opportunity to realign roles and responsibilities.

3.5 Health Inequalities and Access to Care: Addressing health inequalities and ensuring equitable access to healthcare services are core principles of the strategy. Risks associated with disparities in healthcare access, service provision, or patient outcomes will be carefully considered to avoid exacerbating existing inequalities.

3.6 Financial Sustainability: Amidst budget constraints and increasing demand for healthcare services, financial sustainability is a key concern for CTM and the team overseeing the implementation of the strategy. Risks related to funding cuts, budget overspends, or inefficiencies in resource allocation could impact the delivery of services and the achievement of strategic objectives. The senior leadership team will work within the current financial envelope in implementing the elements of the strategy, working

with care groups and other stakeholders in seeking new initiatives in resource, service design and allocation.

3.7 Mitigating these risks requires a comprehensive approach that integrates clinical, operational, and governance perspectives. Collaboration across multidisciplinary teams, robust risk management frameworks, and continuous monitoring of key performance indicators are essential to safeguard patient safety, uphold regulatory compliance, and ensure the effective delivery of healthcare services within the CTM.

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
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: A globally responsible Wales
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Enablers of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Leadership
	If more than one applies, please list below: Learning, improvement and research, whole-system perspective and data to knowledge.
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Domains of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Safe
	If more than one applies please list below: Efficient, effective, equitable, person centred and timely.
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	Yes - Reduce
	If more than one applies please list below: Refine and recycle.

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: Highest score in QIA 6 (impact 2, likelihood 3) where assessing for staff wellbeing. Low impact, will be reviewed at least 6 monthly.	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☒	No: ☐
	Outcome for Equality: POSITIVE Outcome for Welsh Language: NEUTRAL	If no, please include rationale below:
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	Yes (Include further detail below)	
	A workforce evaluation plan will be incorporated into the implementation and service design phase of the strategy.	

5. Recommendation

It is recommended that the committee members note and endorse for Board Approval the implementation of the CTM IPC Strategy 2024/27, emphasising continuous monitoring, stakeholder engagement, and agile adaptation to mitigate potential challenges and ensure the successful execution of the IPC Strategy within CTM.

6. Next Steps

6.1 In conclusion, the development of the CTM IPC Strategy 2024/27 exemplifies our commitment to inclusive, collaborative decision-making. Through interviews, group discussions, and iterative refinement, we have crafted a strategic roadmap that reflects the collective understanding of our diverse stakeholder community.

6.2 As we embark on implementation, we remain dedicated to collaboration, agility, and continuous improvement, ensuring the successful execution of our strategic objectives in the dynamic landscape of infection prevention and control throughout the region, Wales and the UK as a whole.

6.3 The senior leadership team will work with care group and corporate colleagues to ensure the IPC service is aligned to and harmonises with the needs and existing skillsets across the organisation.

6.4 The Deputy Executive Director of Nursing will work with colleagues across CTM to ensure alignment and where required, revision of the governance processes for infection prevention and control to ensure streamlined and achievable processes with the availability of data to inform and assure.

Cwm Taf Morgannwg University Health Board

Infection Prevention and Control Strategy2024/27

OUR BIG IDEA

The aim of this strategic plan is to support the Health Board's values in providing the safest, most effective care possible whilst attending to All Wales national drivers. The strategic plan seeks to provide the Board and Cwm Taf Morgannwg (CTM) community with sufficient assurance that appropriate structures and processes are in place to minimise the risks of health care acquired infections (HCAI) to patients, staff and our community.

Glossary

•AMR	Antimicrobial Resistance
•C.diff	Clostridioids difficile
•DTPS	Diagnostic, Therapies, Pharmacy and Sciences
•E.Coli	Escherichia coli
•HCAI	Health Care Associated Infection
•HIW	Healthcare Inspectorate Wales
•iCTM	Improvement Cwm Taf Morgannwg
•IPC	Infection Prevention and Control
•IPCC	Infection Prevention and Control Committee
•IQPD	Integrated Quality, Planning and Delivery
•MRSA	Methicillin Resistant Staphylococcus Aureus
•MSSA	Methicillin Sensitive Staphylococcus Aureus
•NRI	Nationally Reportable Incident
•Q(1-4)	Period of time (quarters) in the financial years
•PIR	Post infection review
•PC&C	Primary Care and Community

Index

p.5 Introduction	p.6 Known interdependencies	p.7 Roles & responsibilities	p.8 Delivery of the strategy	p.9 Strategic objectives in summary
p.10 Strategic objectives in detail (pp.10-19)	p.20 Implementation (pp.20-21)	p.22 Strategic milestones	p.23 Assurance framework (pp. 23-24)	p.25 Associated governance, key challenges & next review date

INTRODUCTION

Health Care Acquired Infections (HCAIs) remain high on the Welsh Government's agenda with Wales committed to achieving the goals of the UK AMR Strategy and the 5-year ambitions outlined in the UK National Action Plan 2019-2024 and addendum published in May 2022 (Welsh Government 2023). Furthermore, maintaining safe care environments is reinforced by the Healthcare Inspectorate Wales (HIW) ensuring we meet the Quality Standards (2023), actively promoting safety and welfare. All risks will be/must be identified and monitored in order to prevent or reduce them.

The quality of care and the safety of our patients and staff is paramount to the Health Board and integral to our CTM2030; 'Our Health, Our Future' strategic vision. The provision of a robust infection prevention strategy is an essential element in contributing to and achieving this vision, whilst in ensuring compliance to the Duty of Quality Statutory Guidance and to national, regional and local targets. With specific targeted interventions to reduce microbial related infections such as Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia, surgical site infections and Clostridioids difficile (C.difficile) infection. In support of our teams providing clinical care directly within our hospitals and community setting, our Infection Prevention and Control team in partnership with our care group and our public health team will build on the work underpinned by the aforementioned quality and safety drivers and continue to actively promote a culture of zero tolerance to avoidable HCAIs.

The prevalence of HCAIs is not associated with any single factor, but to several recognised interdependencies.

Known interdependencies

- The use of invasive devices such as urinary, peripheral and central devices which compromise the body's natural defence mechanisms.
- The reliance on antibiotics which increases the resistance to infections over time.
- Organisational factors such as staff to patient ratios and the increase in bed occupancy levels.
- Physical infrastructure e.g. building works and lack of isolation facilities.
- Poor compliance with best practice e.g. failure to decontaminate hands before/following key activities.
- The cleanliness of the clinical environment is critical when dealing with certain micro-organisms such as C.diff.
- The demographics of patient population suggesting an older, increasingly clinically complex and vulnerable population.
- Global factors and travel contribute to the rapid nature of spread of infectious agents as seen in COVID-19 and novel influenza strains.

Roles & responsibilities

Staff

Are responsible to ensure they maintain and support a coordinated approach to infection prevention within their areas of responsibility. All staff must comply with Health Board policies and attend to their mandatory education requirements.

Clinical care groups

Have a responsibility to ensure staff have the tools and resources to implement best practice to facilitate a safe working environment and formulate action plans and take corrective action where shortfalls exist. Any corrective actions will be monitored at Care Group Quality, Safety, Risk and Experience (QSRE) groups, Infection Prevention and Control Committee and local governance forums.

IPC Team

Have the mandate to deliver the strategic plan using expert knowledge and to facilitate operational and strategic support for clinical leaders across CTM. This will maximise their influence in ensuring infection prevention principles are to embedded into the Care Groups and Directorates daily professional practice.

Delivery of the Strategy

Leadership

- Board leadership; the strategic plan is approved by the Quality and Safety Committee with the delivery supported and overseen by the Infection Prevention and Control Committee (IPCC).
- The care group leadership teams are responsible for local performance against the prevention and control of HCAI.
- Health Board business planning processes; IPC issues must be considered in business plans and advice sought from the IPC where required.

Governance and monitoring

- IPC policies; based on national best practice guidance with performance against the policies being monitored through extensive clinical audit.
- Local and Health Board performance management; performance against HCAI trajectories and ward/unit accreditation are reported through key performance indicators, clinical governance and the IPCC.

Clinical practice and responsibilities

- Training and education; the IPC Team to ensure provision of training for all new and existing staff.
- All Health Board staff have a responsibility to adhere to infection prevention and control policies in order to reduce the occurrence of HCAI.
- The IPC Team; delivering an Infection Prevention and Control Annual Programme.

Strategic objectives

Surveillance & reporting

Working with the Patient Safety and digital teams, explore and update surveillance mechanisms and reporting to facilitate embedding of best practice.

Partnership

In partnership with stakeholders such as Llais, Local Authorities, Public Health Wales and CTM Public Health, enhance patient and public involvement in infection prevention in order to improve patient experience.

Learn and develop

Working with the CTM Learning Academy and local educational providers to Develop innovative methods of educating staff in the delivery of high quality infection prevention and control.

IPC fit for the future

Complete and implement strategic review of operational IPC service delivery by Q3 of 2024 to ensure relevance to the Health Board's requirements.

Minimise harm

Minimise the risk of HCAIs to patients with the goal of reducing all avoidable infections by ^50%.

Compliance

Continue to comply with statutory requirements related to the Duty of Quality, Welsh Government goals (2023/23), HIW, Public Health Wales and related bodies to maintain a safe environment.

Antimicrobial stewardship

Review antimicrobial stewardship arrangements across acute, primary care, community and mental health settings within the Health Board. Formulate and adopt national tools to enhance processes with the aim of achieving:

a. *25% reduction in antimicrobial usage in the community from 2013 baseline.
b. *10% reduction in the use of "reserve" & "watch" antibiotics in hospitals from 2017 baseline.

Improvement, innovation & sustainability

Working with iCTM, Research and Development and other key stakeholders to explore opportunities to participate in research and quality improvement in underpinning future practice attending to sustainability as well as improving both patient experience and outcomes.

^using 2023/23 CTM HCAI data as the baseline for improvement
[1]Welsh Government (2023) Welsh Health Circular: AMR & HCAI Improvement Goals for 2023-24. https://www.gov.wales/sites/default/files/publications/2023-08/amr-hcai-improvement-goals-for-2023-24.pdf

Surveillance & reporting

The ambition

The Health Board has a process for reviewing learning from infection events using national reporting and local mechanisms. The surveillance of ‘alert microorganisms’ such as mandatory reporting e.g. C.difficile, MRSA, E.Coli and MSSA is already well established using a PIR process.

It is anticipated through multidisciplinary collaboration with Planned care and Children & Families care groups, surveillance of surgical site infection will be further expanded to strengthen reporting and learning opportunities.

Working with the care groups, the IPC team will review and align other processes for identifying, sharing, collaborating and responding to incidences of alert microorganisms including associated common sources of infection e.g. urinary catheters and intravascular devices.

The commitment

- Review current surveillance approaches and refine to best meet the needs of the service and take into account national priorities and regulatory compliance.
- Identify new digital and business intelligence opportunities in data capture and visibility.
- Focus on embedding a robust surgical site monitoring scheme focusing on elective joint replacements with timely feedback to clinicians on a key performance indicators (to ensure futureproofing in support of elective delivery plans).
- Develop surveillance schemes to minimise infections from invasive devices and feedback mechanisms to maintain practice within best published results.
- Continue to carry out and enhance Post Infection Review processes to help refine current approach governance and the IPCC both in the acute and community settings.

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Surveillance & reporting (cont.)

The ambition

- The Health Board will also work with NHS Wales Executive colleagues in achieving a standardised approach to the reporting of HCAIs across Wales.

The commitment

- Work with Patient Care and Safety team as well as NHS Wales Executive team in reviewing and implementing internal and external reporting pathways.

Partnership

The ambition

In partnership with stakeholders such as Llais, Local Authorities, Public Health Wales and CTM Public Health, enhance patient and public involvement in infection prevention in order to improve patient experience.

The IPC team and the Health Board are committed to improving on the involvement of our community and patient population to provide a service that meets the needs of those using the service.

The commitment

- A wholescale review and update of the communication media whilst exploring new ways of disseminating information.
- Working with the Corporate Nursing Team, Patient Experience colleagues, Llais and our Communications Team, we will set out to review signage, posters and information sources ensuring maximum community and stakeholder involvement.
- The introduction of the CTM Infection Prevention Charter in 2024 aligned with CTM2030 will set out the Health Board's commitment to strengthening partnership arrangements and expand on the opportunities for infection prevention across all of our community and acute services.

Learn & develop

The ambition

The Health Board is committed to ensure our workforce have the knowledge, skills and tools to enable them to provide high quality care. In partnership with the CTM Learning Academy the IPC team will create a suite of educational activities such as hand hygiene, high impact interventions (Aseptic Non Touch Technique) which will monitored annually by the academy's faculty and IPC senior leadership team.

Staff training compliance data will be monitored by the respective care group leadership teams through local governance monitoring arrangements and will be reported to the Infection Prevention and Control Committee.

Working with the Corporate Nursing and Patient Safety Team, ward practice will be monitored by structured quarterly visits from the IPC team, as well as participation in the structured accreditation .

The commitment

- In partnership with care groups and educationalists, the IPC Team will review and update the available learning resources for staff to ensure meets needs of staff, volunteers and students.
- Inform the Board of staff training compliance using existing reporting methods.
- Participate in the annual review of the ward accreditation program to ensure infection prevention and control principles are fully updated as part of the accreditation framework.
- Provide a suite of learning tools for use in targeted support and intervention.
- Work with the Learning Academy and South Wales University to develop a curriculum for our emerging and existing IPC practitioners and leaders.

IPC fit for the future

The ambition

Within the new organisational structure of CTM, our IPC service is revieing the model of care and leadership to ensure the service will meet the needs of the service.

In 2024, through widespread stakeholder engagement the IPC service is committed to modifying its techniques and procedures of service delivery to ensure it meets the needs of the care groups, wider Health Board and the CTM community. Through the application of evidence, digital solutions and policy, the IPC team will review and adapt the service to ensure optimal productivity and efficiency.

The commitment

- Complete and implement strategic review of operational IPC service delivery by Q3 of 2024 to ensure relevance to the Health Board's requirements.
- Working with the Digital Clinical Leads and Corporate Nursing team, the IPC service will set out to optimise and advance current digital and data sharing opportunities, ensuring a reduced administrative burden and maximised clinical presence.
- In collaboration with iCTM, the IPC service will review current service regimes to ensure optimal productivity and efficiency.
- The IPC senior leadership team will carry out an annual review of current best practice, evidence, national policy developments to ensure the Health Board is working to the most up to date policies and procedures.

Minimise harm

The ambition

The Health Board is committed to the implementation of a zero avoidable infection culture. To see this embedded, standards of practice will be monitored with measures to support and intervene where practice falls below expected levels.

With support from national and local agencies, the Health Board will set out to minimise the risk of HCAIs to patients with the goal of reducing all avoidable infections by 50%.

All wards and large departments will be expected to participate in the ward accreditation programme which aims to embed and sustain safe levels of practice.

The commitment

- Complete and implement strategic review of operational IPC service delivery by Q3 of 2024 to ensure relevance to the Health Board's requirements.
- Working with the Digital Clinical Leads and Corporate Nursing team, the IPC service will set out to optimise and advance current digital and data sharing opportunities, ensuring a reduced administrative burden and maximised clinical presence.
- In collaboration with iCTM, the IPC service will review current service regimes to ensure optimal productivity and efficiency.
- The IPC senior leadership team will carry out an annual review of current best practice, evidence, national policy developments to ensure the Health Board is working to the most up to date policies and procedures.

Compliance

The ambition

The Health Board is committed to ensuring it retains full compliance aligned to the Duty of Quality (2023) and Duty of Candour (2023) Statutory Guidance.

The Health Board will monitor gaps in compliance through the care groups QSRE, IPC Operational Huddle (two weekly), reporting on exceptions to the IPCC, Quality and Safety Committee and Board.

Through triangulation of IPC audit data, ward accreditation outputs, incident reporting and reports from area visits, care groups and the IPC team will report by exception to the IPCC.

The IPC team will provide monthly analysis for the Executive and Deputy Executive Directors of Nursing for monitoring and discussion with NHS Wales executive colleagues.

The commitment

- We will continue to monitor gaps in assurance through exception reporting, with the aim of achieving full compliance.
- Continue to provide ward, directorate and care group level data, identifying any gaps in compliance.
- Directorates and care groups will continue to monitor compliance and address non-compliance through their governance processes.
- Review and improve cohort and other IPC operational guidance for ward managers and clinical leaders.
- Work closely with Facilities leadership teams to review current operational procedures for general and enhanced cleaning programmes with the aim of designing and publishing a revised and updated approach by Q3 2024

Antimicrobial stewardship

The ambition

The IPC team with stakeholder colleagues will review antimicrobial stewardship arrangements across acute, primary care, community and mental health settings within the Health Board. Formulate and adopt national tools to enhance processes with the aim of achieving:

a. 25% reduction in antimicrobial usage in the community from 2013 baseline.

b. 10% reduction in the use of “reserve” & “watch” antibiotics in hospitals from 2017 baseline.

The IPC team, antimicrobial pharmacist and wider pharmacy team will ensure there are systems in place to monitor prescribing is in accordance with policy and implement measures to address any deviation.

The commitment

- Establish and implement an AMS/HCAI steering group maximise processes on the antibiotic point prevalence to ensure frequency and provision of timely feedback to clinicians/prescribers.
- Establish and review a platform for information to Health Board colleagues across CTM (antimicrobial SharePoint page).
- Review and implement current antibiotic policies to maintain relevance.
- Develop and provide innovative resources and education materials to staff groups.
- Work with public health, pharmacy, primary care and community colleagues to ensure greater impact and support for clinicians and clinical leaders working across the CTM communities on antimicrobial prescribing.

Antimicrobial stewardship (cont.)

Initiatives & priorities

Using a multiple stakeholder approach, CTM will seek to continue and develop on the work already established in the field of antimicrobial stewardship in areas such as:

a. Influencing antimicrobial prescribing on surgical wards
b. Implementation of a fluoroquinolone prescribing aid project and assessment of sustainability/usability/impact on prescribing.
c. Influencing antimicrobial prescribing for Community Acquired Pneumonia across both primary and secondary care
d. Lymphoedema/cellulitis in primary care
e. Evaluating the association of antibiotic prescribing volume in General Practice with hospital admissions related to infection through linking Cwm Taf Morgannwg University Health Board data sets from the financial year 2023/24.

Deliverables & enablers

CTM will seek to deliver on the ambition through a number of commitment principles or goals, some of which are featured below.

- Visual summaries for the management of seasonal infections ahead of the linked season, e.g. respiratory tract infections in winter, urinary tract infections or insect bites summer. Top 12 most common infections
- To determine patient specific characteristics from the infection related hospital admissions, e.g. gender, age, indication for admission, co-morbidities, General Practice origin.
- Primary care: measure current prescribing for community acquired pneumonia, educational intervention around course length reduction, reaudit to assess improvement in compliance to guidelines.

Improvement, innovation & sustainability

The ambition

Working with iCTM, NHS Wales Executive, Research and Development, the Health Board will seek to explore opportunities to participate in research and quality improvement in underpinning future practice to improve patient experience and outcomes.

The IPC team are committed to leading the implementation of research and quality improvement to facilitate implementation of high quality care and to enhance the patient experience

CTM will seek to deliver a modern IPC services for patients and staff aligned to addressing the issues of sustainability in the modern healthcare environment.

The commitment

- Explore opportunities to work with commercial partners to evaluate new product lines.
- Develop and build on research portfolios and promote the Health Board as a leader using publication outputs and conference opportunities.
- Working with CTM communication experts, maintain and improve communication mechanisms e.g. QR code information, leaflets, SharePoint, social media e.g. X feeds.
- Working directly with iCTM and NHS Wales Executive colleagues, the IPC team will identify, review and promote quality improvement programmes that minimise harm from infection.
- Working with experts and key stakeholders, IPC in CTM will ensure services and policies or aligned to and consider the sustainability agenda in Wales.

Implementation

The strategy will be implemented by the Infection Prevention Committee, led by the Executive Director of Nursing. The Infection Prevention Committee will co-ordinate delivery plans in order to implement the strategy.

Members of the Infection Prevention Committee link to other groups and committees (Quality and Safety Committee, Improving Care Board, Medication Safety Group, Care Group QSRE) to ensure that actions to achieve this strategy are fully embedded within the Care Groups delivery plans.

Infection Prevention and Control Committee members will act as a conduit for information, so that care area plans can be linked via the Infection Prevention Committee to the annual Health Board infection prevention programme. The Executive Director of Nursing will continue to have direct access to the Medical Director and / or Executive Lead if matters require immediate escalation and attention.

The following key teams and committees will also support implementation:

- Decontamination Group
- Antimicrobial leadership colleagues
- Laboratory (DTPS and Deputy Director of Therapies and Health Sciences)
- Hospital Management Teams, Out of hours / Clinical Sites Management Team
- Nursing and Midwifery Directors Group
- Care Group Quality, Safety, Risk and Experience Groups
- Directorate Governance Forums
- Estates and Facilities
- CTM Public Health team
- Public Health Wales
- Patient safety Groups
- Local Partnership Forum
- Improving Care Board
- Quality and Safety Committee
- Board

Implementation (continued)

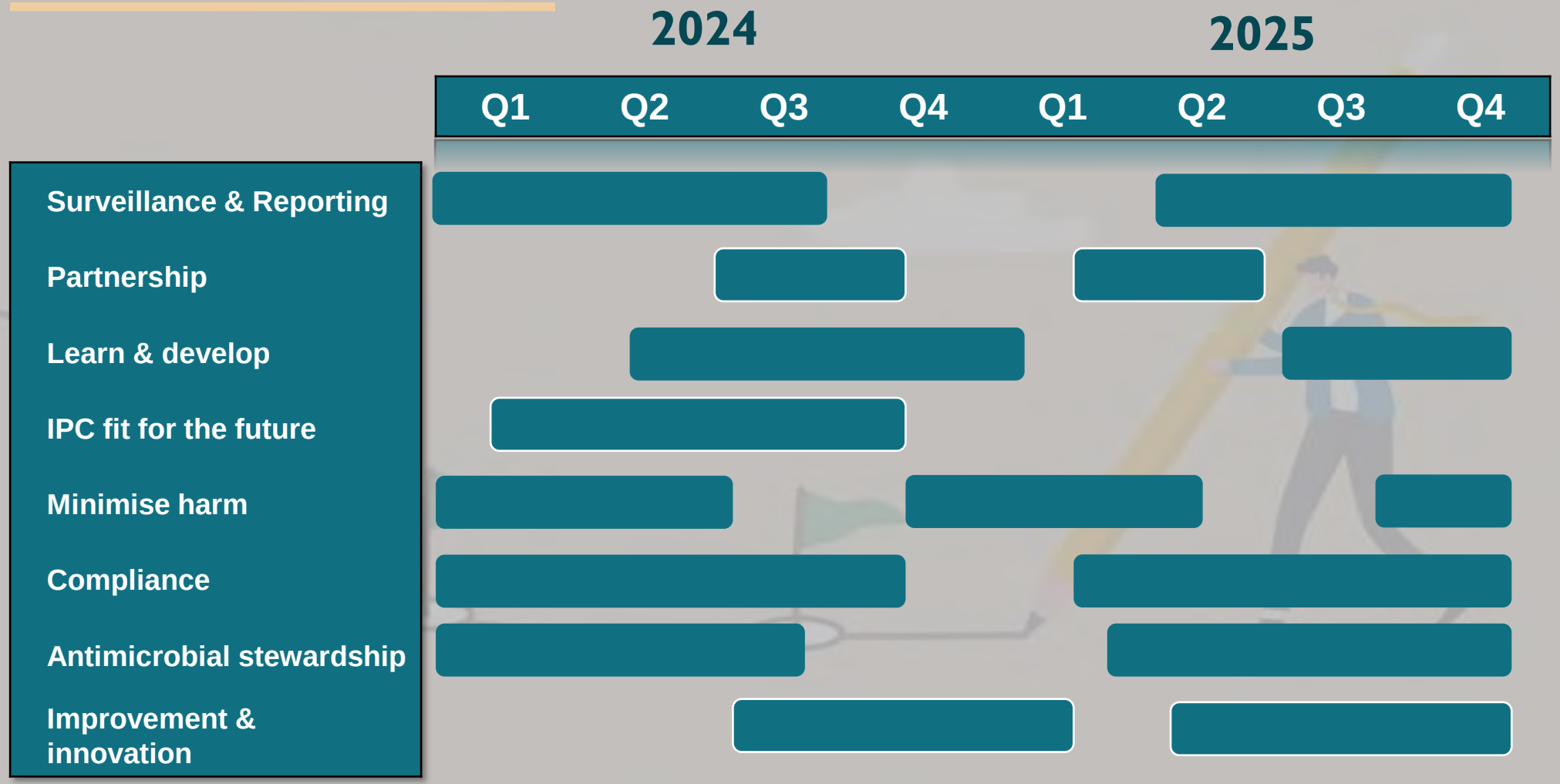
Teams within the Health Board will contribute to the implementation of this strategy and reducing HCAIs through:

- The investigation into and learning of significant infections.
- Working with Clinical Site Manager teams, Heads of Nursing, Lead Nurses, Senior Nurses, Consultants and other clinical leaders to ensure patients with infections are placed appropriately to meet their care needs and in order to protect other patients.
- Seeking specialist Infection Prevention and Microbiology advice where required.
- Ensuring that staff are trained in basic infection prevention and control.
- Working with estates and facilities teams to ensure the clinical environment is clean and safe for patients.
- Ensuring availability of accurate and purposeful data and information for IPC and clinical leaders to make clinical judgements in managing actual and emerging infection control incidents.

Dissemination of strategic plan

Once approved by the IPCC (April 2024) and Quality and Safety Committee (May 2024), the strategic plan will be available on the Health Board SharePoint pages and will be shared for discussion and dissemination with Care Group Directors, Corporate Directors and wider stakeholder agencies.

Milestones


2024
2025
Q1
Q2
Q3
Q4
Q1
Q2
Q3
Q4
Surveillance & Reporting
Partnership
Learn & develop
IPC fit for the future
Minimise harm
Compliance
Antimicrobial stewardship
Improvement & innovation

The Board is responsible for ensuring that the Health Board has appropriate Infection Prevention and Control systems and resources in place to enable the organisation to deliver its objectives and statutory requirements.

Activities to validate that infection prevention and control is an essential part of clinical and corporate governance include:

- The Board receiving and formally approving (Quality and Safety Committee)
- Health Board Infection Prevention and Control Strategic Plan
- The Annual Infection Prevention and Control Report
- Quality and Safety Committee reports.

Assurance framework

The Strategic plan aims to outline objectives and responsibilities and is a requirement of the organisation. The IPCC sets objectives for the year, identifies priorities for action, evidence that policies have been implemented and reports progress against the objectives.

The IPC Annual Report provides performance information from the preceding year and highlights any outstanding issues that need to be addressed by the IPCC and associated stakeholders (e.g. care groups).

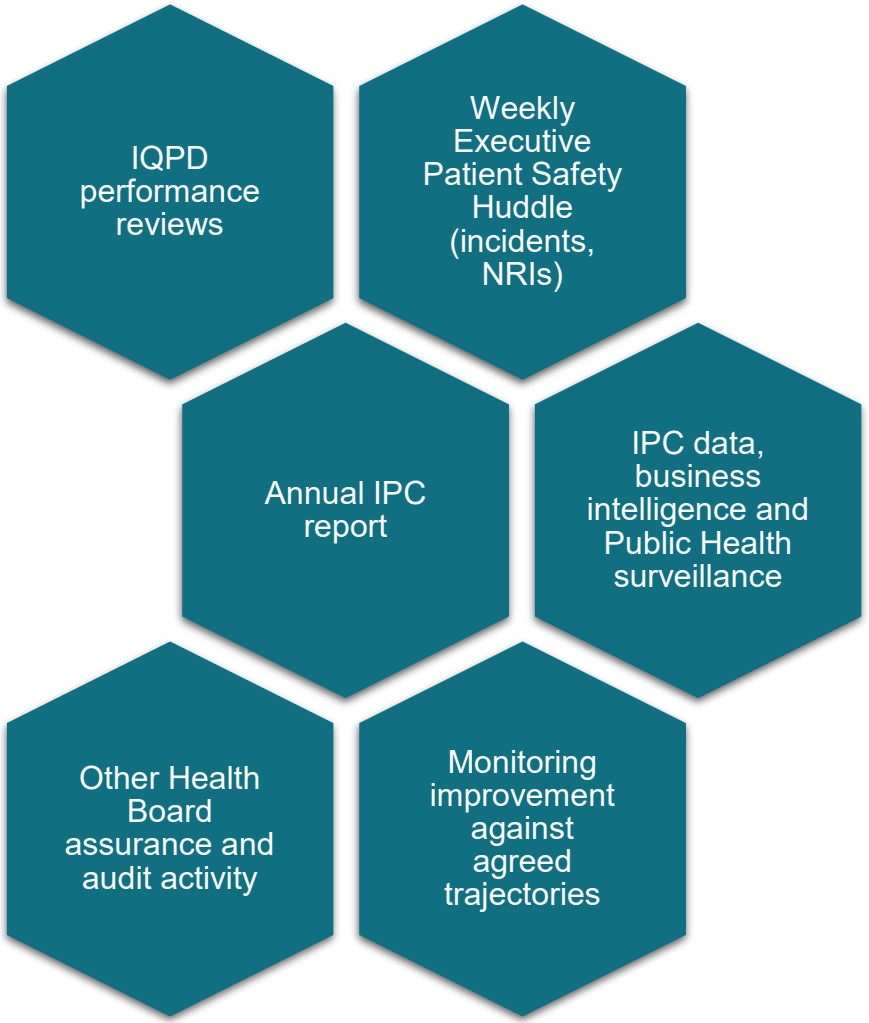
Reporting monthly Health Board infection prevention and control key performance indicators reports through the Board, Quality and safety Committee, the care groups governance forums and to NHS Wales Executive colleagues (IQPD) to the board.

Exception reports are prepared by the Executive Director of Nursing or delegated individual as required. The Infection Prevention and Control Committee's purpose is to seek assurance that the Health Board has a robust framework for infection prevention and control as part of a whole CTM health community. The Committee meets six times a year and is represented by key organisation stakeholders such as hospital leaders and care group leadership teams who will update on IPC performance related concerns.

Assurance framework

Component of plan to be monitored	Lead	Methodology	Frequency	Senior Responsible Officer(s)	Reported to where
Objectives from strategic plan	IPC Head of Nursing (HoN)	IPC Operational Meetings	Two weekly	Executive Director of Nursing	IPCC
Training & Education	Assistant Director (AD) of Education, AD of Nursing, Care Group Nurse Directors	Training needs analysis, compliance ESR data	Training needs analysis (annually), compliance data (monthly)	Deputy Executive Director of Nursing	IPCC
Antimicrobial stewardship	Chief Pharmacist, IPC HoN, Care Group Medical Directors	Point prevalence audits and compliance audits, AMS/HCAI steering group	Monthly	Chief Pharmacist, Medical Director for PC&C Care Group	IPCC
Ward/unit environment and cleanliness	Director of Facilities, Heads of Nursing, IPC HoN	AMaT audits, cleaning schedules, accreditation, visits	Audits and cleaning schedules (monthly), accreditation (annually), visits (quarterly)	Care Group Nurse Directors, AD of Nursing	IPCC, Care Group QSRE
Regulatory and statutory compliance	AD Quality and Safety, AD Risk and Compliance, IPC HoN, Care Group Directors	Risk register management, HIW inspection reports, Welsh Health Circulars	Risk register (monthly), HIW and Welsh Health Circulars (when required)	Executive Director of Nursing, Executive Medical Director, Chief Operating Officer, Director of Corporate Governance	IPCC, Quality and Safety Committee exception reports

Surveillance of the key strategic objectives will also be facilitated through:



Key challenges

- The use of invasive devices such as urinary, peripheral and central devices which compromise the body's natural defence mechanisms.
- Level of hospital activity and capacity
- Community prevalence outside of healthcare settings
- Associated chronic conditions and interdependencies
- Isolation / cohort / ensuite facilities
- Emerging infections and new strains/variants i.e. pandemics
- Ensuring public confidence
- Educating workforce, patients and the public
- Non-substantive and transient workforce
- Ensuring a clean and appropriate environment
- Motivating staff and the engagement of staff
- Meeting national and local targets

Strategic plan for review

The CTM IPC Strategic Plan will be subject to a prescribed review in 2026, however an informal review will be undertaken on a quarterly basis and reported by exception to the IPCC.

Strategic Plan Author: Richard Hughes, Deputy Executive Director of Nursing (2024)

Our stakeholders and partners in Cwm Taf Morgannwg University Health Board:

GIG CYMRU NHS WALES
Iechyd Cyhoeddus Cymru
Public Health Wales

Cyngor Bwrdeistref Sirol
Pen-y-bont ar Ogwr
BRIDGEND
County Borough Council

LLAIS
Eich llais mewn iechyd a gofal cymdeithasol | Your voice in health and social care

University of South Wales
Prifysgol De Cymru

GIG CYMRU NHS WALES
Y Weithrediaeth Executive

GIG CYMRU NHS WALES
Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Cysylltu Trawsffurfio Cymru | ICTM | Connect Transform Motivate
Innovation

Cyngor Bwrdeistref Sirol
MERTHYR TUDFUL
MERTHYR TYDFIL
County Borough Council

agic hiw
Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

UK Health Security Agency

RHONDDA CYNON TAF

Powys

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Agenda Item
6.4

Quality & Safety Committee

Proposed CTMUHB NICE Guidance Management and Implementation Process

Dyddiad y Cyfarfod / Date of Meeting	16/05/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Lauren Dyton, Clinical Audit Manager David Morgan, Deputy Assistant Medical Director Clinical Audit
Cyflwynydd yr Adroddiad / Report Presenter	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
Medical Director's Office	28/02/2024	Submit for approval

Acronyms / Glossary of Terms	
AMaT	Audit Management and Tracking
CTMUHB	Cwm Taf Morgannwg University Health Board
HTW	Health Technology Wales
NICE	National Institute for Health and Care Excellence
NCAORP	National Clinical Audit and Outcome Review Plan
SLA	Service Level Agreement

1. Situation /Background

1.1 Welsh Government expects Health Boards in Wales to:-

- Develop systems and processes for disseminating, implementing and risk assessing against NICE guidelines and quality standards.
- Identify any gaps and action required to improve the quality of services.
- Provide assurance to Welsh Government that NICE guidelines have been considered, if requested.

1.2 The Medical Directorate Team requested support from the Clinical Audit Department in the development of a process for use within CTMUHB on the management and distribution of NICE guidance (focus on NICE clinical guidelines and NICE Quality Standards), aligned to the new organisational structure following the establishment of the Care Groups. Refer to Appendix I.

1.3 The CTMUHB Quality Strategy (2022-2025) sets out Six Domains of Quality [Safe Care, Timely Care, Effective Care, Equitable Care, Efficient Care and Patient Centred Care] and Our Quality Ambitions. NICE compliance activity sits at the heart of the Six Domains of Quality.

1.4 The role of National Institute for Health and Care Excellence (NICE):

"The national point of reference for advice on safe, effective and cost effective practice in health and social care, providing guidance, advice and standards aligned to the needs of its users and the demands of a resource constrained system."

According to NICE, following published NICE guidance can:

- Improve health and wellbeing outcomes for service users and carers
- Promotes integrated care
- Ensure that care provided is effective and makes efficient use of resources
- Support national consistency of care provision
- Reduce inequalities and unwarranted variation
- Supports quality improvement activities
- Demonstrates quality to commissioners and to service users and their families
- Support professional decision-making and continuous development

1.5 Since August 2018, a Service Level Agreement (SLA) gives health and social services within Wales access to NICE guidance, quality standards, advice and other services including a dedicated NICE Implementation Facilitator.

The acknowledgment and use of NICE guidance can support healthcare professionals in their day-to-day work by guiding practice, by providing a pragmatic approach to clinical problems seen every day and helps keep practice up to date to maintain professional regulation requirements.

1.6 Currently, NICE guidance compliance is monitored via national audits contained within the CTMUHB national clinical audit forward plan, which aligns to the NCAORP for Wales. The proposed process will allow wider review of NICE guidance.

2. Specific Matters for Consideration

2.1 From reviewing the current situation and the Welsh Government documentation that underpins the provision of evidence-based practice, there is need for a pragmatic approach to the management and implementation of NICE guidance, through the establishment of a clear process aligned to the Care Groups, that takes into account cross-Care Group collaboration and accountability.

2.2 Establish a pragmatic process to support the management and implementation of NICE guidance whilst understanding the continuing pressures faced by the Health Board.

2.3 The process outlines the receipt of the guidance, distribution, acknowledgement, review of applicability, where cross-Care Group collaboration is required, and emphasis on clinical directors as key decision makers. Utilising the Audit Management & Tracking (AMaT) system to hold implementation activity information and support the process.

(Refer to Appendix I)

2.4 Within Wales, non-medicine Health Technology Guidance is organised through Health Technology Wales (HTW), a national body working to improve the quality of care in Wales. HTW's remit covers any technology or model of care and support in health and social care that is not a medicine; examples included medical devices, diagnostics, procedures and psychological therapies.

2.5 There is also an expectation on Health Boards to participate in the annual Health Technology Wales adoption audit and respond to management and implementation of evidence-based non-medicine technologies.

2.6 It is anticipated that the management and implementation of HTW guidance and the HTW adoption audit activity will closely follow this process.

3. Key Risks / Matters for Escalation

3.1 CTMUHB is required to develop systems and processes for disseminating, implementing and risk assessing against NICE guidelines and quality standards.

Without a robust mechanism for the monitoring of NICE guidelines and quality standards, CTMUHB will be unable to evidence compliance as part of its clinical assurance framework.

3.2 CTMUHB has not participated in the 2024 Health Technology Wales adoption audit, due to the establishment of the care groups and the requirement for a formalised process for the monitoring of compliance with guidelines and quality standards.

Assessment Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Living Well If more than one applies please list below: Ageing Well Dying Well Growing Well Starting Well
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Enablers of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Learning, Improvement & Research If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Domains of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Effective If more than one applies please list below: Efficient Equitable Person centred Timely Safe
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: Engagement with senior colleagues has been undertaken. Positive clinical effectiveness impact.	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: This is 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.	

4. Recommendation

4.1 That the Committee NOTE the receipt of the proposal for a process for the management and implementation of NICE guidance.

5. Next Steps

5.1 To implement the CTMUHB NICE Guidance Management and Implementation Process, by the end of March 2025.

Appendix I

Last working day of each month, collation of guidance released / updated during that month.

Action by: Clinical Audit Team

Circulate details guidelines to the Care Group Directors (Medical, Nursing & Service), Director of Performance, Head of Governance for information.

Action by: Clinical Audit Team

Highlight guidelines to the appropriate Clinical and Medical Directors for action. If uncertainty regarding the appropriate Care Group(s) Medical Director's office to provide advice

Action by: Clinical Audit Team

Clinical Director(s) to determine the applicability of the circulated guidelines and decide the status of the guideline

a) Priority Guideline - action required
b) Non-priority Guideline – set review date
c) Not applicable to CTM

(Response to Clinical Audit within one month: Failure to respond – Escalation to Medical Director)

Where guideline crosses over more than one specialty within a Care Group, Care Group MD to involve all appropriate CDs

Where guideline crosses over more than one Care Group, involve all applicable Care Group MDs

<u>Priority guidelines - action required</u>

Decide if full baseline assessment or compliance review and statement only required.
(Propose full baseline assessments are required where subject matter relates to priority Governance concerns)

Action by: Appropriate Clinical Director(s) for the guideline

<u>Non-priority guidelines</u>

Set review date for 12 months hence.

Action by: Appropriate Clinical Director(s) for the guideline

(Response to Clinical Audit)

Undertake review of guideline, upload baseline assessment (NICE Excel template) and / or set compliance statement on AMaT.

Action by: Appropriate Clinical Director(s) for the guideline

Maintain and review log of non-priority guidelines

Action by: Care Group Management Team

Where there is partial compliance, improvement action plan required with MDT input and monitored using AMaT.

Action by: Appropriate Clinical Director(s) for the guideline

Maintain risk log of outstanding NICE activity and NICE improvement actions for reporting purposes.

Action by: Care Group Management Team

NICE activity reports presented at proposed Clinical Effectiveness Committee meetings

Action by: Appropriate Clinical Director(s) for the guideline

Reporting Committee	Quality Patient Safety Committee (QPSC)
Chaired by	Carolyn Donoghue
Lead Executive Director	Director of Nursing & Quality
Date of Meeting	19 February 2024

Summary of key matters considered by the Committee and any related decisions made

1.0 MENTAL HEALTH UPDATE (INCLUDING NEUROPSYCHIATRY PATIENT SOTRY)

Members received a comprehensive presentation and an update on developments within Mental Health. The presentation delivered by David Roberts (DR) provided updates on the following key areas;

- Mental Health Strategy
- Secure Services
- CAMHS
- Eating Disorders
- Mother & Baby Unit (MBU)
- Neuropsychiatry

The Interim Business Manager for the Wales Neuropsychiatry Service provided members with a presentation containing an outline of the Neuropsychiatry service in Wales and it was noted that the sustainability of the service was highlighted as a risk on the CRAF.

Members received an informative patient story about a gentleman who had sustained a serious brain injury at the age of 59 and how a technique called "Rich Pictures" was used to obtain his thoughts and feedback. Members noted the challenges that the patient faced at the outset and how the Neuropsychiatry service helped the patient and his family to obtain much needed support. The patient story highlighted the positive impact that the Neuropsychiatry services had made to the patient's quality of life.

2.0 WELSH KIDNEY NETWORK REPORT

Members received a report outlining the current Quality and Patient Safety issues within the services that are commissioned by the Welsh Kidney Network (WKN) across Wales. Some queries were raised on the new WKN risks which included Interventional Radiology and the Financial risk and growth within the Integrated Commissioning Plan (ICP).

In terms of interventional radiology, it was noted that this was not a WHSSC commissioned service, but it has an impact on renal service provision as there is

a need to often access urgent treatments for patients following complications from kidney biopsies, urgent and elective vascular access procedures. Members were assured that all Chief Executives were currently aware of the issues and significant work was underway to address the sustainability of the service. Members of the committee asked for this to be highlighted to the JC.

3.0 COMMISSIONING TEAM AND NETWORK UPDATES

Reports from each of the Commissioning Teams were received and taken by exception. Members noted the information presented in the reports and a summary of the services in escalation is attached to this report. The key points for each service are summarised below and updates regarding services in escalation are attached in the tables at the end of the report.

3.1 Cancer & Blood

Members received an update of the quality issues for services relating to the Cancer and Blood Commissioning Team Portfolio.

- The All-Wales Lymphoma Panel (AWLP) service was removed from the WHSSC escalation process in November 2023 due to implementation of the agreed action plan and an improvement in immunohistochemistry turnaround times.
- The Burns service has been de-escalated from Level 3 to Level 2 due to the capital case having been approved by Welsh Government. It is anticipated that the interim staffing arrangements can be sustained until the new build is complete.
- Plastic Surgery outreach in BCUHB remains in Welsh Government escalation/special measures framework and the next escalation meeting is due to take place in March 2024. WHSSC is contributing to the Welsh Government escalation arrangements and continue to attend the Task and Finish Group as an advisor. There has been some progress on some of the Commissioning and operational arrangements.
- South Wales Plastic Surgery - It was noted that Plastic Surgery waiting times continued to breach the Ministerial measures waiting times for treatment at Swansea Bay UHB but there has been some improvement. The service will remain in escalation level 2 to ensure this continued improvement. The Health Board shared the plastic surgery delivery plan and trajectory at the escalation meeting in October 2023.
- An update on the BCUHB plastics surgery and the harms review was provided. The interim report found no evidence of patient harm but once completed, the report will the shared with WHSSC QPSC after it has been through BCUHB QPSC. Members requested that this be highlighted to the JC.

3.2 Cardiac

Members received an update of the quality issues for services relating to the Cardiac Commissioning Team Portfolio and noted that two new risks for the portfolio had been added to the Risk Register since the last report.

- The first risk relates to waiting times for patients from BCUHB and North Powys awaiting obesity surgery procedures in Salford Royal Hospital. The waiting times were unlikely to reduce in the short to medium term. Since writing the report, a pathway has been agreed and the pathway is open for patients to travel to south Wales to access treatment at the Welsh Institute of Metabolic and Obesity Surgery (WIMOS).

- The second risk relates to a cyber-security attack on the Trauma Audit Research Network Database (TARN) which resulted in the database being taken offline. A sustainable long-term solution for this data collection which will support the ability of the Network to benchmark performance is delayed. TARN has issued a standardised spreadsheet for interim data collection, but this will not be sufficient to undertake national benchmarking and WHSSC will be unable to monitor performance against the business case. A letter has been written to NHS England and this has been escalated and a response is awaited. There is also clinical concern as the data is also used for clinical audit.

- Both cardiac services remain in escalation level 2. In terms of CVUHB the planned repatriation of cardiothoracic surgery to UHW has been delayed until April 2024. An escalation focused review meeting with the Health Board was convened on in January 2024, at which progress against those outstanding escalation actions was noted with a follow up meeting arranged for March 2024.

- Swansea Bay Cardiac Surgery Service continues to make progress against its planned escalation actions as assessed by means of its performance dashboard. A report providing an update on the status of the remaining actions was delayed as a result of the HB reconvening its Gold Command meetings and the need for the report to be subject to internal governance and oversight. NJ provided members with assurance that the Gold command meetings were not as a result of cardiac surgery – the Gold command was instigated in response to very high levels of emergency pressures across the Health Board during December 2023 and January 2024.

3.3 Neurosciences

Members noted one new risk and one increased risk relating to neurosurgery waiting times in both south Wales and north Wales. Both are being managed through the Performance Management Framework and were being closely monitored.

Concerns with the Deep Brain Stimulation (DBS) service in Bristol were highlighted. Concerns had been raised around communication with referring clinicians and patients but there had been no engagement and no improvement despite repeated efforts. As a result, expressions of interest were requested for a new provider to support the south Wales gatekeeper.

The ALAC service review around Micro Processor Knee (MPK) was also highlighted, and it was noted that this will be fed into Individual Patient Funding Requests (IPFR) as part of the outcomes work.

3.4 Women & Children

Members received an update on the quality issues for services relating to the Women & Children Commissioning Team Portfolio. The risks largely mirror the services in escalation, and it was acknowledged that the volume of risks and escalation issues within the portfolio are concerning and make this a complex and challenging area.

Members were informed that the Paediatric Cardiac Surgery service in University Hospital Bristol had shown improved performance against waiting times. There had been a notable decrease in the number of children breaching their recommended treatment date and the length of time patients were waiting beyond their recommended treatment date had also decreased. The risk was reduced, and the service de-escalated to Level 2 in January 2024.

There remain three services in escalation Level 3 and one in escalation Level 4. Three of the services (Paediatric Surgery, PICU and Neonatal Intensive Care) are at Level 3 and are provided by Cardiff and Vale University Health Board. The escalation continues to be managed as a 'Triple Escalation'. Due to the complexity of managing all three escalations together there are two Executive Leads from the Health Board and two Executive Leads from WHSSC involved.

Neonatal Care

Members were informed that an escalation meeting took place this morning and WHSSC will consider the next steps following this meeting.

Paediatric Surgery

Members received an update following the Joint Committee workshop that was held in November 2023 in which Paediatric Surgery was discussed. Members were informed that a commitment was made by the HB to deliver against a target of zero paediatric patients waiting over 52 weeks by the end of March 2024. This was to be delivered to through a hybrid model of additional lists within the Health Board and continued outsourcing to Nuffield. There is evidence of improvement and there is a high confidence rating that the service will deliver. Joint Committee also agreed with a recommendation in the ICP 2024/25 that the 52 week is maintained now that the backlog is reduced.

Paediatric Intensive Care

Financial support has been provided to the HB to support winter pressures by increasing the workforce to support the unit. Despite previous assurance received from the Health Board regarding pressure area concerns WHSSC has been notified that a Joint Review of Child Protection Arrangements (JIGPA) that was undertaken in December 2023 has highlighted concerns which need to be

readdressed. A letter has been received from the CVUHB Director of Nursing on the 9th February outlining the request for the Acute Child Health Directorate to undertake a retrospective audit of the care of thirty children in PICU since September. The results of this audit will be shared with WHSSC on completion and brought back to the QPS committee. Assurance has also been given that the CVUHB Executive Team are sighted on the concerns and work needed to review the cases.

The Committee were informed that since writing the report a letter had been received from the DoN in CVUHB and this provided detail of the actions that they were taking. It was agreed to highlight these continued concerns to JC in the QPSC Chairs Report and await an update on the further actions currently being undertaken.

Wales Fertility Institute
Despite the service remaining in escalation Level 4 there has been some recent progress with securing a new Person Responsible (PR). The HB have nominated a number of staff to sit the HFEA exams ; this will enable each site Neath and Cardiff to have their own PR, with staff ready to step up should they become unavailable to fulfil the statutory requirements of the role of PR. The PR had been a single point of failure and the intention to have more than one PR will help mitigate this risk in the future.

3.5 Mental Health
The Mental Health and Vulnerable Groups update was provided during the presentation.

3.6 Intestinal Failure (IF) – Home Parenteral Nutrition
Members received an update on the quality issues for services relating to the Intestinal Failure Commissioning Team Portfolio and noted that no new risks for the portfolio had been added to the Risk Register and since the report had been written a letter of assurance had been received outlining measures for the sustainability for the service going forward. They will be appointing a local consultant, and it is likely that on the basis of this letter of assurance the risks will be reduced at the next commissioning team meeting.

4.0 OTHER REPORTS RECEIVED

Members received reports on the following:

4.1 Services in Escalation Summary
Members noted the content of the report and the three Paediatric services in escalation Level 3 were noted and were discussed in detail above under the Women and Children's Report.

A copy of each of the services in escalation is attached to the report at Appendix 1.

4.2 CRAF Risk Assurance Framework

Members received a report outlining WHSSC's current risks scoring 15 or above on the commissioning teams and directorate risk registers. Members noted the updates in red.

One new organisational risk was highlighted and this related to the formation of the new JCC and the business continuity risk associated with this. The mitigations required will be critical as we are close to the go live date for the new JCC and a lot of the detail was still unclear. Members requested for this to be highlighted as a matter of concern to the JC.

4.3 Care Quality Commission (CQC)/ Health Inspectorate Wales (HIW) Summary Update

A briefing on Healthcare Inspectorate Wales (HIW) and Care Quality Commission (CQC) reports published during the period July 2023 to January 2024 was presented to the committee.

4.4 Incident and Concerns Report

Members received a report outlining the incidents and concerns reported to WHSSC and the actions taken for assurance.

4.5 Service Improvement and Innovation

Members received a report providing an update on the Service Improvement and Innovation Days and similar externally organised events relating to specialised services.

Members noted the content of the report, the summary of activities, aims and key points of learning and sharing. The report demonstrated the positive work that had been achieved and undertaken by clinicians. Members also noted the comprehensive update following the WHSSC QPSC development day.

4.6 Duty of Quality

Members received a report providing the steps taken by the organisation to meet the requirements of the Duty of Quality Act and to consider the revised templates to support the reporting mechanisms in accordance with the Act. Members noted that the report and the template was developed following the work undertaken in the Development Day.

5.0 ITEMS FOR INFORMATION:

Members received a number of documents for information only:

- Chair's Report and Escalation Summary to Joint Committee November 2023,
- Oversight and Escalation Framework – NHS Wales Organisations; and
- QPSC Distribution List.

6.0 ANY OTHER BUSINESS

There was no other business.
Key risks and issues/matters of concern and any mitigating actions Key risks are highlighted in the narrative above and summarised below; • The Interventional Radiology risk and impact on the renal service provision. • The outstanding Harms review and BCUHB plastics. • The pressure issues and Paediatric Intensive Care and general concerns with paediatric services CVUHB • Approval of proposed templates to meet Duty of Quality Act • The Business Continuity Risk on the CRAF Members continued to express concerns regarding the number of services that were in escalation in the Women & Childrens portfolio and asked that these were escalated for the attention of the Joint Committee.
Summary of services in Escalation • Attached (*Appendix 1*)
Matters requiring Committee level consideration and/or approval None
Matters referred to other Committees As above.
Confirmed minutes for the meeting are available upon request

Date of Next Scheduled Meeting	TBC

Executive Director Lead: Nicola Johnson
Commissioning Lead: Luke Archard
Commissioning Team: Cancer and Blood

Date of Escalation Meetings: 27/09/22, 01/12/2022, 03/03/2023, 03/05/2023
Date Last Reviewed by Quality & Patient Safety Committee: 23/10/23

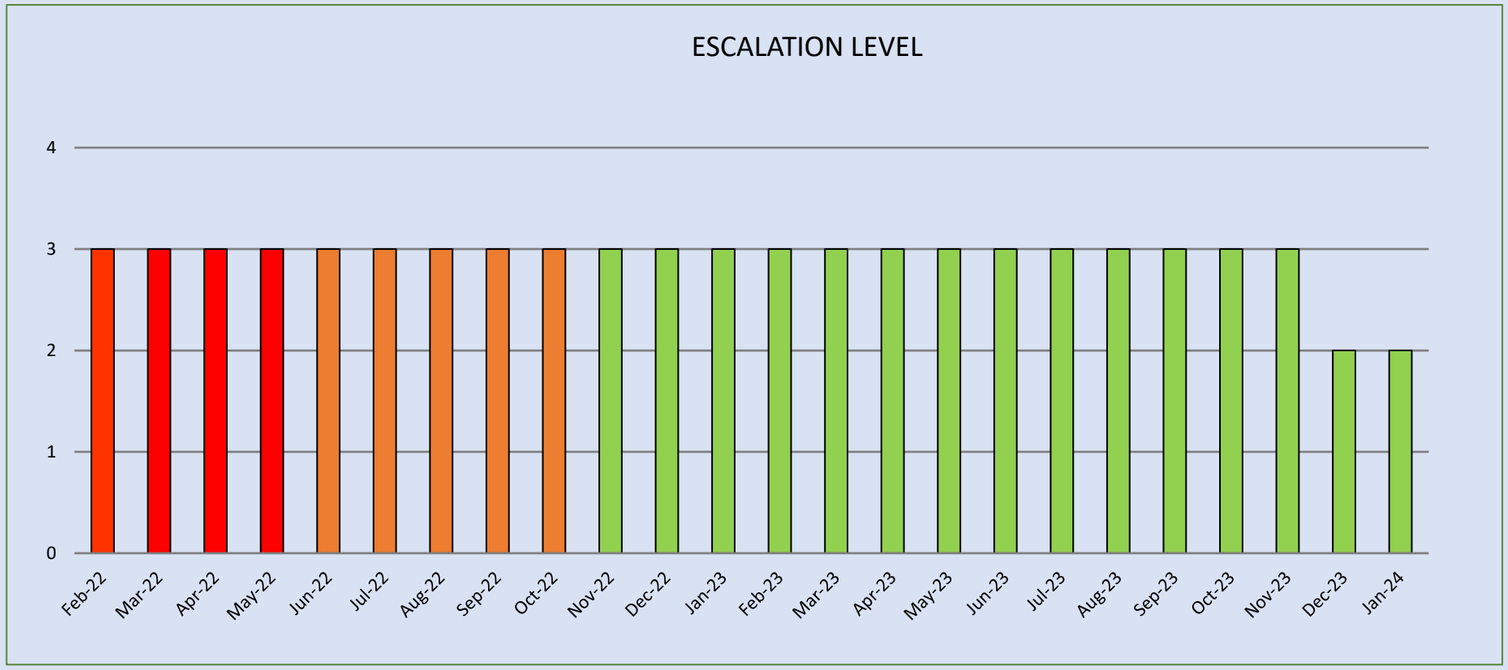
Service in Escalation: Burns

Current Escalation Level 2

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↓ December 2023
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
November 2021 – South West Burns Network escalation	**4**
February 2022 – WHSSC escalation	**3**
August 2022 – WHSSC escalation	**3**
September 2022 – WHSSC escalation	**3**
December 2022 – WHSSC escalation	**3**
December 2023 – WHSSC escalation	**2**

Rationale for Escalation Status :
De-escalated to 2.
The current timeline for completion of the capital works to enable relocation of burns ITU to general ITU at Morriston Hospital is Autumn 2024.

Background Information:

At the time of initial escalation, the burns service at SBUHB was unable to provide major burns level care due to staffing issues in burns ITU. An interim model was put in place allowing the service to reopen in February 2022. The current escalation concerns the progress of the capital case for the long term solution and sustainability of the interim model.

Actions:

Action	Lead	Action Due Date	Completion Date
To escalate and liaise with SBUHB at CEO and MD level with regard to the immediate actions needed to provide continued access to burns care for patients in Wales and the Network.	MD/CEO		Completed
To work with NHS England south west commissioners and the SWW Burns Network to support clear pathways and ensure continued access to burns care for patients in Wales and the Network.	MD/Exec Lead WHSSC		Completed

To monitor the SBUHB action plan through formal escalation meetings.	MD/ Exec Lead WHSSC		Ongoing
The peer review report was received by WHSSC and discussed at the Burns Network meeting on the 16th December 21. The interim mitigations are still in place at present.	Senior Planner		Completed
SBUHB are to provide a plan based on the recent peer review by the end of January 22.	Senior Planner		Completed
A series of monitoring meetings are being put in place and LA to ask SBUHB if they are confident as to whether 2 beds meets their requirements. The unit has reopened with reduced capacity, i.e. 2 ITU beds instead of 3. Full capacity will return in the longer term. WHSSC has responsibility for monitoring implementation rather than the burns network. It was agreed that the risk score could be reduced to 9 (3 x 3) and considered for further reduction when assurance as to whether the service considered the reduced capacity to be sufficient for their needs.	Senior Planner WHSSC/ Service Manager SBUHB		Completed
Interim arrangements to sustain burns service are in place while the business case is developed to collocate burns intensive care with the general intensive care unit. Interim arrangements appear to have taken effect. Risk may be reduced once escalation meetings can be confirmed.	Senior Manager/ Senior Planner WHSSC	Ongoing	Completed
WHSSC to look at the business continuity plan in the event of potential loss of staff.	Senior Planner WHSSC	Ongoing	Completed
Since the last escalation meeting, there has been a degree of delay relating to the process of Welsh Government scrutiny of the case which went to their Investment in Infrastructure Board on 22nd June; it had been hoped that the works would commence in May. There may, therefore, be a 2 month or so departure from original timelines. At the SLA with Swansea on 5th June, it was confirmed that this message had been conveyed to the staff supporting the interim rota arrangements (one of the concerns has been to ensure the resilience of this rota which in turn is felt to depend in part on there being demonstrable progress with the business case so they can see the finish line).	Senior Team SBUHB/WHSSC Med Director/ Senior Planner WHSSC	Ongoing	Completed
The capital case has now been approved by Welsh Government. The capital programme has commenced and is due to complete by October 2024. In view of this, the level of escalation has been reduced from level 3 to level 2. It is anticipated that the interim staffing arrangements can be sustained until the new build is complete. Level 2 escalation has been maintained in case issues or risks arise during the implementation of the capital development.	Senior Team SBUHB/WHSSC Med Director/ Senior Planner WHSSC	Ongoing	

Issues/Risks:

- **July 2023 The Welsh Government Infrastructure Investment Board considered the burns case on June 22nd the outcome is not confirmed as yet.**
- **October 2023 The capital case has been approved by Welsh Government. Timeline tbc.**

Executive Director Lead: Nicola Johnson
Commissioning Lead: Kimberley Meringolo
Commissioning Team: Women and Children

Date of Escalation Meetings: 26/04/23, 23/05/23, 20/06/2023, 26/07/23, 12/09/23, 10/10/23 & 19/12/23
Date Last Reviewed by Quality & Patient Safety Committee: 23/10/23

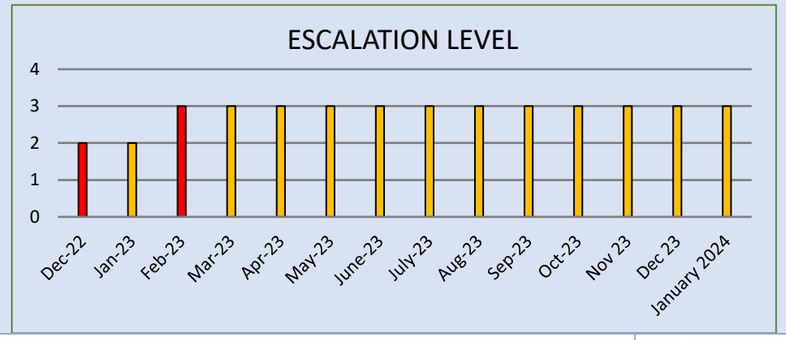
Service in Escalation: Paediatric Surgery

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ January 2024
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
March 2023 – WHSSC escalation	**3**

Rationale for Escalation Status :
As a result of the service failing to engage fully with WHSSC regarding the weekly submission of contract delivery and waiting time profiles, it was agreed that the C&VUHB Paediatric Surgery service should be further escalated from Level 1 to Level 3 of the WHSSC Escalation Framework.

Background Information:
There is a risk that Paediatric patients waiting for surgery in the Children's Hospital of Wales are waiting in excess of 36 weeks due to COVID-19. The consequence is the condition of the patient could worsen and that the current infrastructure is insufficient to meet the backlog.
• Original recovery plan trajectories have reflected a nominal improvement on the waiting list position, and clarity is required on zero waits > 104 weeks,
• The original plan did not deliver contracted volume,
• Timely assurance on delivery against the baseline for future recovery, via weekly reports, as opposed to monthly reporting suggested by the UHB.

WHSSC assurance and confidence level in developments:

High – Action plan developed and positive progress made in designing a number of new pilot schemes and securing additional capacity, some delays in implementation. The service has committed to deliver a 52-week inpatient waiting list position by year end. The delivery of this is against a robust plan of increasing day case surgery and outsourcing 37 cases to Nuffield. Monitoring progress on a monthly basis and the >52 weeks position is improving as set out in the trajectories.

Actions:

Action	WHSSC Lead	Action Due Date	Completion Date
Monthly escalation meetings with CVUHB to review progress against the improvement plan.	Senior Planning Manager	Monthly	
Action plan to be monitored through the monthly escalation meetings and when data shows improvement consideration will be given to de-escalation.	Senior Planning Manager	Monthly	
Requested revised trajectories to be issued to WHSSC by the end of June 2023.	Senior Planning Manager	30 June 2023	Completed 20/06/23
Further reprofiling of waiting times being undertaken by the HB in line with meeting contract volumes by December 2023.	Senior Planning Manager	August 2023	Completed 06/10/23
Special Executive to Executive meeting scheduled with provider.	Director of Planning & Performance	23 October 2023	Completed 23/10/23
Triple escalation meetings established to monitor progress of all three services in escalation against overarching objectives.	DOP and DON	23 January 2023	

Issues/Risks:
April 2023 – Action plan presented by HB and actions agreed to progress in time for next meeting.
May 2023 – A number of actions within the action plan are in progress, action at meeting to update trajectories in time for the July meeting in order to allow measurement of improvement.

Executive Director Lead: Nicola Johnson
Commissioning Lead: Kimberley Meringolo
Commissioning Team: Women and Children

Date of Escalation Meetings: 10/10/23 & 19/12/23
Date Last Reviewed by Quality & Patient Safety Committee: 23/10/23

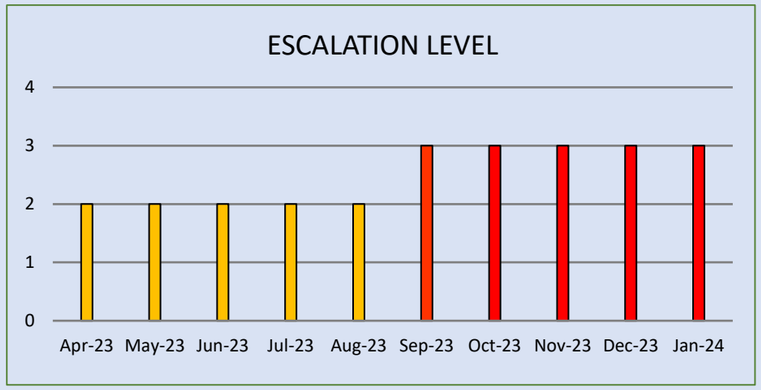
Service in Escalation: Paediatric Intensive Care

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ January 2024
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
April 2023	**2**
September 2023 – Increased level from 2 to 3	**3**

Rationale for Escalation Status :

Following concerns regarding bed availability due to workforce shortages, refusal rates and pressure sore incidents the service was escalated to level 2. There was limited progress over a 3 month period against the objectives therefore the decision was taken to further escalate to level 3.

Background Information:

There is a risk that a Paediatric intensive care bed, in the Children's Hospital for Wales, will not be available when required due to constraints within the service. There is a consequence that Paediatric patients requiring intensive care will be cared for in, inappropriate areas where the necessary skills or equipment is not available or the patient being transferred out of Wales. The availability of a bed and staffing constraints have been brought to the attention of WHSSC through various routes including HiW and the daily SITREP.

WHSSC assurance and confidence level in developments:

Low – HB have submitted draft action plan, a final version has been requested. The escalation is predominantly linked to workforce and the lead in time for mitigations is medium term, in particular the recruitment of International Nurses. New streamliners have begun in the HB and although supernumerary at present and will not directly fill PIC vacancies it will support the wider workforce challenges across the Children's Hospital. WHSSC are still awaiting detailed demand and capacity in order to develop a sustainable contracting framework for Paediatric Intensive Care and High Dependency. Further work is required on the Pressure area concerns following a JIGPA review undertaken in December 2023.

Actions:

Action	WHSSC Lead	Action Due Date	Completion Date
Requested demand and capacity plan from HB to develop sustainable contracting framework for PIC and HD	Senior Planning Manager	23 January 2024	
Requested action plan to be developed against the escalation objectives.	Senior Planning Manager	31 October 2023	Completed 19/12/23
Requested sight of the Pressure Sore report presented to the HB Quality and Patients Safety Committee.	Director of Nursing	Ongoing	
Special Executive to Executive meeting scheduled with provider	Director of Planning	23 October 2023	Completed

Issues/Risks:

Executive Director Lead: Nicola Johnson
Commissioning Lead: Kimberley Meringolo
Commissioning Team: Women and Children

Date of Escalation Meetings: 10/10/23 & 19/12/23
Date Last Reviewed by Quality & Patient Safety Committee: 23/10/23

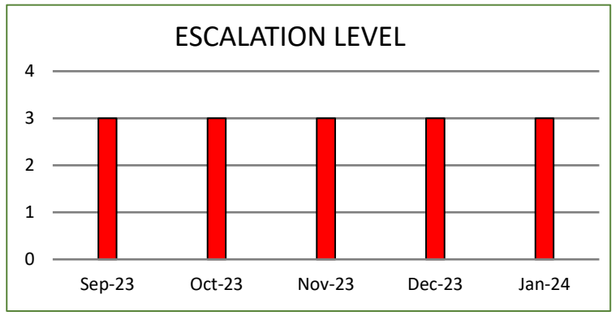
Service in Escalation: Neonatal Intensive Care Unit

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ January 2024
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
September 2023	**3**

Rationale for Escalation Status :

High levels of cot closures reported across all three levels of care, blood stream infection rates and progress implementing the new cot configuration.

Background Information:

There are currently two risks on the CRAF relating to Neonatal services at Cardiff and Vale UHB, lack of cot availability due to workforce and the service being a negative outlier status for blood stream infections, on the National Neonatal Audit Programme (NNAP). Limited progress has also been made against implementing the workforce required to support the cot configuration.

WHSSC assurance and confidence level in developments:

Low / Medium – First draft of an action plan has been received however further detail has been requested. The mitigations required to support safe staffing levels and improvements against infection rates requires a robust workforce plan which has a medium to long term lead time for completion.

Actions:

Action	WHSSC Lead	Action Due Date	Completion Date
Develop agreed objectives for escalation	Planning Manager	31 October 2023	Completed 19/12/23
Health Board to develop detailed action plan against the agreed objectives	Planning Manager	14 November 2023	Completed 19/12/23
Special Executive to Executive meeting scheduled with provider	Director of Planning	Date currently being agreed	

Issues/Risks:

Executive Director Lead: Nicola Johnson
Commissioning Lead: Kimberley Meringolo
Commissioning Team: Women and Children

Date of Escalation Meetings: 14/12/23
Date Last Reviewed by Quality & Patient Safety Committee: 23/10/2023

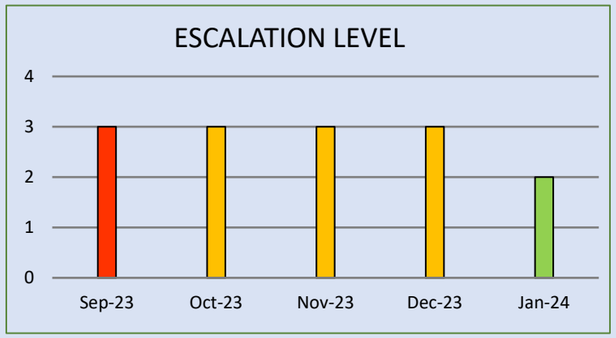
Service in Escalation: Paediatric Cardiac Surgery

Current Escalation Level 2

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↓ January 2024
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
September 2023	**3**
January 2024	**2**

Rationale for Escalation Status :

A number of waiting were breaching the recommended date for treatment as set by the Joint Cardiac Committee. The period of time people were breaching was far in excess

Background Information:

Paediatric Cardiac surgery was placed in escalation level 3 due to the number of patients waiting in for surgery and those breaching their target date by over 200 days. Formal escalation meetings were established in September 2023 with Executive leadership from both the Trust and WHSSC.

WHSSC assurance and confidence level in developments:

High – Service de-escalated to level 2, robust reporting mechanisms have been established and the waiting list position has improved. There are currently only two patients that are breaching their recommended surgery date.

Actions:

Action	WHSSC Lead	Action Due Date	Completion Date
Escalation meeting to discuss progress and trajectories	Director of Nursing & Quality	14 December 2023	Completed 14 December 2023

Issues/Risks:

Executive Director Lead: Iolo Doull
Commissioning Lead: Dominique Gray-Williams
Commissioning Team: Women and Children
Date of Escalation Meetings: 07/08/23, 19/09/23, 10/10/23, 07/12/23
Date Last Reviewed by Quality & Patient Safety Committee: 23/10/23

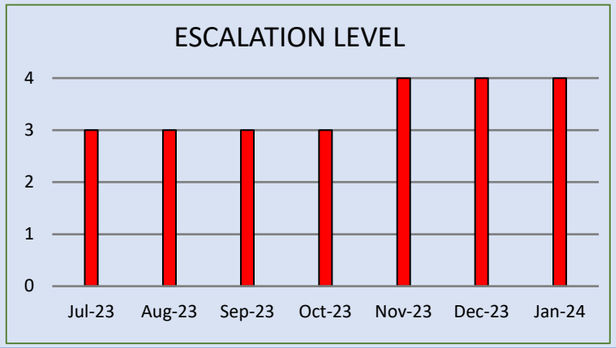
Service in Escalation: Wales Fertility Institute

Current Escalation Level 4

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↑ November 2023
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
July 2023 – WHSSC escalation	**3**
November 2023 – WHSSC escalation	**4**

Rationale for Escalation Status :
Concerns from a number of routes with regards to the service including the WHSSC contract monitoring data submission; adherence to WHSSC policies and HFEA performance outcomes below National average.

Background Information:
A number of concerns regarding the safety and quality of service had been raised through different routes, including HFEA re-inspection report January 2023, WHSSC quality and assurance meetings and WFI IPFR requests regarding Wales Fertility Institute leading to the escalation of the service.
There is a risk the Wales Fertility Institute (WFI) in Neath & Port Talbot Hospital is not providing a safe and effective service due to 7 major concerns identified during a relicensing inspection by HFEA in January 2023. There is a consequence that families who have treatment at this centre are not receiving the quality of care expected from the service and in turn impacting outcomes.

WHSSC assurance and confidence level in developments:
Medium – The Health Board have instigated regular Gold Command and operational service improvement meeting with positive progress made in addressing HFEA concerns. The Action plan has been agreed and progress has been made with regards to WHSSC data submissions, however, the service need to ensure time is given both internally and to WHSSC to allow for review and consideration of documentation.
The service submitted an audit of notes to the HFEA at the end of December, they are awaiting feedback from this submission.
The service have identified a number of suitable staff members to prepare and take on the role of PR. The intention is for all staff to sit the exam, to ensure sustainability of the service with a PR over Cardiff and a PR over Neath Port Talbot. Neath Port Talbot are due to be inspected in March 2024 and Cardiff in January 2024.
A review of the HB escalation process has been undertaken and reconfigured to form a WFI sustainability group which feeds into the WFI Assurance, Recovery and Accountability Board.
The Directorate Manger and Associate Directorate managers have left and being replaced with a clinical manager.
The HB have agreed to undertake a comprehensive service review to include, performance, finance, complaints, incidents and risks. This review is due to be completed by the end of January and identify if any outsourcing is required.

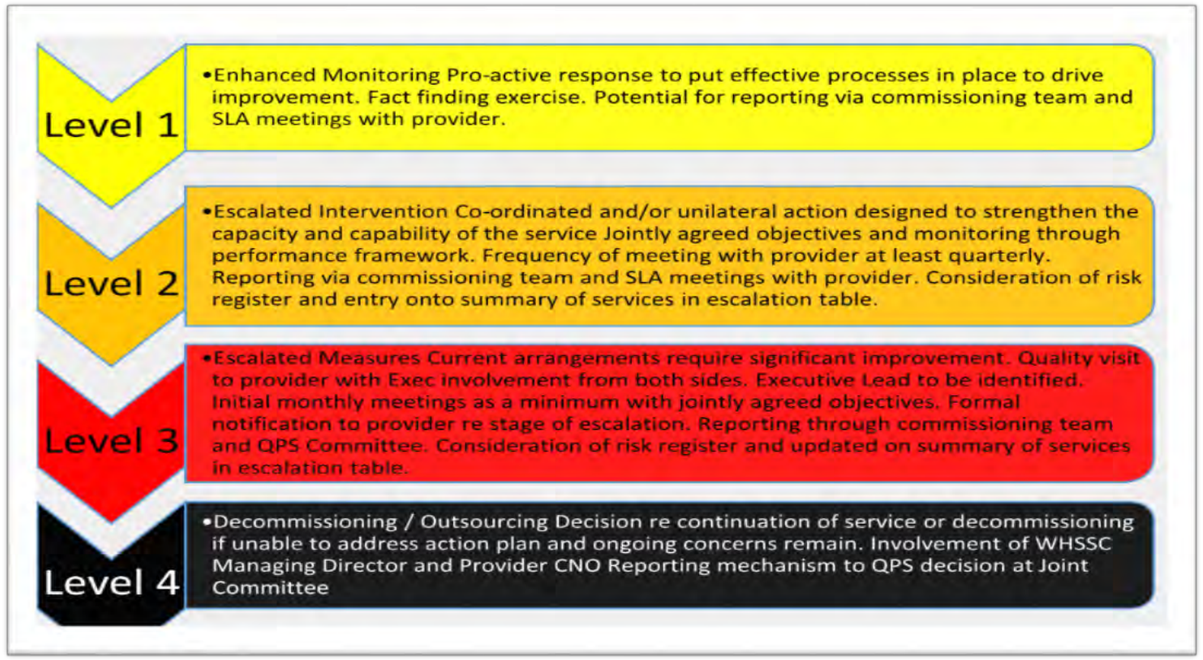
Actions:

Action	Lead	Action Due Date	Completion Date
Initial escalation planning meeting Exec to Exec	Assistant Specialised Planner	7th August 2023	7th August 2023
Monthly escalation meeting to review progress against Action Plan, Escalation meeting 19th September 2023, 10th October 2023, 7th December 2023	Assistant Specialised Planner	Monthly	Ongoing
Quality visit, this has been temporarily paused due to increase in escalation level to escalation level 4	Assistant Specialised Planner	14th November 2023	
SMART Action plan from WFI, action plan has been requested in order that it can be agreed with WHSSC colleagues	Assistant Specialised Planner/ Service Manager	7th August 2023	7th August 2023
SMART Action plan reviewed and agreed	Service Manager	19/09/2023	19/09/2023
Regular Executive to executive meetings 16th November 2023, 21st November 2023, 1st December 2023, 7th December 2023, 21st December 2023	Executive lead SBUHB/ Medical Director WHSSC	16th November	Ongoing

Issues/Risks: There is a risk the Wales Fertility Institute (WFI) in Neath & Port Talbot Hospital is not providing a safe and effective service due to 7 major concerns identified during a relicensing inspection by HFEA in January 2023. There is a consequence that families who have treatment at this centre are not receiving the quality of care expected from the service and in turn impacting outcomes.

Level 1 ENHANCED MONITORING	Any quality or performance concern will be reviewed by the Commissioning Team. Enhanced monitoring is a pro-active response to put effective processes in place to drive improvement. It is an initial fact finding exercise which should ideally be led by the provider and closely monitored and reviewed by the commissioning team. The enquiry will lead to one of the following possible outcomes: • No further action is required routine monitoring will continue. The concern which raised the indication for inquiry will be logged and referred to during the routine monitoring process to ensure this has not developed any further. • Continued intervention is required at level 1 and a review date agreed. • Escalation to Level 2 if further intervention is required There is the potential for reporting via commissioning team report to Quality Patient Safety Committee and through SLA meetings with provider
Level 2 ESCALATED INTERVENTION	Escalated intervention will be initiated if Level I Enhanced Monitoring identifies the need for further investigation/intervention. There should be a Co-ordinated and/or unilateral action designed to strengthen the capacity and capability of the service. At this stage there should be jointly agreed objectives between the provider and commissioner and monitored through the relevant commissioning team. Frequency of meeting with provider should be at least quarterly and possible interventions will include • Provider performance meetings • Triangulation of data with other quality indicators • Advice from external advisors • Monitoring of any action plans A risk assessment should be undertaken, and logged on the Commissioning Team Risk Register. Where appropriate the risk will be included on the WHSSC Risk Management Framework. Reporting is via commissioning team report to Quality Patient Safety Committee report and SLA meetings with provider. The investigation will lead to on to the following possible outcomes: • Action plan and monitoring are completed within the allocated timeframe, evidence of progress and assurance the concern has been addressed. De-escalation to Level 1 for ongoing monitoring. • If the action plan is not adhered to and further concerns are raised by the Commissioning team or by the provider team or further concerns are identified it may be necessary to move to Level 3 Escalated Measures
Level 3 ESCALATED MEASURES	Where there is evidence that the Action Plan developed following Level 2 has failed to meet the required outcomes or a serious concern is identified a service will be placed in escalated Level 3. At this stage the quality of the service requires significant action/improvement and will require Executive input. In addition to routine reporting through QPS a formal paper will be considered by the WHSSC Corporate Directors Group (CDG) and an Executive Lead nominated. Formal notification will be sent to the provider re the Level of escalation and a request made for an Executive lead from the provider to be identified. An initial meeting will be set up as soon as possible dependant on the severity of the concern. Meetings should take place at least monthly thereafter or more frequently if determined necessary with jointly agreed objectives. Provider representation will depend on the nature of the issue but the meetings should ideally comprise of the following personnel as a minimum: • Chair (WHSSC Executive Lead) • Associate Medical Director - Commissioning Team • Senior Planning Lead – Commissioning Team • WHSSC Head of Quality • Executive Lead from provider Health Board/Trust • Clinical representative from provider Health Board/Trust • Management representative from provider Health Board/Trust An agreed agenda should be shared prior to the meeting with a request for evidence as necessary. At the conclusion of the meeting a clear timeline for agreed actions will be identified for future monitoring and confirmed in writing if appropriate. Reporting will be through commissioning team to QPS Committee. Consideration of entry on the risk register and summary of services in escalation table for Chairs report to Joint Committee. Consideration to involve and have a discussion with Welsh Government may be considered appropriate at this stage. If there is ongoing concern relating patient care and safety with no clear progress then further escalation will be required to Level 4. On the other hand if progress is made through the escalation Level 3 evidence of this should be presented to CDG/QPS and a formal decision made with the provider to de-escalate to Level 2.

Level 4 DECOMISSIONING/OUTSOURCING	Where services have been unable to meet specific targets or demonstrate evidence of improvement a number of actions need to be considered at this stage. This stage will require notification and involvement of the WHSSC Managing Director and CEO from the provider organisation. Both Quality Patient Safety Committee and Joint Committee should be cited on the level of escalation. The following areas will need to be considered and the most appropriate sanction applied to help resolve the issue: 1. De-commissioning of the service 2. Outsourcing from an alternative provider. This may be permanent or temporary 3. Contractual realignment to take into account the potential need to maintain and agree an alternative provider. Involvement with Welsh Government and the Community Health Council is critical at this stage as often there are political drivers and levers that need to be considered and articulated as part of the decision making. Moving in and out of escalation and between Levels In addition to the Levels described above the process has introduced a traffic light guide within each level. The purpose of this is to help demonstrate the direction of travel within the level. It sets out an approach to help identify progress within the level and lays out the steps required for movement either upwards (escalation) or downwards (de-escalation) through the level. At every stage a red, amber or green colour will be applied to the level to illustrate whether more or less intervention is in place. Red being a higher level of intervention moving down to green. It will also help determine the easing of the escalated measures described and inform movement within the stages of escalation. As the evidence and understanding of the risks from a provider and commissioner become evident decisions can be made to reduce the level of intervention or there may be a need to reintroduce intervention should conditions worsen and trigger the re-introduction of measures if progress is unacceptable. In this way organisations will be able to understand what is being asked of them, progress will be easily identified and it will help avoid any confusion. It will also help in the reporting to provide assurance that action is being taken to meet the agreed timescales.



SERVICES IN ESCALATION

Level of escalation reducing / improving position

Level of escalation unchanged from previous report/month

Level of escalation increasing /

Agenda Item
6.6

Quality & Safety Committee

NHS WALES JOINT COMMISSIONING COMMITTEE PAPER

Dyddiad y Cyfarfod / Date of Meeting	16/05/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Nigel Downes, Assistant Director of Quality & Safety
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

Acronyms / Glossary of Terms	
CVUHB	Cardiff & Vale University Health Board
CQPR	Contract Quality and Performance Review
CTMUHB	Cwm Taf Morgannwg University Health Board
JCC	NHS Wales Joint Commissioning Committee
PHW	Public Health Wales
PTHB	Powys Teaching Health Board
SLA	Service Level Agreement
SBUHB	Swansea Bay University Health Board
WHSSC	Welsh Health Specialised Services Committee

1. Situation /Background

1.1 The purpose of this report is to provide assurance to the Quality and Safety Committee on the commissioning arrangements, specifically relating to Quality and Safety that Cwm Taf Morgannwg University Health Board (CTMUHB) has with NHS organisations, both as a commissioner of services and where CTMUHB is commissioned by other NHS organisations.

2. Specific Matters for Consideration

2.1 CTMUHB currently has Long Term Agreements (LTAs) and Service Level Agreements (SLAs) with Powys Teaching Health Board (PTHB), Swansea Bay University Health Board (SBUHB), Cardiff & Vale UHB (CVUHB), Public Health Wales (PHW) and NHS Wales Joint Commissioning Committee (JCC) (previously the Welsh Health Specialised Services Committee – WHSSC).

2.2 The SLAs include monitoring of the commissioning arrangements, including for elements relating to Quality and Safety, to be reviewed in regular Contract Quality and Performance Review (CQPR) meetings. Review meetings are held in the following format:

- CVUHB Review Meetings take place bi-monthly
- PTUHB Review Meetings take place monthly
- SBUHB Review Meetings take place 6-weekly
- PHW Review Meetings take place 6-monthly
- JCC Review Meetings take place monthly.

2.3 All elements of Quality and Safety, specifically related to the commissioned services, include (but are not limited to): Concerns, Complaints, Incidents, system changes, system pressures, etc… are raised and discussed at the CQPR meeting. An Action Log is recorded at each of the meetings, which is updated and monitored, with escalation as required. Assurance is accordingly provided for any issue/challenge raised at each of the CQPR meetings.

2.4 In addition to the Contract Quality and Performance Review meetings, a separate quarterly Quality Meeting is held between the JCC and CTMUHB Quality and Safety leads: Assistant Director Quality & Safety at CTMUHB; Head of Quality & Safety at JCC. All areas of the quality and safety agenda, relating to the commissioned areas, and include (but are not limited to): Concerns, Complaints, Incidents, system changes, system pressures, etc. are reviewed at this meeting. Once again, an Action Log is recorded of the meeting, which is updated and monitored accordingly by the quality team

of the JCC. Assurance is accordingly provided for any issue/challenge raised at each of the Quality Meetings.

2.5 If required, issues may also be escalated outside of the above meetings. In the event of issues being escalated outside of the above meetings, updates will be included within the agenda of the next CQPR or Quality meeting.

2.6 SLAs are reviewed, updated and agreed by CTMUHB on an annual basis; with specific elements of quality and safety undergoing review and scrutiny by the Assistant Director Quality & Safety at CTMUHB.

2.7 Commissioning of new services either require a new SLA or would be included within an amendment to the LTA, and specific elements of quality and safety undergoing review and scrutiny by the Assistant Director Quality & Safety at CTMUHB.

3. Key Risks / Matters for Escalation

Nothing to escalate in terms of risk at this stage.

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	Choose an item.
	If more than one applies please list below: Starting Well Growing Well Living 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))*	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))*	Choose an item.
	If more than one applies please list below: Safe Timely Effective Efficient Equitable Patient Centred
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* Quality *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not Required – paper for noting. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment.
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 – paper for noting. 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.
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 Committee is asked to NOTE the contents of this report and the activity providing assurance of the commissioning processes, both as a commissioner of services and where CTMUHB is commissioned by other NHS organisations, relating to CTMUHB.

Agenda Item
7.1

Quality & Safety Committee

Patient Safety & Quality Dashboard

Dyddiad y Cyfarfod / Date of Meeting	16/05/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Kellie Jenkins-Forrester, Head of Concerns & Business Intelligence Kellie.l.jenkins-forrester@wales.nhs.uk
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
Discussions with key individuals in corporate services and within directorates and localities	Various dates	

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

1. Situation /Background

This presentation of the Patient Safety & Quality Dashboard to Committee provides data from 01.03.24 to 30.04.24 taken from systems on 07.05.24, unless otherwise specified.

This report contains the Patient Experience overview as appendix 1.

Key areas to note in this reporting period are:

- Number of Complaints managed via PTR (formal) remain relatively consistent.
- Compliance with the 30 working day target for responding to complaints remains over 75%.
- The Nationally Reportable Incidents submitted increased in March 2024.
- Updated Comparison data of reporters view on level of harm and severity post investigation included in the report.
- Decrease in the number of medication incidents reported.
- The number of incidents reported relating to patient falls decreased slightly during the period.

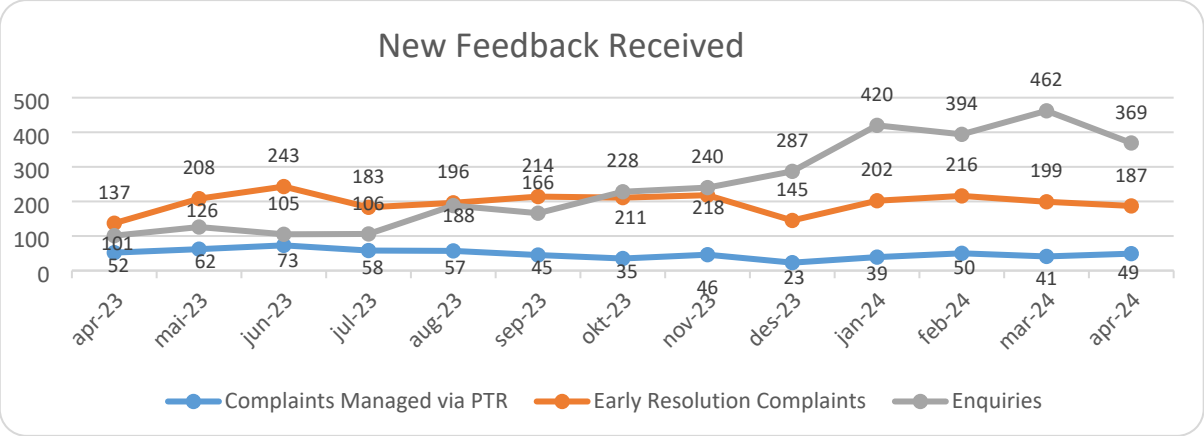
2. Specific Matters for Consideration

2.1 Patient / Service User Feedback

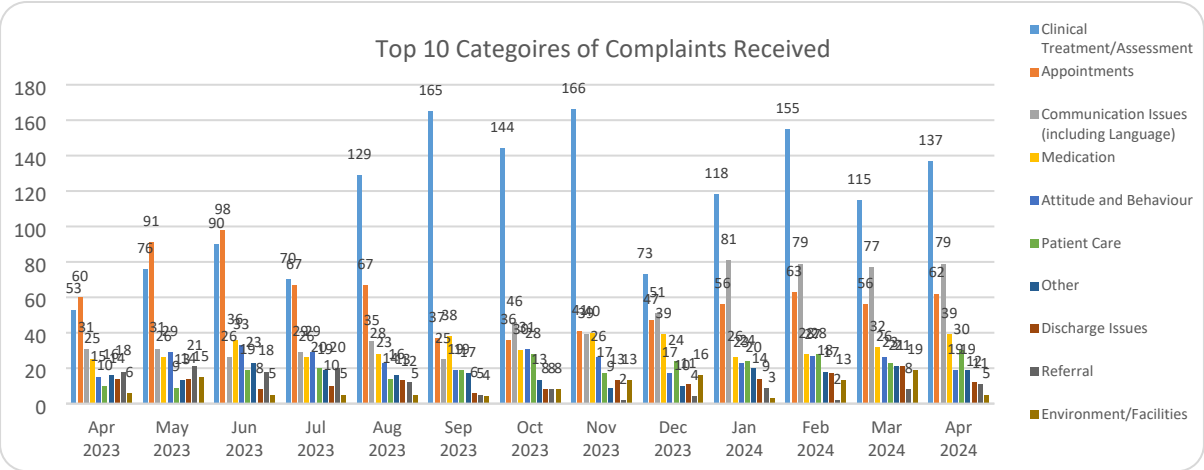
Complaints

New Complaints Received

Between the 01.03.24 and 30.04.24 the Health Board received a total of 476 complaints. Of these, 90 were categorised as formal and managed under the Putting Things Right Regulations (PTR). This remains relatively consistent with the previous two month period. As highlighted in the last report to Committee the increase in the number of enquiries being recorded is reflective of robust reporting of prison interactions as well enquiries managed via the Concerns and PALS Team.

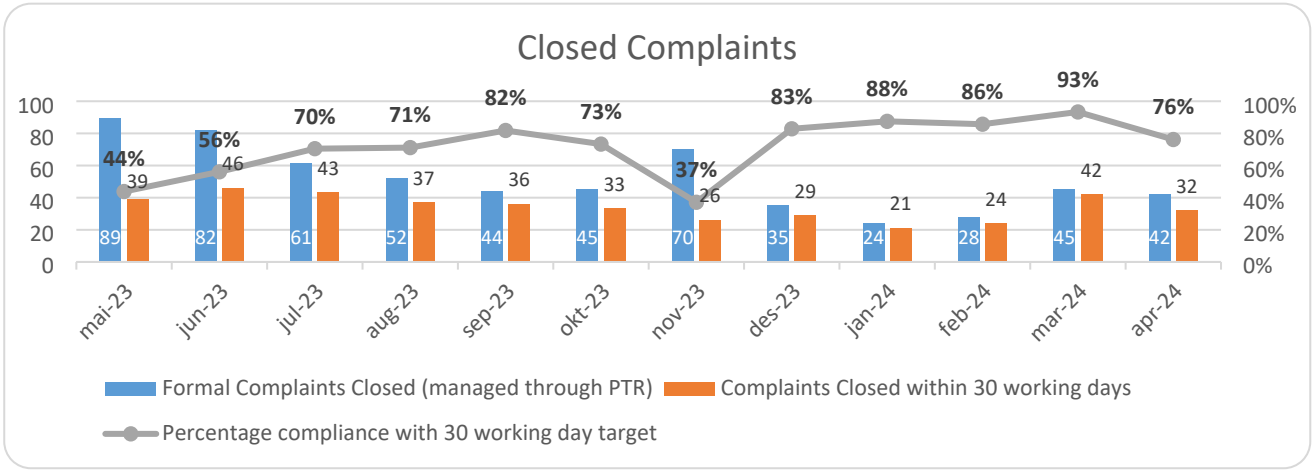


For all complaints received in March and April 2024, the top 3 types of complaints received remain consistent with previous months. These relate to Clinical Treatment / Assessment (252), Communication Issues (156) and Appointments (118).



Closed Complaints

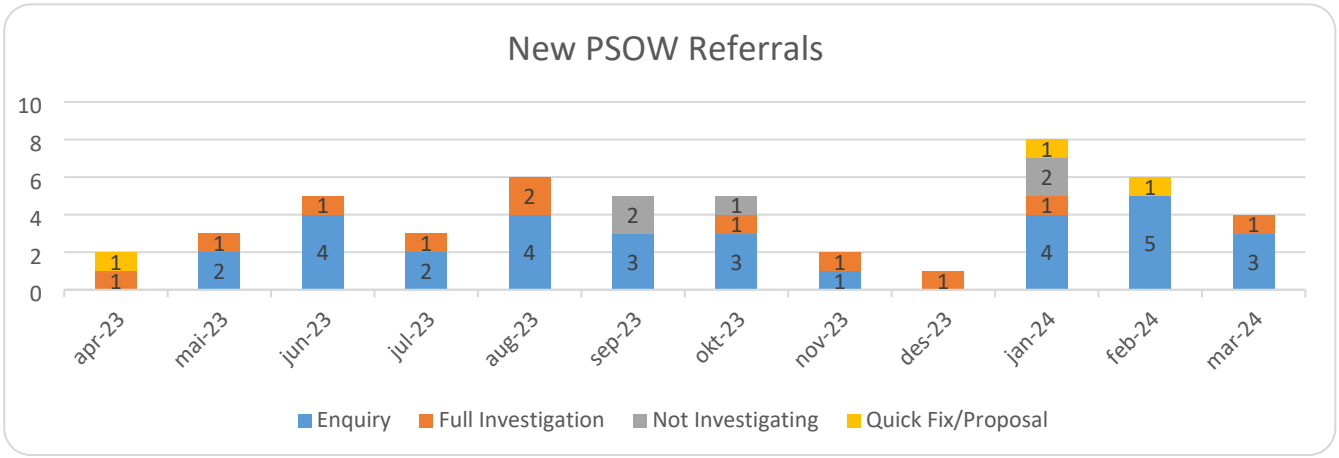
Within the period of 01.03.24 to 30.04.24, the Health Board closed a total of 87 formal complaints (managed through PTR). Whilst compliance has remained over the national target of 75% since December 2023, compliance decreased below the Health Board's internal target of 85% during April 2024. Compliance during April was impacted by the availability of clinicians to provide comments and quality assure responses. A review of processes has been impacted to ensure robust escalation is in place. As at 03.05.24, the Health Board had 62 open formal complaints. Of these, 10 complaints were open over 30 working days.



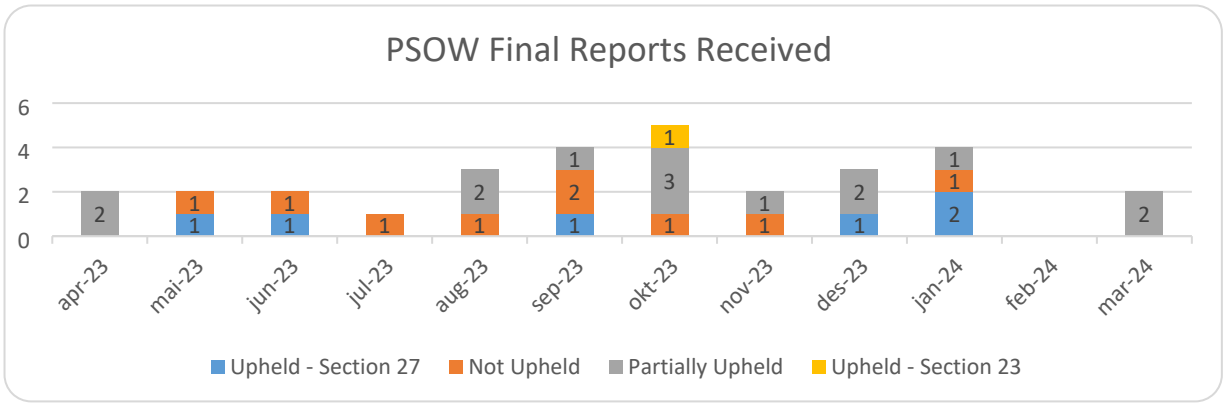
Public Services Ombudsman for Wales

At the time of preparing this report April data was being collated and validated, updates will therefore relate to March PSOW activity only with April updates being provided in the next report.

The Health Board received notification of 4 new referrals to the Public Services for Ombudsman for Wales (PSOW) during March 2024. Of the 4 referrals, 3 were received as enquires and 1 as a full investigation.



During the same period, the PSOW issued 2 final reports to the Health Board, both of which were partially upheld and related to services provided by Mental Health and Unscheduled Care.

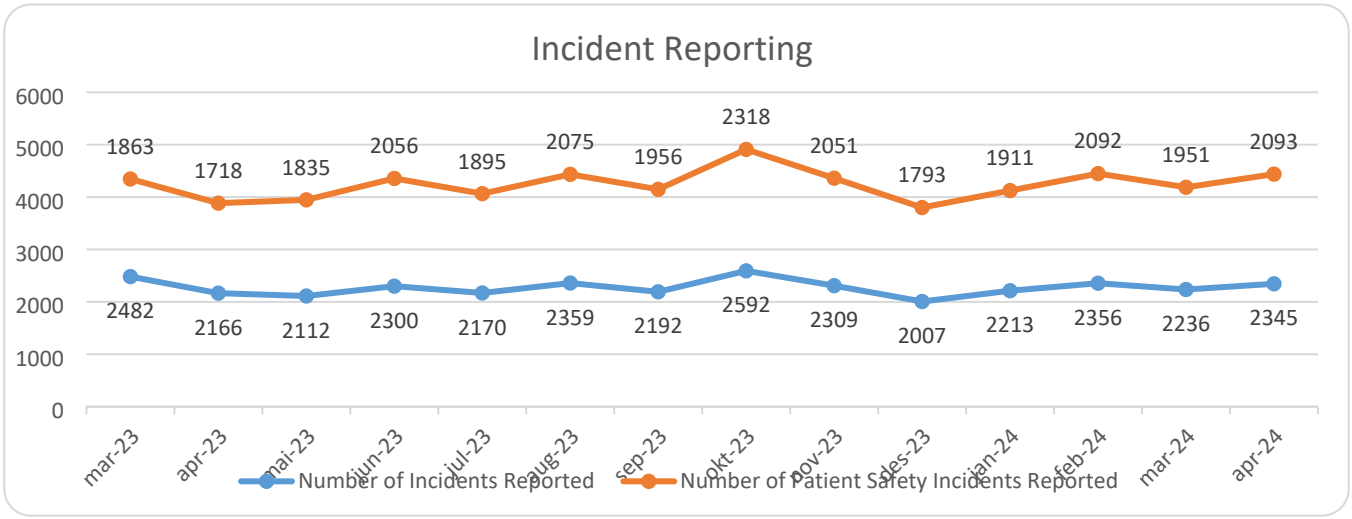


As at 01.04.24, the Health Board had 51 Open PSOW cases, of these 28 are awaiting a response from the PSOW to instigate any further action required. Compliance has been submitted and confirmation of closure is awaited on 12 of the 51 cases. 8 are at final report stage with actions being implemented by the Care Groups.

2.2 Patient Safety Incidents

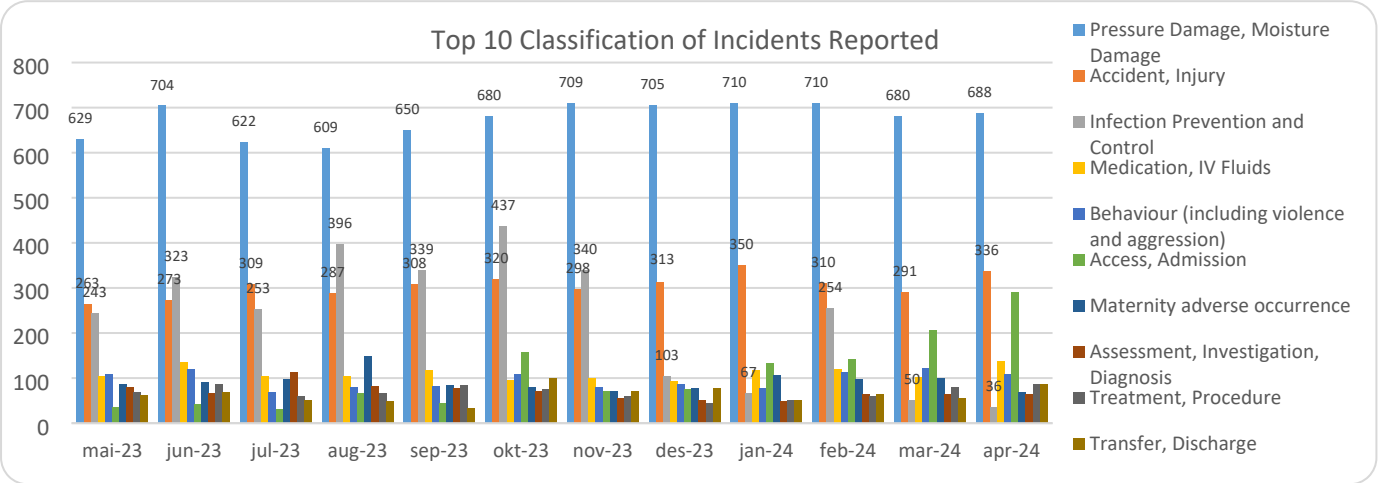
Total Patient Safety Incidents

A total of 4,581 incidents were reported between 01.01.24 and 29.02.24, this represents a decrease of 12 when compared with the previous 2 months (4,569).



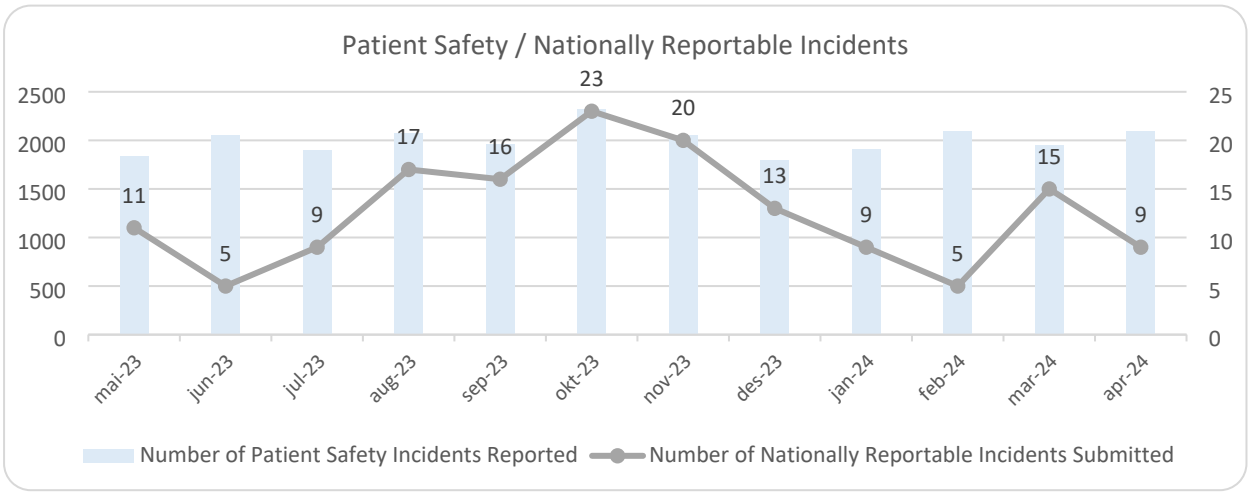
The number of incidents reported where the patient is identified as the person affected has remained relatively consistent over the last 6 months period. Of the 4,581 incidents reported, 88% (4,044) were reported as the patient affected.

The top 3 types of incidents reported for March and April 2024, linked to a patient affected are: Pressure Damage /Moisture Lesion (1,368), Accident, Injury (627) and Access, Admission (496). This represents a change in the top 3 classifications of incidents as access, admission has replaced Infection, Prevention & Control during this time period.



Nationally Reportable Incidents

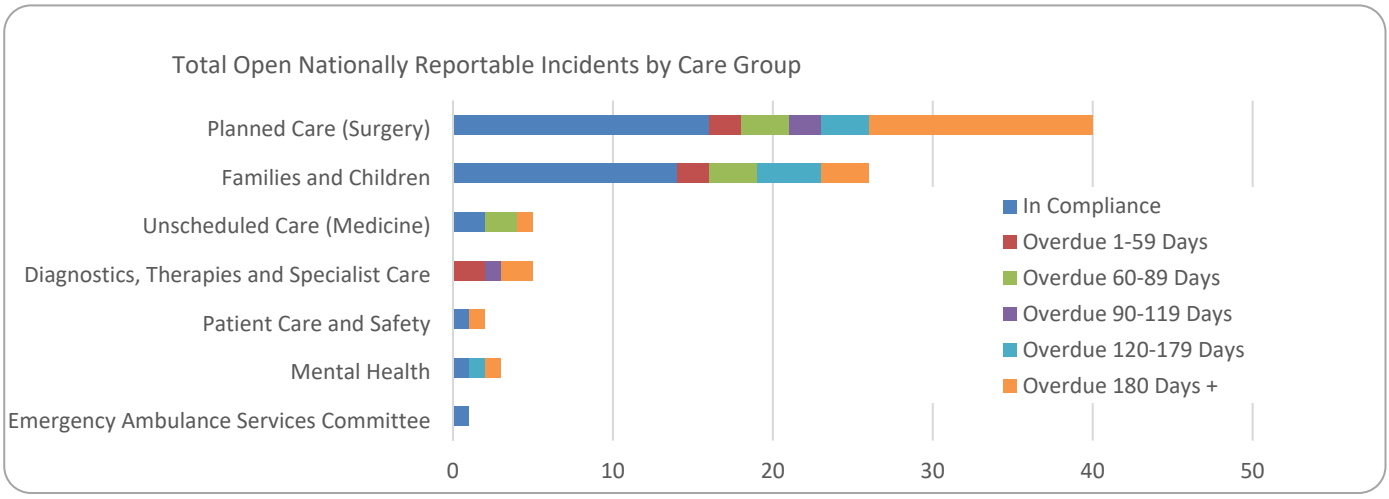
Between 01.03.24 and 30.04.24, 24 Nationally Reportable Incidents were submitted to the NHS delivery unit. The ratio of Nationally Reportable Incidents to the overall number of patient safety incidents is demonstrated in the chart below.



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 (formerly known as the “Delivery Unit”). This is reflected in the increase in both October 2023 (23) and Mar 2024 (15) which are linked to the notification of Ophthalmology incidents, following completion of the harm review process that occurred prior to the reporting period and pressure damage deemed avoidable following review at scrutiny panel. The trend for the classification of Nationally Reportable Incidents submitted is reflected in the table below:

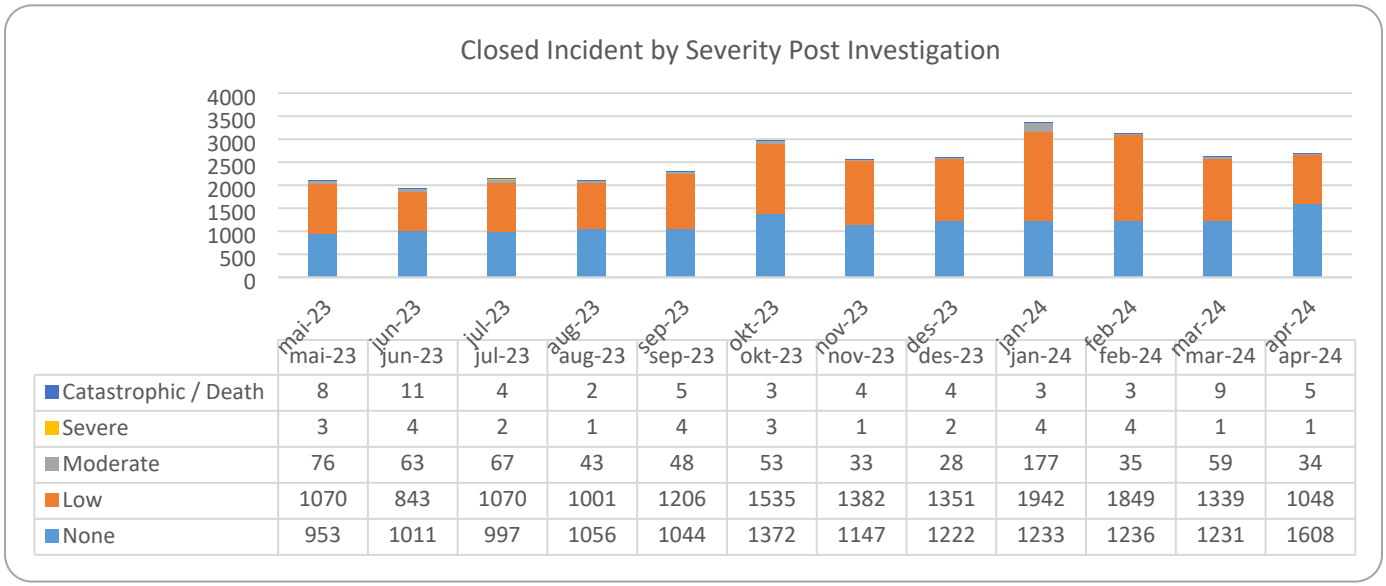
	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	Total
Access, Admission	0	0	1	0	0	1	1	1	2	0	2	1	9
Accident, Injury	0	0	0	0	0	0	0	0	0	1	0	0	1
Assessment, Investigation, Diagnosis	1	1	2	1	3	0	5	3	0	0	2	0	18
Behaviour (including violence and aggression)	0	0	0	0	0	0	0	0	0	0	0	1	1
Equipment, Devices	1	0	0	0	0	0	0	0	0	0	0	0	1
Infection Prevention and Control	0	0	0	6	10	13	5	1	0	0	0	1	36
Infrastructure (including staffing, facilities, environment)	0	0	0	0	0	0	1	0	0	0	0	0	1
Maternity adverse occurrence	2	0	1	4	0	0	0	1	2	1	2	4	17
Medication, IV Fluids	0	0	1	0	0	1	0	0	0	0	0	0	3
Patient/service user death	3	1	0	1	0	0	0	0	1	0	2	0	8
Pressure Damage, Moisture Damage	5	3	2	5	2	7	8	5	3	3	5	1	50
Transfer, Discharge	0	0	0	0	0	0	0	0	1	0	0	0	1
Treatment, Procedure	0	0	2	0	1	1	0	2	0	0	1	1	9
Safeguarding	0	0	0	0	0	0	0	0	0	0	1	0	1
Total	12	5	9	17	16	23	20	13	9	5	15	9	156

As at the 30.04.24, the Health Board currently has 82 open Nationally Reportable Incidents, of which 47 are overdue the timescale (60 days) for completion. A trajectory plan is in place to ensure investigations are concluded and an outcome provided patients and their families. An overview of the open Nationally Reportable Incidents by Care Group is provided in the chart below:



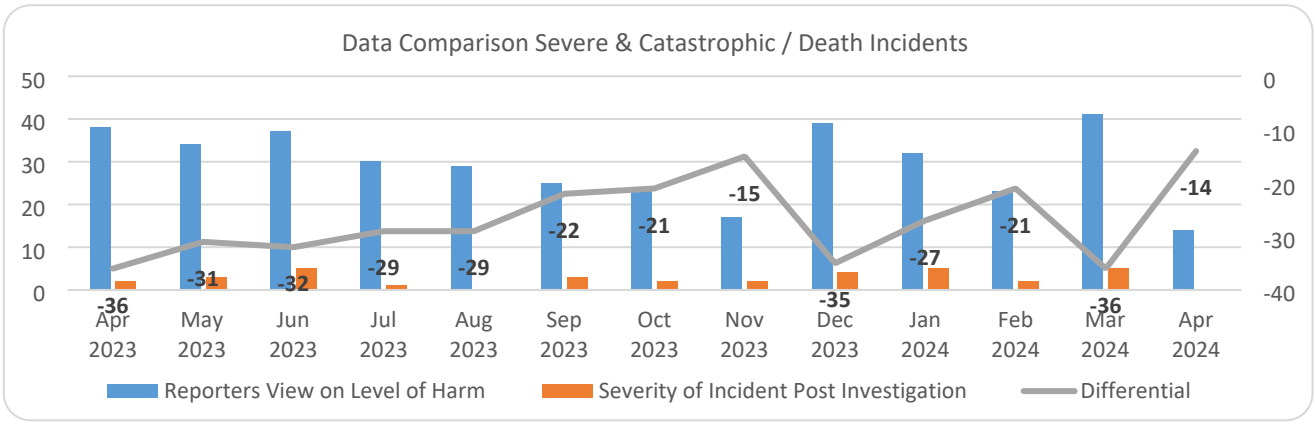
Closed Patient Safety Incidents

Between the 01.03.24 and 30.04.24 a total of 5,335 patient safety incidents were closed. Of the 5,335 patient safety incidents closed, 16 were closed with severity post investigation of severe harm (2) or catastrophic/ death (14). The 12 month trend is reflected in the table below. Of the 9 incidents closed with a severity post investigation of catastrophic / death, 5 are classified as a healthcare associated infection.



	mai-23	jun-23	jul-23	aug-23	sep-23	okt-23	nov-23	des-23	jan-24	feb-24	mar-24	apr-24
Catastrophic / Death	8	11	4	2	5	3	4	4	3	3	9	5
Severe	3	4	2	1	4	3	1	2	4	4	1	1
Moderate	76	63	67	43	48	53	33	28	177	35	59	34
Low	1070	843	1070	1001	1206	1535	1382	1351	1942	1849	1339	1048
None	953	1011	997	1056	1044	1372	1147	1222	1233	1236	1231	1608

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



Duty of Candour

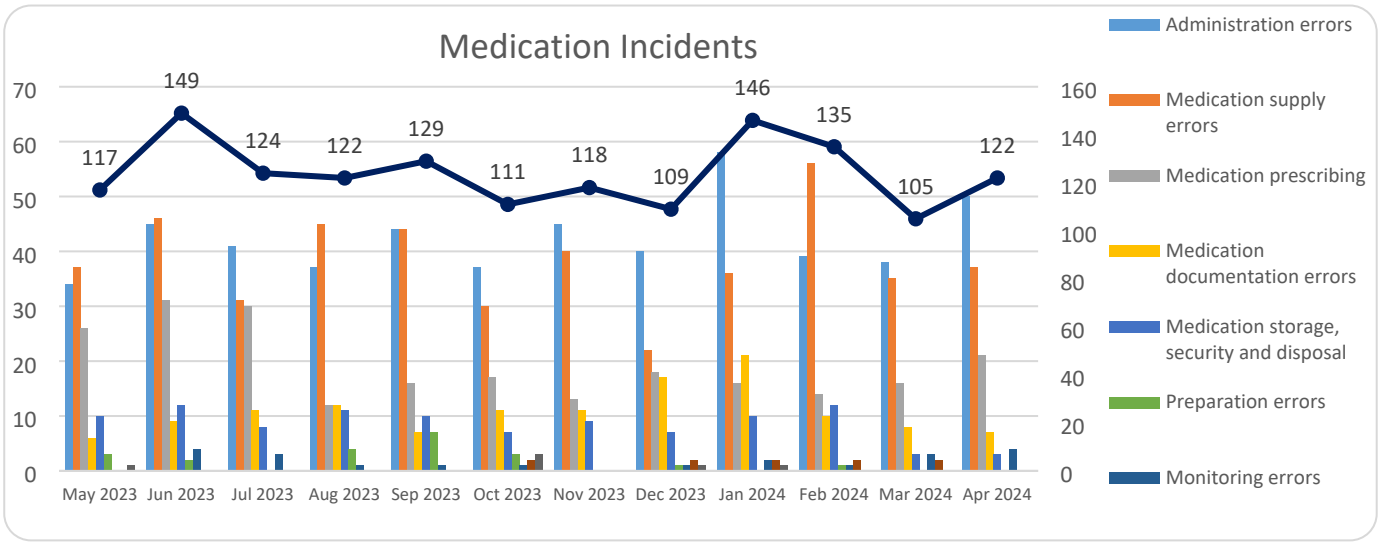
The Duty of Candour regulations were implemented from the 01.04.23. To enable monitoring of requirements, a number of metrics have been devised, which are summarised in the table below. To support the implementation of the Duty of Candour processes, dashboards have developed to provide 'live' data at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

Number of Incidents	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024
Where Duty of Candour Triggered	7	9	13	12	13	14	12	6	18	26	9	5
Where In-person notification completed	5	6	10	11	11	14	11	6	15	21	7	4
Where letter of notification sent	5	6	10	9	11	10	9	5	10	11	3	2

2.3 Specific Quality & Safety Metrics

2.3.1 Medication Safety

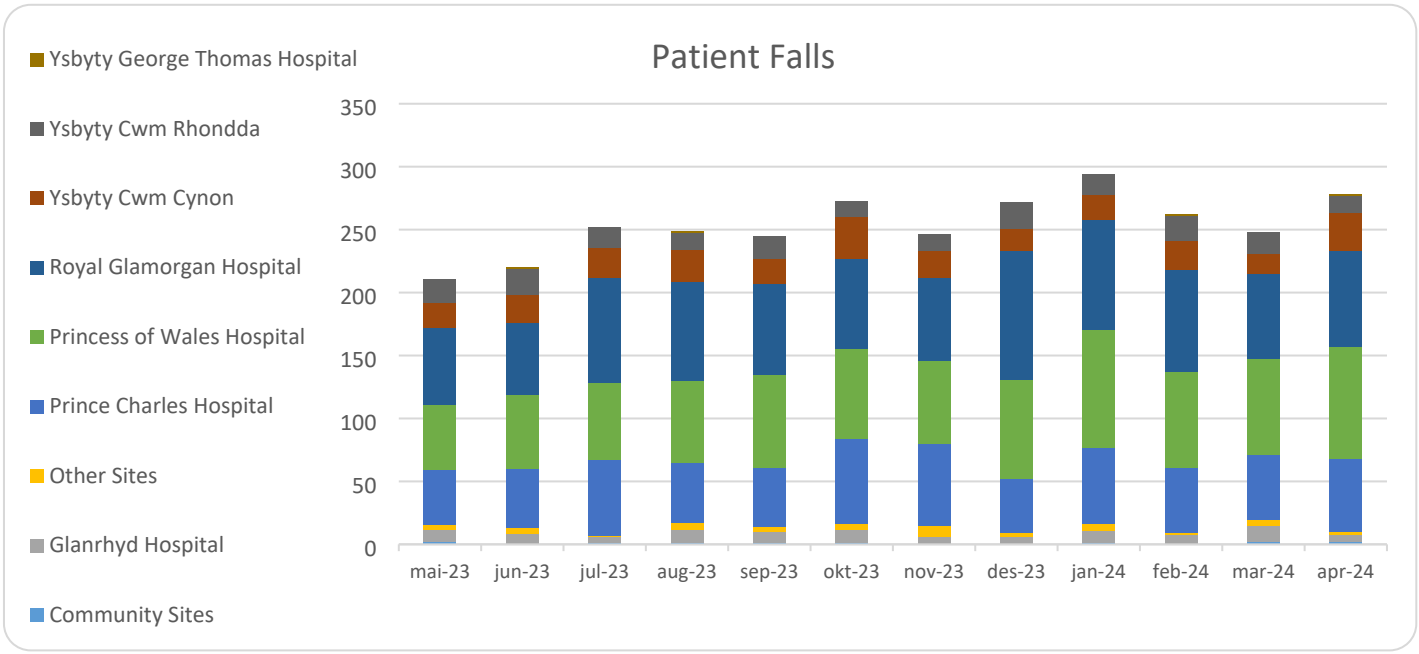
A total of 227 medication incidents were reported as occurring between 01.03.24 and 30.04.24. This is a decrease of 54 when compared with the previous 2-month period. Of the total number of medication incidents reported, the top 3 types of medication incidents relate to administration errors (88), supply errors (72), and medication prescribing errors (37).



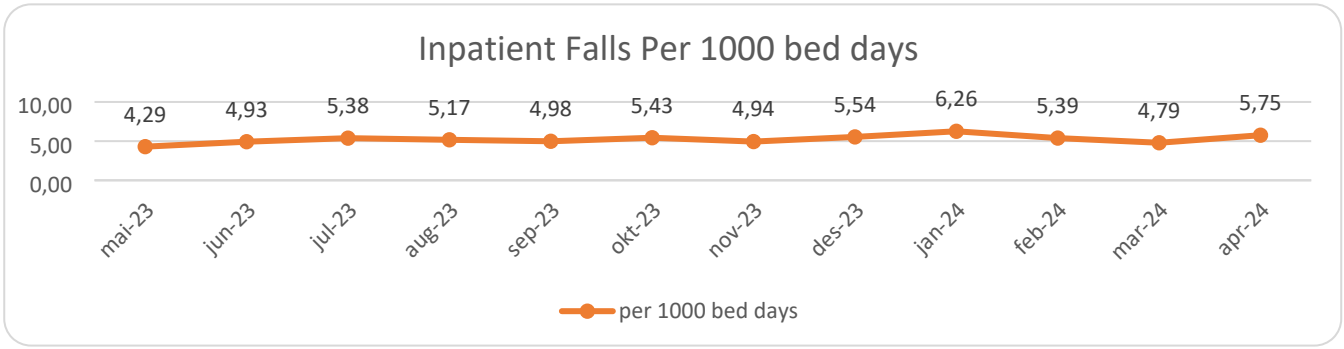
88% of the medication incidents were reported as resulting in no (84) or low (116) harm, with the remaining reported as resulting in moderate harm (22), severe (3) harm and catastrophic harm (2). It should be noted that this is the reporter's view of the level of harm and is subject to change following investigation.

2.3.2 Patient Falls Incidents

A total number of 529 falls, where the person affected was a patient, were reported during March and April 2024. This represents a slight decrease of 27 compared with previous months. Of the falls incidents within the time period, 88% were reported as no (143) or low (347) harm. The remaining incidents were reported as moderate (36) and severe (3) harm. No incidents relating to patient falls were reported as resulting in 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.



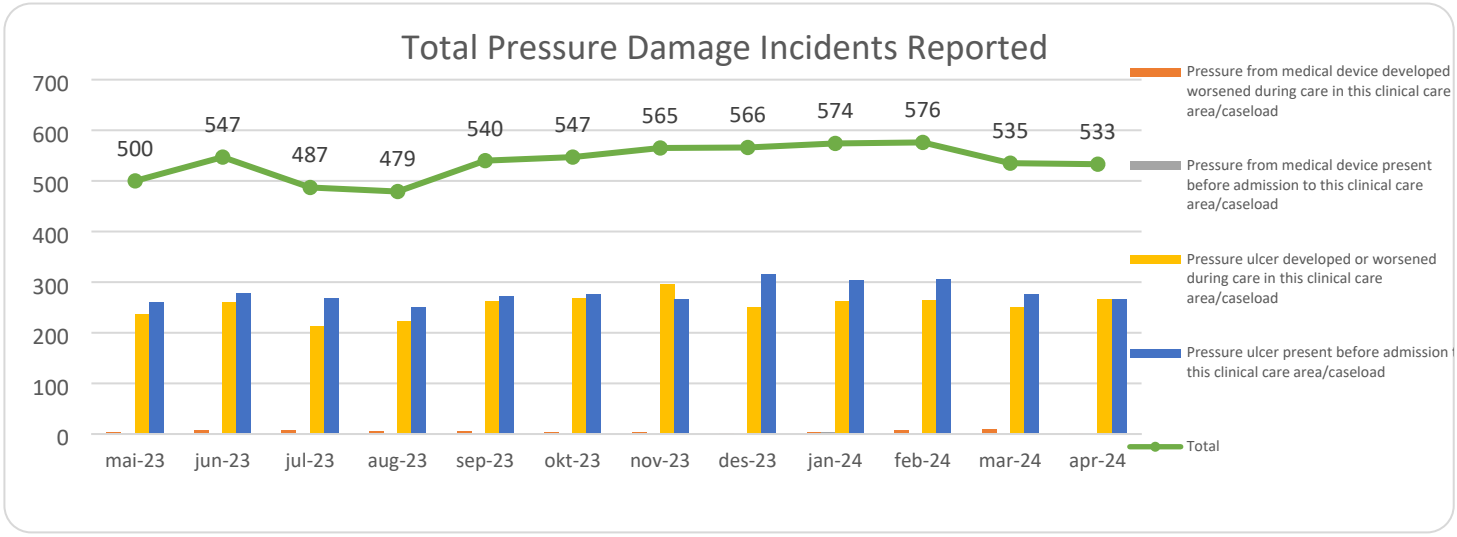
During the time period, the highest number of inpatient falls were reporting as occurring on Ward 15 (22), Ward 18 (17), Ward 9 (16) and AMU Acute (16) at Princess of Wales Hospital.



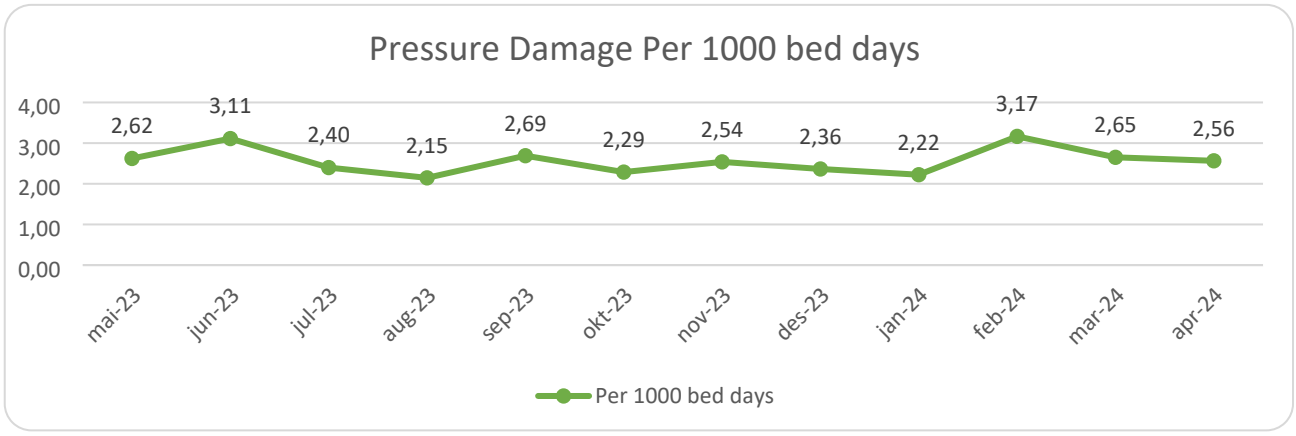
The falls improvement programme continues to implement agreed initiatives to reduce the number of patient falls.

2.3.3 Pressure Damage

Between the 01.03.24 and 30.04.24, a total of 1,068 pressure damage incidents were reported, of which 525 were reported as developing or worsening during the current case load. The remaining pressure damage incidents (543) were reported as being present before admission to this clinical care area/caseload.



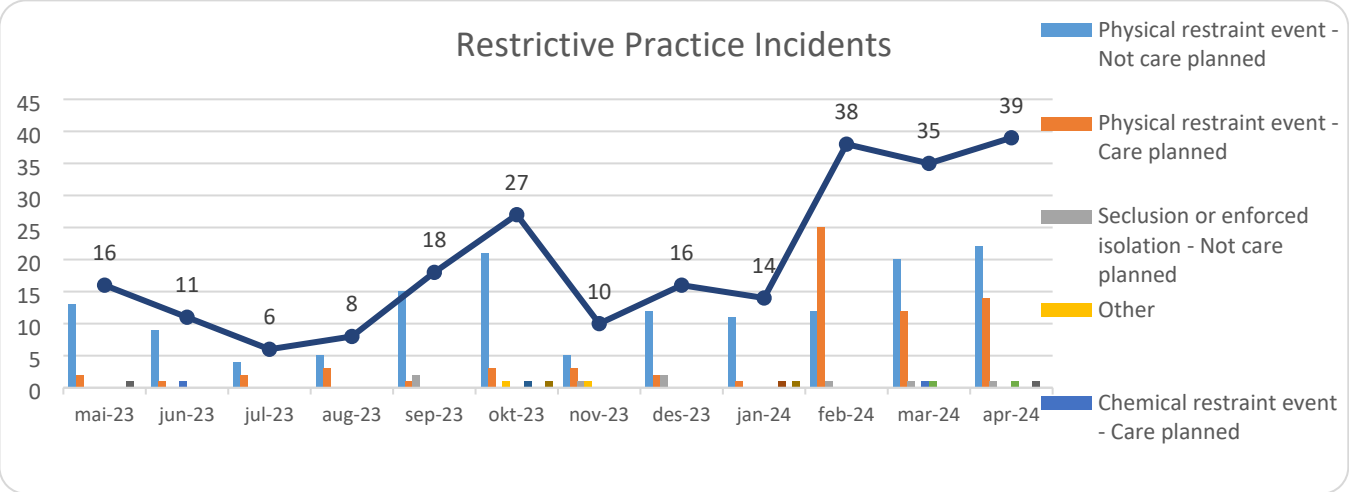
Of the 525, identified as developing or worsening during current caseload, 216 were identified as occurring within the community, which is consistent with the previous two month period.



The pressure damage improvement programme continues to progress with a particular focus on grading of pressure damage and completion of required documentation.

2.3.4 Mental Health Metrics

Restrictive Practices

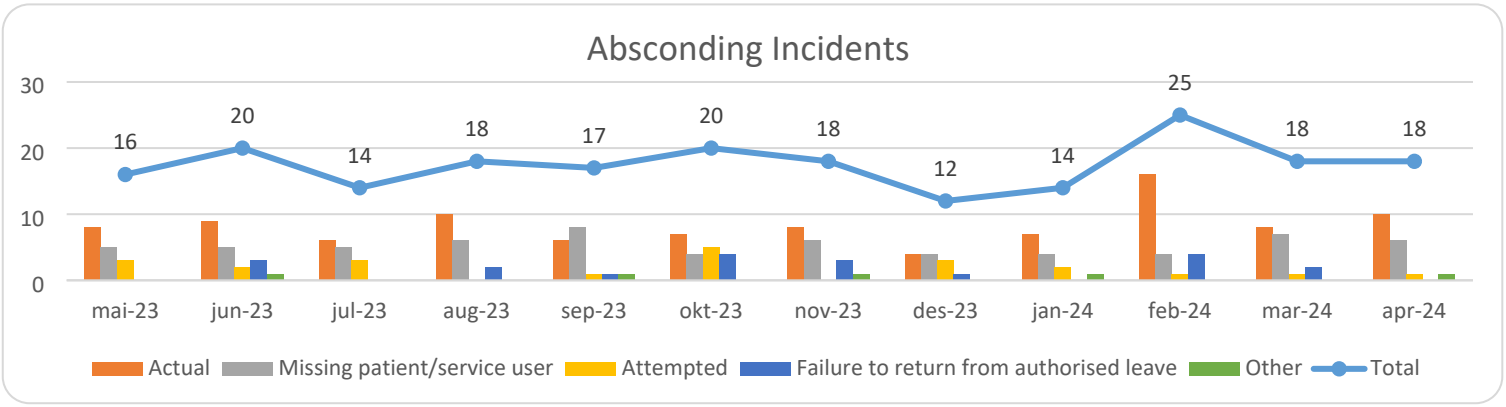


Between 01.03.24 and 30.04.243, a total of 74 incidents relating to using Restrictive Practices were reported within Mental Health. This is an increase of 22 incidents when compared to the previous two months.

Of the 74 incidents, 27 were reported as care planned (included in the care and treatment plan for the patient) and 47 were reported as not care planned (not included in the care and treatment plan for the patient). The highest number of incidents were reported as occurring on the Seren Unit (26) and Ward 14 Princess of Wales Hospital (13). The increase in incidents during March and April 2024 are related to a cohort of 4 patients.

Absconding incidents

During March and April 2024, a total of 36 Absconding incidents were reported, a decrease of 3 when compared with the previous 2-month period. 18 were recorded as actual absconding, with the remaining recorded as missing patient / service user (13), failure to return from authorised leave (2), attempted (2), and other (1). The highest number of incidents were reported as occurring in Emergency Care at Royal Glamorgan Hospital (10).



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.
- Trajectory plan for reduction of 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:
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: This report outlines key areas of quality across the Health Board.	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg?* / Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: This is an overarching position report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment.
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	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.	
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

Members of the Quality & Safety 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
- SUPPORT the direction of travel in developing a wider reach of quality reporting and locality based assurance reports

6. Next Steps

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

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

People's Experience Activity Report Feb – March 24 for Quality & Safety Committee

Dyddiad y Cyfarfod / Date of Meeting	16/05/2024
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, Head of Q&S and People's Experience
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
People's Experience Forum	02/04/2024	Minutes & Agenda for submission to Q&S Committee for noting.

Acronyms / Glossary of Terms	
POW	Princess of Wales Hospital
RGH	Royal Glamorgan Hospital
YCC	Ysbyty Cwm Cynon
YCR	Ysbyty Cwm Rhondda
HB	Health Board

1. Situation /Background

1.1 The purpose of this report is to provide an overarching update on the work that has been undertaken by the People's Experience Team and the areas that fall within this remit.

2. Specific Matters for Consideration

Population Engagement – Key Events

The People's Experience Team as a whole continues to engage and raise awareness of the support it can provide to internal/external stakeholders and shared learning that focuses on patient centred care.

Date	Event	Staff member
7th February	School Leaver Fayre, Nantgwyn School,	Clinical Bereavement Lead.
8th February	ICTM Training Day – Armed Forces & Unpaid Carer's	Head of People's Experience & Carer's Co-ordinator.
29th February	Women's Health Event 'Let's Talk', CTM 2030.	Clinical Bereavement Lead and PALS.
29th February	Veterans Network BAVO	Head of People's Experience.
1st March	National Program Engagement Event for End of Life Palliative Care	Clinical Bereavement Lead and Carer's Co-ordinator.
14th March	School Leaver Fayre, Hawthorn Highschool	Clinical Bereavement Lead.

Ongoing Projects

Work continues with the review of main site entrances to enhance service user's experience, wayfinding and signage across hospital sites. A survey to establish service user's perception of the entrances was undertaken across POW, RGH, YCC and YCR. This will be presented to the working group in April to take forward with capital involvement. This will also include the opportunity to revamp some of the garden spaces within this.

The People's Experience Team undertook Cultural Competency Training with Diverse Cymru on 7th March and are in the process of updating the workbook as to how we can implement/influence changes.

People's Experience Forum is a newly created arena, chaired by the Executive Director of Nursing, Midwifery & People's Experience that will allow the HB to collate feedback and triangulate data from varying sources within the care groups to drive shared learning, reporting up through the Quality & Committee. This will take place on a bi-monthly basis to embed across the HB, with the first meeting on 3rd April 2024.

Patient Satisfaction Feedback

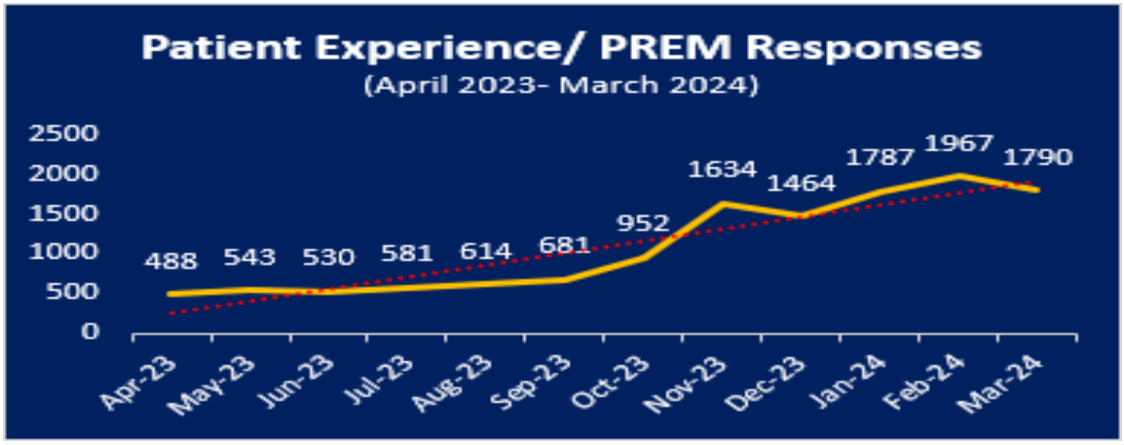
Feedback is a mainstay element as to how we understand if the services the Health Board provides, are effective and the shared learning from this. Three main formats are used to capture this detail, paper 'have your say 'cards, quick response (QR) codes and text messaging (SMS). SMS has proven the most effective way of increasing feedback and there are ongoing discussions within the HB as to how this can be utilised further.

Maternity services, Emergency department, and gynaecology utilise SMS presently and neonatal services are looking to implement this method very soon.

Example below of the feedback received from the Emergency department:

To inform the increase of feedback and ensure that the system is being utilised as the mainstay to collate this, a survey was sent to the Care Groups to provide a bench line. The feedback from this was presented to the People's Experience Forum on 3rd April and will be linked to the HB's Service User Feedback Group to progress.

Please see below graph highlighting response rate:



National Surveys

The last survey to be reviewed was the 'Looked After Children' survey and is being taken back for further discussion following comments from the All Wales Editorial Board.

Chaplaincy

The chaplaincy team continues to support patients, families, unpaid carers and staff in times of extreme distress.

Significant Spiritual and Pastoral care	Numbers involved
Patients	996
Relatives/Carer's	160
Staff	289

The chaplaincy team have also supported 10 student nurse placements to provide an insight into spiritual care and their roles during March. These placements will continue across the next few months.

Three bereavement workshops created by one of the HB's chaplains have taken place and expressions of interest from communities in the HB footprint (Tonyrefail, Cwmbach, Beddau) to hold 'At a Loss Cafes' themselves have taken place in the form of initial discussions.

Bereavement

Work to support the Bereavement Standards continues with the Clinical Bereavement Lead supporting a Hydra training module for Health Care Support Workers for 20 people.

Training was provided to 18 newly qualified nurses on bereavement services. Interaction with the BAME network increases to ensure that there is insight into the specific needs of the HB footprint.

The impact of HB communal cremations services continues to be well received and families attending increasing in numbers. This period saw 38 families invited and 22 attended, feedback from families has been positive.

"*Morning XX, Just wanted to say thank you so so much for yesterday. It was truly so beautiful and a perfect send off for our babies. As heartbreaking as it was to see that little white coffin knowing my baby was inside it brought me some kind of comfort and I'll treasure that day forever.*

I will never be able to put into words how thankful and grateful I am for you. You have helped me in more ways than you will ever know. Thank you for everything you have done for me."

"*Thank you so much XX. It was a lovely service.*

Note: Names have been removed from the above feedback.

Volunteers

To enable the HB to review different mechanisms to increase volunteer numbers, training was undertaken on the All Wales Volunteering system within the third sector to promote opportunities on a larger scale.

There are further discussions being held within the All Wales NHS Volunteer Manager forum, with Shared Services and WVCA to create an NHS centralised database. This would align to the Welsh Government proposal of the roll out of an NHS Volunteer Passport, exploration of funding streams to support this are also included.

Patient stories to support Volunteer Week are underway and links made with BAVO, Interlink and VAMT to co-produce within this week from a community aspect.

Volunteer Information sessions and interviews to increase the presence across the wards was undertaken. Local orientation sessions for POW and RGH Emergency Departments were also completed.

Veterans

The HB signed the Armed Forces Covenant on 25th March with the CEO, Senior Executive representation, workforce reservists, Valley Veterans and Armed Force Liaison Officers. A working group representative of departments/specialties across the HB is in place to take this forward within the Care Groups.
An application for the Silver Employer Recognition Scheme has been submitted and work to highlight the HB as a prospective employer within the Armed Forces Family is underway to utilise the expertise they hold.

The HB continues to be represented within the Cwm Taf and Bridgend Armed Forces Steering group to drive co-production with external stakeholders across the regions.

Patient Advisory Liaison Service (PALS) Team

The teams work proactively across the HB to support patients, families and carers. Care to Share clinics are undertaken across the sites/wards that

enables patients, families, unpaid carers to speak to staff who can support the resolving of issues on a proactive basis.

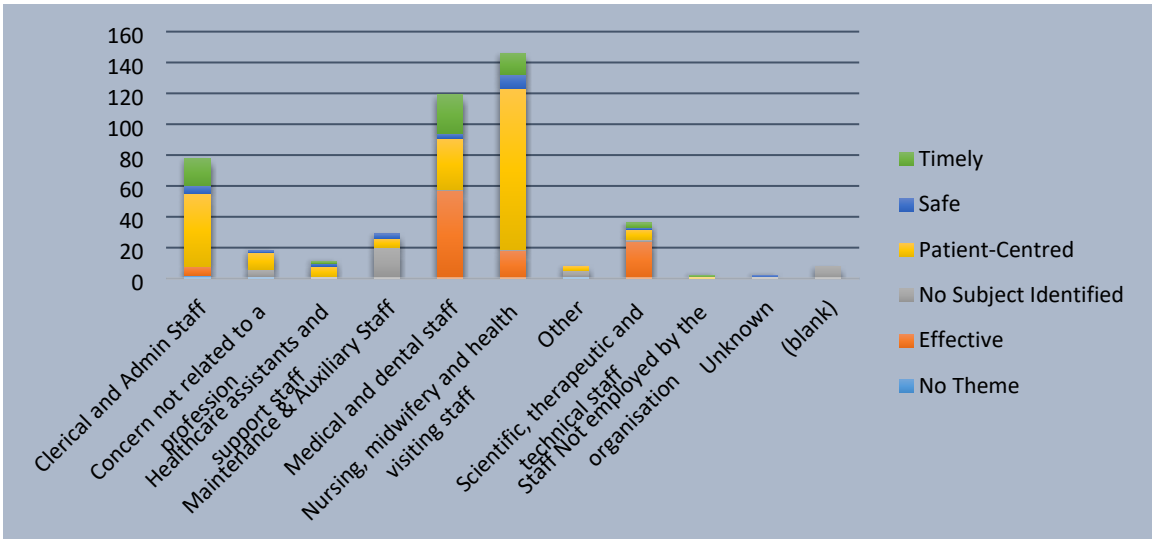
As the service embeds and engagement increases the team will look to support project work identified within the People's Experience Forum and other opportunities.

Number of contacts

HB PALS
457

Top three themes HB PALS
Communication Issues
Clinical Treatment
Patient care

Highlighted below are the HB PALS subject themes aligned to the Duty of Quality indicators.



Unpaid carers

Carer's Co-ordinator has attended a number of events internal/external to the HB to raise the profile of the unpaid carer's voice and forge relationships within this.

- Progression of access and recording of unpaid carers data within the Welsh Nursing Care Record is now available. Further scrutiny as to the 'so what' element of the data recorded is being progressed.
- Links with Optimise program are being cemented to look at the different work streams and best represented to ensure voice of the unpaid carer within this.
- Exploration of reinvigorating the staff carers forum is being progressed via new terms of reference for the group and looking to see if feasible to relaunch in Carers Week, 10th-16th June.

- Engagement with the communication team to create an interactive staff map during carers week to increase awareness of staff support within CTM.

3. Key Risks / Matters for Escalation

3.1 IT support to implement the sms element of patient feedback remains an issue due to staff vacancies but is being supported via the team when needed.

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: Applicable to all the strategic areas within this.
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 Wales of Cohesive Communities
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Enablers of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Culture and Valuing People
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Domains of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Person Centred
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment

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

5. Recommendation

The Committee is asked to NOTE the information contained within this report.

Agenda Item
7.2

Quality & Safety Committee

CTM Nursing and Midwifery Plan

Dyddiad y Cyfarfod / Date of Meeting	16/05/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Ana Llewellyn, Nurse Director Becky Gammon, Assistant Director of Nursing
Cyflwynydd yr Adroddiad / Report Presenter	Ana Llewellyn, Nurse Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Review and Endorsement

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Executive Nursing Meeting	03/04/2024	

Acronyms / Glossary of Terms	
CTM	Cwm Taf Morgannwg
HCSW	Health Care Support Worker
N&M	Nursing and Midwifery
QR	Quick Response

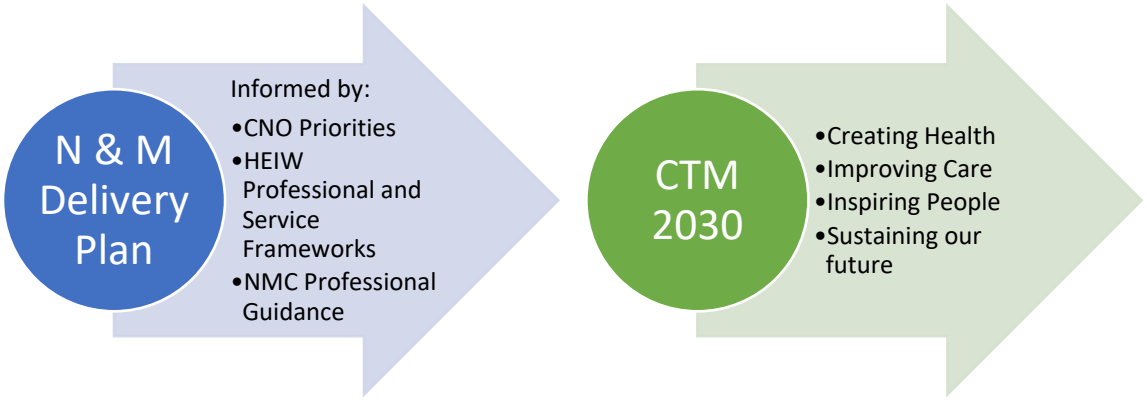
1. Situation /Background

1.1 The Nursing and Midwifery workforce make up the largest single group of professions in the Health Board. The registered workforce and the HCSWs in the nursing and midwifery structures are critical to the delivery of safe and effective care.

1.2 In 2022 the Chief Nursing Officer launched the Nursing Priorities for Wales setting out a clear strategic direction for the Nursing and Midwifery Professions.

1.3 Although these priorities were set for only two years they have influenced the work in the Health Board to develop a Nursing and Midwifery Plan for CTM.

1.4 Discussions around the development of the Nursing and Midwifery Plan have also been structured around the four goals of CTM2030 Our Health, Our Future, as well as other national professional drivers.



1.5 In devising a Nursing and Midwifery Plan for CTM it was of critical importance that there was a good understanding of 'what matters' to our nursing, midwifery and HCSW colleagues. The intention for the Nursing and Midwifery Plan is that it is fully co-produced and owned by the workforce.

2. Specific Matters for Consideration

2.1 A programme of work to develop the plan commenced during 2023, with the development of a working group. The first stage included an in-depth literature review and scoping of Nursing and Midwifery Plans and Strategies across the United Kingdom. The working group initially evaluated these from a number of perspectives, including how readable the plans were, how co-produced they were and also whether they were progressing a professional ambition.

2.2 Phase 2 commenced in May 2023 with an engagement exercise across the Health Board using an Appreciative Inquiry approach. There were multiple opportunities and means of engaging including using QR codes on posters in the workplace, social media and staff meetings.

2.3 Colleagues were asked to answer the following Appreciative Inquiry questions:

2.3.1 *Discovery*: What makes you proud to work as a nurse / midwife / HCSW in CTM?

2.3.2 *Dream:* What would you like to see more of in CTM for nurses, midwives and HCSWs?

2.3.3 *Design:* Fast forward to CTM in 2030, what does the best Health Board in Wales look like for nurses, midwives and HCSWs?

2.4 The 61 responses, which were made up of individual and team responses, were analysed and reflected significant pride in the profession and appreciation of collaborative team working, the commitment and passion of the workforce and the ability to deliver high quality care in the face of challenge. Nurses, midwives and HCSWs aspired to a future where they feel professionally and financially valued; they are professionally supported; they have access to a range of professional development opportunities; they work in teams that are sufficiently staffed and they experience low stress and high satisfaction.

2.5 A number of iterations of the Nursing and Midwifery Plan have been developed and tested with nursing and midwifery colleagues and a first draft was presented to the Nursing and Midwifery Executive Group in December 2023.

2.6 The Plan was further revised and during February 2024 there was a formal engagement exercise with the Nursing and Midwifery workforce, before a Formal Consultation across the Health Board in April 2024, both of which resulted in some minor amendments.

2.7 The final Nursing and Midwifery Plan 2024-2027 is presented today for the Committee's consideration.

3. Key Risks / Matters for Escalation

3.1 The key risk to the CTM Nursing and Midwifery Plan 2024-2027 is that the CNO may make further revisions to the national priorities and it is possible that any new priorities may not be reflected in CTM's plan. However, it is of note that CTM's plan provides robust evidence of co-production with the Nursing and Midwifery workforce.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Inspiring People If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Enablers of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Culture and Valuing People If more than one applies please list below: Learning, Improvement and Research
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Domains of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Effective If more than one applies please list below: Links to all of the domains of quality
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	Yes - Reduce If more than one applies please list below: Links to all of the domains of sustainability

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* Quality *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: No formal assessment impact undertaken but the Nursing and Midwifery Plan focusses on quality as one of its priorities
Cydraddoldeb a'r Gymraeg	Yes: ☐	No: ☒

Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? / Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: No formal equality and welsh language impact assessment undertaken but the Nursing and Midwifery Plan outlines CTM's intent in terms of both equality and diversity and the Welsh language for the professions.
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	Yes (Include further detail below)	
	This Nursing and Midwifery plan focusses entirely on CTM's people	

5. Recommendation

5.1 The Committee is asked to ENDORSE the launch of the CTM Nursing and Midwifery Plan 2024-2027.

6. Next Steps

6.1 Subject to endorsement, the CTM Nursing and Midwifery Plan 2024-2027 will be formally launched on the Health Board's intranet site by the Executive Director of Nursing and Midwifery.

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Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

NURSING AND MIDWIFERY DELIVERY PLAN

2024-2027

CREATING HEALTH | IMPROVING CARE | INSPIRING PEOPLE | SUSTAINING OUR FUTURE

version 8

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Greg Dix, Executive Director of Nursing introducing the Plan for 2024-2027 which was made with the help of healthcare professionals, and expresses gratitude for their dedication to patient care, and he shares his aspirations for the future.

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The NMC (Nursing and Midwifery Council) code lays out the ethical and professional standards expected of nurses and midwives in the UK.

Workforce ---------- 08

Outlines the current demographics for our workforce in Cwm Taf Morgannwg.

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Fill in the following text fields with appropriate explanations.

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Our Nursing and Midwifery vision and six principles.

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How we intend to monitor our progress towards CTM 2030.

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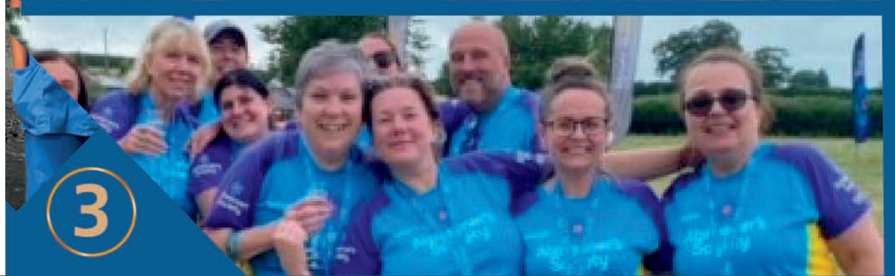
Thank you CTM ----------

Foreword from Greg Dix, Executive Director of Nursing

I am delighted to introduce you to the Nursing and Midwifery delivery plan for the years 2024-2027. This document isn't just a set of goals and aspirations but a living plan that has been developed and shaped by our nurses, midwives, and healthcare support staff. At its core, it seeks to elevate the standards of nursing and midwifery practice across the Health Board, by fostering a culture of continuous learning, improvement and innovation. Central to our approach is the recognition of the diverse needs of our staff and the population for which we serve. By understanding and respecting cultural differences, we aim to strengthen our professional relationships; supporting our staff to be the best that they can be, whilst being relentless in providing care to the highest of standards.

I am truly looking forward to embarking on this journey with you over the next three years, as we stand together as a nursing and midwifery profession.



Introduction

Cwm Taf Morgannwg University Health Board is passionate and driven to ensure that every patient is provided with the highest standard of safe, high-quality care 24 hours a day, seven days a week. Supporting our service users to access the services they need at the right time, the right place, and delivered by a motivated, educated, and competent workforce who hold the core values of nursing care, compassion, competence, communication, courage, and commitment.

The nursing and midwifery professionals offer a rich tapestry of diverse roles that cater to various healthcare needs. From bedside care to community and health nursing, the range of roles is extensive. Beyond the traditional clinical roles nurses and midwives contribute to leadership positions, educational roles, policy development, and advocacy. This delivery plan is written with this in mind recognising the diversity of roles to ensure that healthcare professionals in these fields can contribute their unique expertise and skills across multiple settings, making a positive impact on service users, health outcomes, and the overall healthcare system.

Our nursing and midwifery delivery plan has taken shape over several months, and has been co-created and consulted on with colleagues and teams at all bands and positions across the health board. Nurses, midwives, and health care support workers told us what they wanted the organisation to focus on.

Cwm Taf Morgannwg

- Prince Charles Hospital
- Princess of Wales Hospital
- Royal Glamorgan Hospital
- Ysbyty Cwm Cynon
- Ysbyty Cwm Rhondda
- Cefn Yr Afon
- Dewi Sant Health Park
- Glanrhyd Hospital
- Keir Hardie University Health Park
- Maesteg Community Hospital
- Community Settings
- Pontypridd Cottage Hospital
- Pinewood House
- Ysbyty George Thomas
- Y Bwthyn Newydd
- Y Bwthyn

The Health Board is one of the largest employers in the area and a considerable proportion of our workforce, around 80 to 85%, live and work within these communities. As such, the Health Board has a real chance to impact its population's lives by offering improved job prospects and career pathways that provide opportunities for people to gain experience in work and understand the full range.

Nursing and Midwifery Code (NMC)

The NMC code contains the professional standards that as Registered Nurses and Midwives we must uphold.

UK Nurses and Midwives must act in line with the code, whether they are providing direct care to individuals, groups or communities or bringing our professional knowledge to bear on nursing and midwifery practice in other roles such as leadership, research or education.

The standards include ensuring practice is safe, effective and puts the interests of patients and service users first and promoting trust through professionalism. The code underpins all that we do as nurses and midwives and fundamentally supports our strategy. The NMC Code is one code with four themes, which together signify good nursing and midwifery practice with the aim of public protection.

Resilient

Dedicated

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Compassionate

Caring

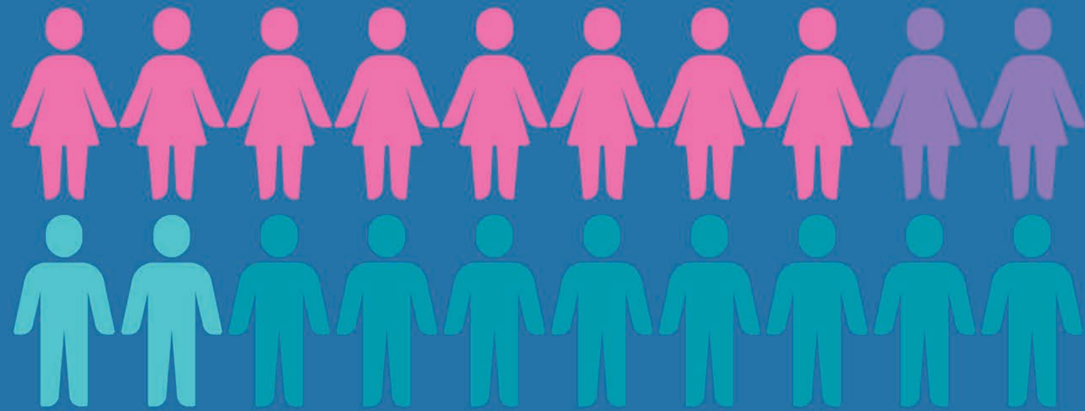
Current Workforce Demographics

- The Health Board Currently Employs ~11,193 whole time equivalent (WTE) colleagues and teams, with a headcount of 12,809, and 76.50% of our workforce live within the health board's footprint.

- Among these committed professionals, there are 4,077 nurses providing essential care, alongside 308 skilled midwives ensuring maternal health and well-being. Additionally with have 1,788 Healthcare Support Workers (HCSWs) contributing significantly to the delivery of quality healthcare services across our facilities. These numbers underscore the strength and dedication of our healthcare team in serving our community.

- Turnover is at 11.66% (Rolling 12 months to March 24) with hotspots areas in Estates and Ancillary (16.17%) and Healthcare Scientists (13.11%) with slight reductions in Nursing and Midwifery and Additional Clinical Services.

- The workforce is ageing with 33.68% of the workforce aged 51+ and challenges for Health Care Support Workers at 33.41%, Nursing and Midwifery at 27.98%, and AHPs (Additional Health Professionals) at 22.36% in this age bracket. The average retirement age is 61 years and the Health Board has 3,770.29 WTE who are that age or older.



The gender split of the workforce is 80:20 female:male.
Of the workforce 31.63% are part-time employees; among these 36.67% of the workforce are female and 11.79% are male.

Feedback from Colleagues and Teams Surveys

What you told us you are proud of

What you told us success looks like

How you want the organisation to look like in 5 years

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CREATING HEALTH

Principle 1

We will maximise opportunities to improve population health including that of our workforce

IMPROVING CARE

Principle 2

We will listen to our population, patients, families, carers, and colleagues and learn from their experience

Principle 3

We will provide safe and compassionate care across the whole of our population every time

Our six principles for the Nursing and Midwifery plan

INSPIRING PEOPLE

Principle 4

We will Recruit, Attract, and Retain a competent and skilled nursing and midwifery workforce.

Principle 5

We will invest and practice professional development to ensure a competent and knowledgeable workforce to deliver high-quality care.

SUSTAINING OUR FUTURE

Principle 6

We will strive to create an environment that is sustainable and reduces inequalities.
An environment that improves health outcomes and helps reduce costs

STARTING WELL

GROWING WELL

LIVING WELL

AGEING WELL

DYING WELL

Reducing health inequalities, equal focus of mental and physical health, supporting our communities, being a healthy organisation.

Delivering safe and compassionate care, developing new models of care, digital transformation for patients and colleagues and teams, ensuring timely access to care.

Becoming a green organisation, ensuring our services' financial sustainability, embedding value-based healthcare, ensuring our estate is fit for the future.

Visible and inspiring leadership, promoting diversity and inclusion, embedding our values and behaviours, encouraging local employment.

Principle 1

CREATING HEALTH

We will maximise opportunities to improve population health including that of our workforce

How

- Making Every Contact Count a consistent model for all healthcare professionals to engage with patients on reducing their personal risk.
- Reduce health inequalities by supporting measures such as screening, policymaking, and education.
- Regional engagement and collaboration with Stakeholders and strategic.
- Support public health agendas specifically around Prevention and screening.

- Embed the professionalism of Nursing and Midwives as role models and ambassadors of good health.
- Empower nurses and midwives to manage their health, self-help, and keep well at all levels.
- Promote and embed well-being strategy ensuring access is equitable for all.
- Promote clinical supervision, coaching, mentorship, and preceptorship to all Nurses and Midwives.
- Recognise and promote the benefits of flexible working to maintain a healthy work-life balance.

Principle 1

Measurable

CREATING HEALTH

We will maximise opportunities to improve population health including that of our workforce

- Increase in the number of colleagues and teams attending wider engagement events and influencing population health agendas.
- Using the data captured by Health Care Research Wales.
- Embed digital platforms to help stakeholders develop measures to reduce health inequality in Wales.
- Increased number of opportunities for flexible working.

- Decrease in nursing and midwifery sickness levels.
- Increased uptake in vaccination rates and support for targeted immunisation programs.
- Increased numbers of colleagues in retire and return options.
- Increased uptake of staff surveys.

Principle 2

IMPROVING CARE

We will listen to our population, patients, families, carers, and colleagues and learn from their experience

How

- Promote a culture of openness and transparency embedding a just and restorative culture.
- Promoting a culture of listening, learning and always improving.
- Responding to concerns and complaints in line with Putting things right and the Duty of Candour.
- Empower patients and colleagues to feel psychologically safe and to feel confident to engage and contribute to co-designing services.
- Promote/support learning events and work with colleagues to facilitate a safe environment, where colleagues feel free to speak up.
- Use narrative and patient/people stories as a basis for learning and continuous improvement; working with patients, people and carers to inform our approach and embedding the Digital stories framework.

- Embrace various communication tools and media to communicate with our patients, people, colleagues, service users, and carers.
- Work in collaboration with partners – voluntary, charity, community groups, and organisations to encourage listening and engagement; seeking opportunities to develop and learn together.
- Embed the principles of Value-based Health care and Prudent principles.
- Evaluate service user feedback and promote the coproduction of service design and delivery.

Principle 2

Measurable

IMPROVING CARE

We will listen to our population, patients, families, carers, and colleagues and learn from their experience

- Improved national inpatient survey outcomes with a top quartile target and continued success with "Have Your Say" and other people experience feedback software.
- Embedding a digital story framework to ensure service users' voices are heard for listening, learning, and celebrating good care.
- Partnership working with carers and families to promote individualised family-centred care.
- Embed a people's experience forum.
- Increase the opportunity for service users to leave timely feedback across all services provided using a mixed approach of digital, face-to-face, and written collection methods.
- Increase compliance with colleague surveys.
- Increase in training and use of digital systems to support data collection.

- An open and transparent culture of listening and learning.
- Extend the opportunities for co-production and people's voices influencing service provision.
- Promoting the visibility of service user feedback through "you said we did" initiatives in all clinical areas.
- Promoting partnership working to complete small and larger scale improvement projects with internal and external partners.

Principle 3

IMPROVING CARE

We will provide safe and compassionate care across the whole of our population every time

How

- Embed a formal Clinical Accreditation Programme across CTMUHB which underscores our commitment to patient safety, care effectiveness, and person-centred quality care.
- Recognising and celebrating well-led wards and departments and strong front-line leadership.
- Be open to learning and encourage innovation and new ways of working.
- Actively encourage participation in research to ensure the care provided is based on the best available evidence and meets national standards.
- Embed the principles of Safety II *(1)* to learn from excellence, as well as from incidents and to create the conditions for excellence to be scaled up across the organisation.
- Recognising the unique contribution of nurses and midwives and with the wider multi-disciplinary team we will deliver new models of care to meet people's needs.
- Monitor and demonstrate improvements in quality and safety, with a particular focus on professionally-related incidents.
- Recognise and value the contribution our colleagues make to patient care and the organization by celebrating success and achievements across all specialities including Adult Nursing, Mental Health Nursing, Health Visiting, Midwifery, Paediatric Nursing, and Learning Disabilities Nursing so that we engage all the fields of practice.
- Promote high standards through visible leadership and working to professional codes of practice, conduct, ethics and performance.
- Increase the visibility of ward and department audit activity so that leaders can proactively intervene when required to provide support.
- In collaboration with the Chief Nursing Officer office and Health Education Improvement Wales, establish and embed a robust leadership program to support career progression and leadership.
- Continue to embed the Active Offer approach in CTM UHB with Welsh-speaking patients aligned to the More Than Just Words 5-year Plan
- Recognising and promoting the inclusion of carers in providing care in collaboration.

(1) https://du.nhs.wales/files/incidents/supporting-section-5-safety-ii-guidance-pdf/

Principle 3

Measurable

IMPROVING CARE

We will provide safe and compassionate care across the whole of our population every time

- All wards and departments are formally assessed through the clinical assurance program.
- The development of a quality and safety dashboard that monitors metrics from all services encouraging ownership at the ward level and celebration of well-led wards.
- All nursing and midwifery-related audits are recorded on digital systems.
- Increase in quality improvement activity and sharing best practice through a suite of communication tools.
- Engagement of nursing and midwifery in strategic planning for future models of care.
- Colleagues engaged and knowledgeable in improvement methodology applying theory to practice.
- Increase the number of colleagues applying for scholarships, conferences, publications, and research opportunities.
- Embed colleague recognition wards to celebrate and acknowledge the contribution of the Nursing and Midwifery workforce.

- Colleagues compliant with the NMC code of practice promoting professionalism and raising the profession.
- Increased awareness and compliance with the Healthcare Support Worker Code of Conduct.
- Increase in compliance against key performance indicators relating to Infection Prevention, Falls, and Pressure Care.
- Increase in collaborative working with carers in supporting the delivery of care.
- Develop and deliver a robust clinical leadership program that supports career progression.
- Promote the engagement in the Health Board Leadership programme to all colleagues.
- Actively encourage staff to apply for scholarship opportunities ,such as Bevan Commission and Florence Nightingale.

Principle 4

INSPIRING PEOPLE

We will Recruit, Attract, and Retain a competent and skilled nursing and midwifery workforce.

How

- Promote engagement at a strategic level to influence the workforce requirements of the future considering new roles to shape the workforce of the future.
- In collaboration with Workforce and People's Services develop and implement a robust Attraction, Recruitment, and Retention plan to ensure that the future workforce meets the needs of our patients to have the right staff, with the right skills, in the right place. This will include developing the Welsh language skills of current staff and how we recruit new Welsh-speaking staff where needed, aligned to the More Than Just Words 5-year Plan.
- Provide clear, clinical leadership at all levels of the organisation, with role models who inspire their teams, our patients and service users to achieve the best possible outcomes.
- Provide personal career development and progression through appraisal, objective setting, providing access to training and teaching, and identifying potential talent at every level. Embedding a dynamic and deliverable Education Strategy that is applicable to all.
- Promoting safe working environments where colleagues feel valued and supported and have the confidence and support to speak up when risks are identified.
- Develop a diverse, robust, and sustainable workforce that meets the needs of the service.
- Raise the Nurse and Midwifery profile and voice and ensure colleagues feel confident to speak up safely and embrace learning and new ways of working.
- Ensure that CTM nursing and midwifery workforce plans align with HEIW strategic workforce plans.
- In collaboration with the University of South Wales and local colleges create a Nursing and Midwifery Academy.
- Embracing a diverse workforce promoting acceptance of Diversity and Inclusion across all specialties.
- Continue to provide a framework for colleague support and wellbeing.

Principle 4

Measurable

INSPIRING PEOPLE

We will Recruit, Attract, and Retain a competent and skilled nursing and midwifery workforce.

- The Heath Board attracts the best Nurses and Midwives both nationally and internationally who are then able to progress their careers within the organisation.
- Our colleagues use the best tools and technological advances to inform workforce and recruitment plans e.g. acuity dependency tools, birth rate plus, and E-Rostering.
- Openness and transparency with our nursing and midwifery staffing levels, by publishing these at ward level and through Welsh Government reporting.
- Nurses, Midwives and Health Care Support Workers receive recognition awards
- A reduction in levels of sickness and an aspiration that the Health Board has the lowest levels in Wales
- Improved Nursing and Midwifery retention rates, evidenced through a reduction in turnover.
- Reduced Nursing and Midwifery vacancy rates.
- A valued, empowered, and energized workforce, evidenced by the Annual Staff Survey responses.

- Increased student to registered nursing and midwifery conversion rates across the Health Board.
- Embed the Speaking up Safely framework set out by the Welsh government.
- Increased participation in the Annual Staff Survey.
- Embed a Just and Restorative Culture supporting learning and service improvement at all levels.
- Increase the number of Advanced Clinical Practitioners, Consultant Nurses and Consultant Midwives.
- Increase the number of leadership positions filled by an ethnically diverse workforce.
- Robust clinical supervision programme in place and increased access to expert mentors and coaches.
- Embed the lateral flow policy and monitor compliance and outcome.

Principle 5

INSPIRING PEOPLE

We will invest and practice professional development to ensure a competent and knowledgeable workforce to deliver high-quality care.

How

- Support advanced practice in line with the HEIW Enhanced, Advanced Consultant Framework of Advanced Practice.
- Have a competent workforce, supported by national and professional guidance, and support health care professionals in meeting their re-registration or revalidation requirements.
- Equip colleagues with the relevant safeguarding skills and knowledge, so that they can support, protect, and enable vulnerable people within their care.
- Ensure that nursing and midwifery colleagues have quality improvement skills and are supported to use those skills.
- Promote nursing and midwifery research and ensure that learning from research is embedded into practice.
- Learn from when things go well; understand what contributes to high-quality care and scale that up across the organisation
- Embed a framework that supports clinical supervision, mentorship, and preceptorship.
- Provide personal career development and progression through appraisal, objective setting, providing access to training and teaching, and identifying potential talent at every level. Embedding a dynamic and deliverable education strategy applicable to all.
- Develop strong, compassionate leaders who will be the patients' advocates and the voice of our patients, families, and relatives.
- Recognise the importance of Health Care Support Workers and ensure they have opportunities for development.
- Recognise the importance of research and actively encourage Nurses and Midwives to participate in research and collaborate with Higher Education Institutions.
- Promote and support access to higher education opportunities, encouraging nursing and midwifery specialists to teach in education settings.
- Maximise opportunities for nurses and midwives to have the careers that they want.
- Embed an learning academy and support all levels of training and education.

Principle 5

Measurable

INSPIRING PEOPLE

We will invest and practice professional development to ensure a competent and knowledgeable workforce to deliver high-quality care.

- A supportive learning culture that sees revalidation being used as a well-developed support mechanism for the individual development of registered health professionals.
- Have an up-to-date register of all Advanced Clinical Practitioners working in the health board with a robust governance process in place to ratify individual portfolios.
- Increase in quality and improvement training.
- Increase in nursing and midwifery research participation.
- Robust clinical supervision framework in place, where colleagues feel supported and leaders are guided to get the best from individuals.
- Increase in all levels of nurses and midwives accessing internal leadership programmes and external professional development courses.

- Increase in honorary contracts.
- Increase the number of colleagues teaching with HEI, HEIW and colleges.
- Increase in applications for Postgraduate education from Diploma to Doctorates.
- Increase in range of nursing and midwifery opportunities in a diverse range of roles including research, leadership, clinical practice and in roles that are either specialist or generalist.
- Increase in training that is delivered in collaboratively with partners such as Higher Education establishments, HEIW and colleges.

Principle 6

SUSTAINING OUR FUTURE

We will strive to create an environment that is sustainable and reduces inequalities. An environment that improves health outcomes and helps reduce costs

How

- In line with the Chief Nursing Officer (CNO) for Wales' sustainability ambitions, create a culture that supports environmentally sustainable healthcare through embedding the 3 E's – Empower, Educate & Enable.
- Embed the principles of sustainable healthcare into a wide range of nursing operational functions, including clinical accreditation and policy, utilising guidance from CNO's Climate Smart Strategies for Nursing and Midwifery Practice document.
- Include the principles of sustainable healthcare into existing clinical training, so that nurses and midwives are regularly discussing how we can minimise our environmental impact.
- Embed a network of sustainable champions throughout the nursing and midwifery family, supported by the Health Board's identified Nurse Sustainability Lead, to maximise nursing engagement in climate efforts.
- To increase nursing and midwifery visibility within the Health Board decarbonisation governance structures.
- Support and locally implement the national "Best use of gloves" initiative to reduce PPE associated waste.
- Make a commitment to reduce the use of single-use plastics and waste through a variety of mechanisms, such as effective and efficient procurement, stock control, and stock rotation.
- Maximise the appropriate use of digital alternatives to face-to-face consultations to reduce patient and staff travel.
- Support the workforce to access dynamic colleague benefits such as cycle-to-work schemes and improve access to charging points for electric cars in the workplace.
- Develop a culture of ownership by reducing over-prescribing of medication, digital prescribing and uses of Quick Reader (QR codes).
- Nursing and midwifery-led Value-Based Healthcare projects that consider patient reported outcomes and patient-reported experience, balancing this with financial efficiency and environmental considerations.
- Clinical areas provide evidence of positive environmental impact working towards Gold accreditation.
- Nurses and Midwives effectively engage and promote positive environmental behaviours with the public.

Principle 6

Measurable

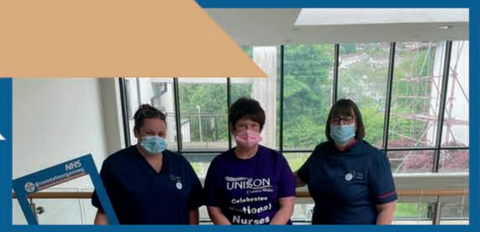
SUSTAINING OUR FUTURE

We will strive to create an environment that is sustainable and reduces inequalities. An environment that improves health outcomes and helps reduce costs

- Reduction in waste from overstocking areas and from expired equipment.
- A tangible change in culture and conversation supporting climate change and ownership of solutions.
- Increasing number of nurses and midwives who are trained as carbon literate via HEIW.
- Increasing number of nurse/midwifery-led climate initiatives and innovations.
- Increased presence of nurses/midwives within Health Board decarbonization board.
- Increase in nurses and midwives being trained in Value-Based Healthcare and increase in Value-Based Healthcare projects.

- Gold applications for accreditation status to evidence improvement programs being implemented.
- Increase the number of nursing and midwifery environmental champions across the Health Board.
- Evidence partnership working to reduce the carbon footprint and support Welsh government and wider climate agendas.
- Increase the number of environmental sustainability initiatives that Nurses and Midwives are taking forward or could be taken forward by the professions.
- All colleagues and teams to complete the e-learning package “Achieving net zero in Wales”.
- Increased awareness of the relationship between healthcare provision and climate change.

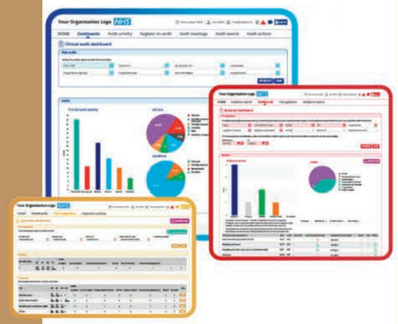
Monitoring our Progress



Ongoing monitoring of the progress of the delivery plan will take place via various arenas and communication with stakeholders to ensure transparency and monitoring of success. The outcome measures can be developed into a report that will act as a visual monitoring report to identify trends and opportunities for learning and sharing of best practices.

The report will be shared through the Executive Nurse Professional Forum, as well as through local cascades via the Director of Midwifery and Care Group Nurse Directors.

There is an opportunity to share the outcome data with the Executive Quality and Safety Board and the People and Culture Committee, focusing on specific workforce data. An annual report will be produced as part of the Annual Report to the Executive Board.



INSPIRING PEOPLE

CREATING HEALTH

IMPROVING CARE

SUSTAINING OUR FUTURE

Our Strategic Goals

THANK YOU CTM

Agenda Item
8.1

Quality & Safety Committee

Mental Health Adult Inpatient Improvement Programme

Dyddiad y Cyfarfod / Date of Meeting	16/05/2024	
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable	
Awdur yr Adroddiad / Report Author	Ana Llewellyn, Nurse Director	
Cyflwynydd yr Adroddiad / Report Presenter	Ana Llewellyn, Nurse Director	
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Lauren Edwards, Executive Director of Therapies & 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
Mental Health In-patient Improvement Board	23/04/2024	

Acronyms / Glossary of Terms	
HIW	Healthcare Inspectorate Wales
MHLD	Mental Health and Learning Disabilities
QSRE	Quality Safety Risk Experience
SRO	Senior Responsible Officer

1. Situation /Background

1.1 This report provides committee members with an overview of progress of the Mental Health Adult Inpatient Improvement Programme.

1.2 In February 2022, HIW wrote to the Health Board to advise that they would be undertaking a local review of the quality of discharge arrangements for adult patients from inpatient mental health services in CTM. This review was commissioned in response to serious incident intelligence.

1.3 The review included both fieldwork and a review of evidence, including a review of patient records. The proposed timescale for publication was August 2022, however HIW continued to seek evidence from the Health Board through to December 2022.

1.4 In June 2022 HIW identified a number of significant patient safety concerns and issued an immediate assurance improvement plan relating to: discharge governance; communication arrangements between teams (including the issue of the lack of a single electronic record); significant limitations in the involvement of patients and carers; and risk management and discharge arrangements.

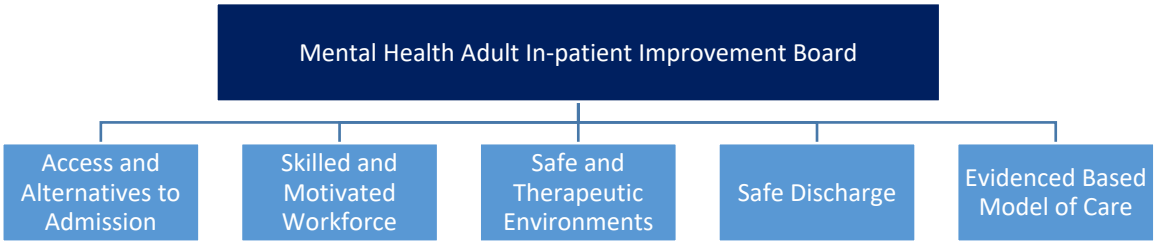
1.5 The discharge review was published on 7th March and includes a further 40 recommendations: Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (hiw.org.uk)

2. Specific Matters for Consideration

2.1 The Health Board Improvement Plan was published by HIW on 6 September 2023: CTMUHB MH Discharge Review - Improvement Plan Final EN.pdf (hiw.org.uk)

2.2 An Executive-led Mental Health Inpatient Improvement Programme was developed with a number of work streams. The HIW actions were aligned to these work streams.

2.3 At the last Quality and Safety Committee, members were advised that the Improvement Programme was undergoing a period of revision and that the programme had been redesigned into fewer workstreams as follows:



2.4 New workstream leads continue to be engaged in re-designing their driver diagrams and priorities for improvement.

2.5 The Improvement Board formally met on 27th February and approved the revised improvement programme structure and re-design. Further completion of HIW recommendations were approved by the Senior Responsible Officer and the Executive Lead, which resulted in the Health Board proactively writing to HIW on 11th April with a further update as follows:

Recommendations	Number completed and approved by Improvement Board	Number with planned later timescales	Number with slipped timescales
40	37	2	1

2.6 Three remaining recommendations are for further completion.

Rec. No	Requirement	Timescale	Update
8	Other training to 85%: • Care and Treatment Planning (CTP) • Information Governance (IG) • Prevention and Management of Violence and Aggression (PMVA)	~~31/1/24~~ HIW advised of revised timescale 30/4/24	• CTP – 66%. Staff booked on training and trajectory to 85% by April. Training model being reviewed to build sustainability. • IG – 87% • PMVA – 86%
19	Clinical Record System	End 2024	The Health Board is currently exploring the procurement of mental health information systems and is meeting

			with providers and users of those information systems.
36	Policies and Procedures	1/6/24	The trajectory for improvement is monitored by the Improvement Board

2.7 The national Mental Health Safety Programme met on 18th April and Health Board leads were notified of the draft first year deliverables. An overview of the programme will be presented to the NHS Wales Chief Executive Meeting and separately to the NHS Wales Executive Directors of Nursing Meeting, which are both due to meet week commencing 22nd April.

2.8 CTM's MHLD Nurse Director will lead a national workstream on Safe Discharge.

2.9 Once the national workstreams are finalised and details of the programme are published, the CTM Mental Health Inpatient Improvement Programme will seek to align itself to the work of the national programme.

3. Key Risks / Matters for Escalation

3.1 Committee members are asked to note the slippage on completing one of the recommendations in full.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Living Well
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:

Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* Link to Enablers of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Learning, Improvement & Research
	If more than one applies please list below: Leadership Data to Knowledge Culture and Valuing People
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: Person-centred Timely Safe
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* Quality *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: No change to service design and provision
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: No change to service design and provision
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	Yes (Include further detail below)	

	There are public and stakeholder concerns about the quality and safety of in-patient mental health services
Effaith Adnoddau *(Pobl /Ariannol)* / Resource Impact *(People / Financial)*	Yes (Include further detail below)
	Improving mental health services is dependent on people – there are challenges to recruitment and retention in in-patient mental health services

5. Recommendation

5.1 Members are asked to note the further progress of the Mental Health Inpatient Improvement Programme and the plans in place for the three outstanding recommendations.

6. Next Steps

6.1 The Adult Mental Health Inpatient Improvement Board, chaired by the Executive Director of Therapies and Health Science, next meets formally on 23rd April 2024 and will review further progress and evidence against the HIW recommendations and progress on the programme refresh.

Agenda Item Number: 9.1.1

Minutes of the Meeting of Cwm Taf Morgannwg University (CTMUHB) Quality and Safety Committee 14 March 2024 held via Microsoft Teams

Members Present:	
Carolyn Donoghue	Independent Member (Committee Chair)
Kath Palmer	Independent Member (Vice Chair)
Dilys Jouvenat	Independent Member (In part)
Nicola Milligan	Independent Member
Patsy Roseblade	Independent Member
Helen Lentle	Independent Member

In Attendance:	
Lauren Edwards	Executive Director of Therapies & Health Science (In part)
Greg Dix	Executive Director of Nursing/Deputy Chief Executive
Hywel Daniel	Executive Director for People
Richard Hughes	Deputy Director of Nursing
Julie Denley	Deputy Chief Operating Officer
Cally Hamblyn	Assistant Director of Governance & Risk
Suzanne Hardacre	Director of Midwifery
Nigel Downes	Assistant Director of Quality & Safety (In part)
Sallie Davies	Deputy Medical Director
Stephen Sarasin	Care Group Clinical Director, Planned Care (In part)
Ana Llewellyn	Care Group Nurse Director
Owen Weeks	Unscheduled Care, Care Group Medical Director
Emma Walters	Head of Corporate Governance & Board Business
Amanda Bassett	Clinical Nurse Specialist
Brian Hawkins	Chief Pharmacist
Gaynor Jones	Staff Side Representative
Ceri Bear	Llais Cymru Representative
Dawn Casey	Macmillan Lead Nurse
Marc Penny	Director of Improvement & Innovation
Ruth Williams	Consultant Chest Physician / Acute Oncology Lead
Rhian Collins	Macmillan AHP Lead for Cancer

Agenda Item

1. PRELIMINARY MATTERS

1.1 Welcome & Introduction

The Committee Chair welcomed everyone to the meeting, particularly those joining for the first time, those observing and colleagues participating for specific agenda items. The format of the proceedings in its virtual form were also noted. Members noted that the meeting would be recorded to aid the Committee Secretariat in ensuring the accuracy of scrutiny related discussions and decisions made during the meeting. Members noted that the recording would be destroyed once the minutes had been confirmed as accurate. Members confirmed they were happy to proceed.

1.2 Apologies for Absence

Apologies have been received from:

- David Miller, Deputy Medical Director for Professional Standards & PC, Primary Care Directorate
- Dom Hurford, Medical Director
- Gethin Hughes, Chief Operating Officer
- Lisa Love-Gould, Clinical Director for Diagnostics, Therapies, Pharmacy & Sciences
- Mary Self, Consultant Psychiatrist, Mental Health
- Emma James, Care Group Nurse Director Unscheduled Care
- Sharon O'Brien, Care Group Nurse Director Planned Care
- Alex Brown, Care Group Clinical Director, Unscheduled Care
- Chris Beadle, Assistant Director of Health, Safety & Fire
- Philip Daniels, Executive Director of Public Health

1.3 Declarations of Interest

There were no interests declared.

2. SHARED LISTENING AND LEARNING

2.1 Listening & Learning Story – Spotlight Presentation – Acute Oncology Service

Dr Ruth Williams shared the spotlight presentation and highlighted the key matters for Members attention.

The Committee Chair extended her thanks to Dr Williams for sharing the presentation, and particularly welcomed the patient stories which showed the added value of the service and the impact on quality of life which was significant.

J Denley also welcomed the presentation which she found to be inspiring, particularly in relation to the impact the service had on people's lives. J Denley made reference to the review being undertaken of Palliative Care Services and added that it may be helpful if the Team could be connected to this review as there may be an opportunity for the Team to help with managing pathways. Dr R Williams advised that she would be more than happy to be linked into discussions regarding this to ensure that robust services were in place which could be delivered effectively. Members noted that whilst the Team were fully aware of the difficulties being faced by the Palliative Care Service at present, there were resourcing issues within the Acute Oncology Service in terms of Specialist Nurse support, particularly at the Princess of Wales Hospital. O Weeks advised that he would be happy to discuss this further with Dr Williams outside the meeting.

R Collins advised that it would be important to note that in order for the Health Board's population, who may be very frail, to live as good as quality of life as possible from an ambulatory perspective and avoid admission, there would be a need to ensure a multi-disciplinary approach was being taken, with support from Allied Health Professionals, alongside the Acute Oncology service, being pivotal to this in terms of service delivery. Members noted that at present, there was no specialist Allied Health Professional Team in place to support the service. The Committee Chair suggested that the points made in relation to inequity of service across sites would need to be considered as part of the work being undertaken in relation to the development of the Acute Clinical Services Plan, and suggested that G Dix and J Denley take steps to ensure this was being featured in discussions.

K Palmer extended her thanks to Dr. Williams for sharing the presentation and for the work being undertaken and added that she fully supported the vision and the aims of the Team. In response to a question raised by K Palmer as to whether the current vacant posts were funded or unfunded, Dr. Williams advised whilst there were initial issues in securing funding for the Clinical Lead post, these had now been resolved and it was hoped that the post would be filled soon. Members noted that whilst funds still needed to be secured for the Band 6 post at Princess of Wales Hospital, the Band 6 post at Royal Glamorgan Hospital was now in place. Members noted that the Team had initially experienced issues and delays in relation to approval of posts via the TRAC system which also impacted on recruitment, and noted that these issues had recently been resolved.

G Dix advised that given the level of operational detail that had been discussed at the meeting today, he felt that it may be helpful for the Team to attend a future meeting of the Operational Management Board to discuss the issues experienced in detail.

Resolution: The Listening & Learning Story was NOTED.

Actions: Discussion to be held outside the meeting in relation to resourcing issues within the Acute Oncology Service in terms of Specialist Nurse support, particularly at the Princess of Wales Hospital.

Inequity of service across sites to be considered as part of the work being undertaken in relation to the development of the Acute Clinical Services Plan.

Acute Oncology Service Team to attend a future meeting of the Operational Management Board to discuss the operational issues experienced in detail.

3. CONSENT AGENDA

The Committee Chair reminded Members that the consent agenda items had been moved to the end of the agenda and noted that there was one item that would be brought forward to the main agenda for discussion as agreed prior to the meeting, which was in relation to agenda item 9.2.4.

4. MAIN AGENDA

4.1 Matters Arising not considered on the Action Log

There were no matters arising.

5. SETTING THE SCENE – SERVICE DELIVERY

5.1 Report from the Clinical Executives

The Clinical Executives presented the report and highlighted the key matters for Members attention.

G Dix advised Members that he remained concerned in relation to the boarding of patients, with patients now being double and triple boarded across a number of ward areas. G Dix added that Emergency Departments were now critically crowded resulting in an impact on patient care and experience. G Dix advised that whilst he fully understood the Health Board's role in relation to system risk, and the impact on the community if ambulances were not being offloaded, he felt as the accountable officer for nursing practice within the Health Board, it would be remiss of him not to

extend his continued concerns in relation to how crowded and cramped the Hospitals within the Health Board were. Members acknowledged that boarding presents a poor experience for patients and staff and noted that a number of discussions had been held with Local Authority partners and Welsh Government regarding this position. He further noted that at present there were currently in excess of 200 patients awaiting onward community provision, with 15 ambulances waiting outside hospitals to offload patients. G Dix advised that whilst there were a number of mitigations in place to ensure that patients receive the best possible experience, he remained concerned, along with Nurse Director colleagues, in relation to continuous boarding throughout all wards.

J Denley advised that the Operational Team share the same concerns in light of the current boarding challenges. She advised that the Chief Operating Officer would be sharing a presentation on flow in the coming weeks and added that data analysis was being undertaken which showed that there were challenges at the back door, with length of stay rising, whilst front door demand was decreasing. J Denley confirmed that boarding was being undertaken on wards daily in anticipation of discharges, with constant balancing of risk being undertaken. Members noted that recent discussions had been held with Bridgend Local Authority regarding the issues being experienced and noted the workforce challenges being faced by Local Authority partners which was impacting on the position. Members noted the focus on flow should help to identify what actions need to be taken during the summer months in order to alleviate the pressures during winter months.

H Daniel shared the concerns raised by G Dix and advised that similar concerns had been raised at the Health, Safety & Fire Sub Committee, particularly in relation to some of the Health & Safety issues and capacity issues in relation to boarding, with some specific concerns raised via the Health & Safety Trade Union representatives. Members noted that the Health & Safety Trade Union representative was a key role within the Health Board which was written into Health & Safety legislation and was a real example of this role functioning well given that these issues were being escalated.

G Jones advised that the challenges in relation to boarding were also discussed at the Local Partnerships Forum held recently, with concerns raised in relation to patients being boarded in unsuitable and unsafe areas, which was resulting in a lack of dignified care.

The Committee Chair advised that Committee Members shared, acknowledged and understood the concerns raised and suggested that this matter was escalated to the Board via the Committee Highlight Report. The Committee Chair added that discussions had been held previously in relation to boarding of patients in front of fire exits, with assurance sought on a number of occasions that patients were no longer being boarded in

areas which could cause an obstruction in the event of a fire. The Committee Chair recognised that the impact on patient dignity and safety was significant and added that she felt concerned that boarding of patients was becoming normal practice and was part of the day to day management of patients which was a risk to both patients and the Health Board. The Committee Chair advised that this practice is below the standard of care and experience the Health Board would wish to afford its patients and staff and that it will continue to be escalated as an area of concern to the Board.

N Milligan advised that a discussion was also held at the Local Partnerships Forum in relation to risk assessments, with a request made to ensure risk assessments were being reviewed regularly when patients were being placed in a boarded position, given the changing nature of a patient's condition.

Following the update provided by S Davies in relation to the Vascular service and Interventional Radiology risks that had been outlined in the report, S Sarasin advised there had been a slight improvement in the position as Swansea Bay University Health Board had recently appointed into one of the posts.

Resolution: The report was NOTED.

Action: Concerns raised in relation to Boarding of patients to be escalated to the Board via the Committee Highlight report.

5.2 Care Group Highlight Reports

5.2a <u>Mental Health & Learning Disability Care group</u>

A Llewellyn presented the report and highlighted the matters contained within the alert/escalate section. Members noted that the completed nurse establishment review required further work and had not been presented to the Care Group Planning, Performance, People and Finance Meeting on 13th March as stated within the report and noted that this would now be presented to the next scheduled meeting.

A Llewellyn provided Members with an update in relation to Right Care, Right Person, following discussions held at the last meeting where Members requested a further update on progress. A Llewellyn advised that the first phase was implemented on 26 February 2024 with no issues reported to date. A Llewellyn advised that this was the phase which included less risk and added that she would be happy to provide an update on progress at a future meeting. K Palmer advised that an excellent presentation had been shared at the last meeting of the Mental Health Act Monitoring Committee and suggested that it would be helpful if this presentation could be shared with Quality & Safety Committee Members as it outlined the progress made alongside phases and risks.

L Edwards made reference to the update provided in the report in relation to the Joint National Review being undertaken by Healthcare Inspectorate Wales, Care Inspectorate Wales and Estyn and advised that it would be helpful if the impacts in relation to Ty Llidiard could be fed into the Post 16 provision. A Llewellyn advised that there was no update available at present in relation to Post 16 provision and added that the Children's Commissioner had written a report on this matter and was in the process of discussing further with Welsh Government.

In response to a query raised by D Jouvenat as to whether there was confidence that the three open Nationally Reportable Incidents and the four overdue actions in the patient safety category would be completed in an appropriate time, A Llewellyn advised that in relation to the incidents, which were highly complex, these were being monitored regularly by the Care Group Quality & Safety meetings. In relation to the four overdue actions, given that the Care Group was one of the last to roll out the AMAT audit programme, A Llewellyn advised the Team were confident that the standards of audit were being met at this stage of implementation. Members noted that this was also being monitored regularly at each Care Group Quality & Safety meeting.

Resolution: The report was NOTED.

Action: Presentation on Right Care, Right Person, which was previously shared at the Mental Health Act Monitoring Committee, to be shared with Quality & Safety Committee Members for information.

5.2b Children & Families Care Group

S Hardacre presented the report and highlighted the matters contained within the alert/escalate section.

In response to a query raised by the Committee Chair as to how long it was envisaged for the work to be undertaken at the Special Care Baby Unit and the Labour Ward at Princess of Wales Hospital Bridgend, S Hardacre advised that the estimated timescale for the completion of works was six weeks.

In response to a query raised by K Palmer as to whether there was any initial feedback that could be shared with Members following the unannounced inspection of maternity services at Prince Charles Hospital undertaken by Healthcare Inspectorate Wales (HIW), S Hardacre advised that from a quality and safety perspective, initial feedback indicated that HIW were assured that safe services were in place and witnessed good documentation, Multi-Disciplinary Team working and safe practices during their visit. Members noted that HIW suggested that the Team reached out to colleagues across Wales to share good practice. S Hardacre advised that some comments within the draft report had been challenged by the Team

as it was felt some information was factually inaccurate and added that a redrafted report was awaited.

Resolution: The report was NOTED.

5.2c Unscheduled Care Group

O Weeks, presented the report and highlighted the matters contained within the alert/escalate section. Members noted that in relation to the ongoing Junior Doctors strikes, whilst these were having a significant impact on outpatient clinics in particular, there was confidence that in-patient safety was not being compromised, with staff working hard to mitigate any risks. Members noted that assurance had also been provided that robust staffing was in place to cover the industrial action taking place over the Easter period.

The Committee Chair noted the excellent response received in relation to the Emergency Department national survey which had significantly improved since the last survey was undertaken and also noted the development of the Advanced Nurse Practitioner role at Prince Charles Hospital which would be significantly impactful on patient care, safety, experience, length of stay and patient flow.

Resolution: The report was NOTED.

5.2d Primary Care and Communities Care Group Highlight Report

A Llewellyn presented the report and highlighted the matters contained within the alert/escalate section. Members noted that there had been an improvement in relation to the backlog of patients awaiting treatment in the Lymphoedema service and noted that 800 patients had now been contacted, with an additional 76 sessions taking place up until end of July 2024 to address the backlog. A Llewellyn extended her thanks to the National Team and the ICTM Team for the support provided in order to address this issue. The Committee Chair welcomed this positive improvement.

K Palmer raised concern regarding the waiting list position in relation to the Paediatric General Anaesthetic list and sought clarity as to what mitigations were in place and the timescales to address the issues. A Llewelyn advised that she was unable to provide timescales at this point in time and advised that the Service Directors within Planned Care and Primary and Community Care were working collaboratively to address the current position.

Resolution: The report was NOTED.

5.2e Diagnostics, Therapies, Pharmacy & Sciences Care Group

B Hawkins presented the report and highlighted the matters contained within the alert/escalate section.

The Committee Chair noted the Quality Exemplar for Dietetics Oncology which was a significant improvement and extended her congratulations to all involved for this achievement. L Edwards added that she was also pleased with the focus being placed on this area given the pressures being faced by a small team of staff.

L Edwards made reference to the Healthcare Inspectorate Wales inspection of Nuclear Medicine which took place recently and advised that informal feedback received following the inspection was positive in relation to quality of service, quality of care and regional working and added that a final report was awaited.

In response to a query raised by the Committee Chair regarding the Controlled Drugs liquids, and the incidents which had been reported on multiple sites of volume discrepancies for Oxycodone, B Hawkins advised that this was an ongoing issue and was related to wastage following transfer from one container to another as opposed to inappropriate diversion. Members noted that consideration was now being given to alternative ways of administering the drug.

Resolution: The Care Group Highlight Report was NOTED.

5.2f Planned Care Group Highlight Report

S Sarasin presented the report and highlighted the matters contained within the alert/escalate section.

The Committee Chair welcomed the Patient Experience Feedback that had been included as an appendix to the report and noted the improvement in pressure damage that had been reported at Prince Charles Hospital and suggested that it would be helpful to share any lessons learnt with other areas.

Resolution: The Care Group Highlight Report was NOTED

6. GOVERNANCE, RISK AND ASSURANCE

6.1 A number of questions were raised by the Committee Chair prior to the meeting as outlined below, together with the responses provided:

Question: Risk 4071 – "I think I noted in previous papers that we have made significant improvement in reducing the bowel screening waiting times. Is that correct and would that reduce this risk?"

Response from Cancer Business Unit – Planned Care - Care Group: "Whilst we have made improvements in waiting times for Bowel Screening Wales, this is only one of, over 200 different types of cancer. A slight impact in our overall performance may be seen, because Colorectal cancer is one of the most common cancers. However, it wouldn't be a large enough to change the overall risk rating as there are so many other pathways."

Question: Risk 5658 - dietetics service in Princess of Wales critical care. "Was this a service that has been in place previously and lost or resulting from a new standard being required?"
Response from the Therapies (DTPS Care Group) - There has always been a service gap. Previously the lack of dietetic workforce was part of a Therapies workforce risk - gaps in therapies staffing to Critical Care in relation to GPICs standards (Guidelines for the Provision of Intensive Care Services). That risk de-escalated was from high risk following investment in the Speech and Language Therapy critical care workforce, leaving just Dietetics holding a high risk, thus this now features as a dietetic service risk.

Question Risk 5417 - paediatric dental Ga lists. "Are the ad hoc lists mentioned now in use and if so is this having an impact? I am not quite sure how this would work, does ad hoc mean that the lists come up at the last minute and therefore dental services would have to be able to put together a team at short notice to utilise that list?"
Response from Primary Care and Community: The CDS will prioritise staff to accommodate any additional lists offered [where this is possible]. To answer the question below, the GA lists that may become available will be part of 6-4-2 process where consultant annual leave being taken allows for theatre lists that will not be used by one service to be offered out to other specialities to maximise use of theatre space.

Planned Care have added that the Community Dental now has their fixed list back in place , this is 1 session per month, this was stopped due to the Pandemic and that Community Dental service held a vacancy for a long time. The adhoc lists are backfill lists that are offered out 4 weeks in advance (in line with 6/4/2-1).

C Hamblyn presented the report and asked the Committee to review and discuss the organisational risk register and consider whether the assigned risks had been appropriately assessed. C Hamblyn advised that a status update had been included within the report of the emerging risks that were highlighted at the last meeting, together within an explanation as to why these risks were no longer being escalated to the Organisational Risk Register at this stage.

The Committee Chair advised that it was helpful to see the discussions that had taken place in relation to the emerging risks and how they had been mitigated and also extended her thanks to officers for providing a response

to the questions raised in advance of the meeting. The Committee Chair extended her thanks to C Hamblyn for all the work undertaken in this area.

Resolution: The report was NOTED

6.2 Continuing Healthcare (CHC) and Funded Nursing Care (FNC) Activity Annual Report

A Llewellyn presented the report and provided members with an update on quality, safety, risk and experience issues in Continuing Health Care services provided across Cwm Taf Morgannwg University Health Board. The Committee Chair welcomed the report which she had found to be helpful and comprehensive.

K Palmer also advised that she felt the report was clear and sought clarity as to what the timescales were for addressing the 22% backlog of commissioned health care package reviews that still needed to be undertaken, and what this meant in terms of risk. In terms of timescale, A Llewellyn provided assurance that the Team were prioritising packages which were overdue and in relation to risk, there was a financial risk in that there may be opportunities to step patients down from higher cost care, in addition to a risk around quality oversight.

Resolution: The report was NOTED

9.2.4 Healthcare Inspectorate Wales Action Plan Tracker

C Hamblyn presented the report and advised that the Team were in the process of transitioning the Audit Trackers into the AMaT system to enable Care Groups to use the one system for updating their audit/inspection recommendations. Members noted that the tracker would be developed further moving forwards, with work being undertaken with System Developers on system content. The Committee Chair welcomed the developments undertaken in this area.

Resolution: The report was NOTED

7. DELIVERING OUR PLAN

7.1 Patient Safety, Quality & Experience Dashboard

N Downes presented the Patient Safety & Quality Dashboard to Committee Members which provided data from 01.01.24 to 29.02.24.

K Palmer welcomed the report which she found to be comprehensive, however drew attention to the sentence on page 12 of the report in relation to “Of the 26 incidents, 27 were reported as care planned and 25 were reported as not care planned” as this did not appear to be correct as read.

N Downes agreed to undertake a review of the statement outside the meeting. A Llewellyn provided some context behind the meanings of 'care planned' and 'not care planned' and advised that 'care planned' usually related to older adults who may need restrictive interventions around self-care and added that 'not care planned' related to the unpredictable use of restrictive interventions.

P Roseblade extended her thanks to N Downes for the inclusion of data on page 9 of the report in relation to the difference in reporting between initial reporting of classification of harm and the final classification, which highlighted that initial reporting seemed to be significantly overstated compared to the final outcome following investigation. P Roseblade sought clarity as to whether any additional training would be offered to staff to address this. N Downes advised that a number of areas of training were being offered within the Duty of Candour and other areas of Quality & Safety investigations and added that a session on Duty of Candour would also be undertaken at the Listening and Learning event taking place in June 2024.

The Committee Chair recognised the significant progress being made and added that she felt the Care Group system was now starting to embed in regards to how these reports are being generated.

Resolution: The report was NOTED.

Action: Review of the statement contained on page 9 of the report in relation to incidents that had been 'care planned'/'not care planned'.

8. DELIVERING OUR IMRPOVEMENT PROGRAMMES

8.1 ICTM Annual Report

M Penny presented the report and provided an update on the progress made against the 3 year business plan.

The Committee Chair extended her thanks to M Penny for presenting the report which she found to be helpful and easy to read through. The Committee Chair advised that she thought the work being undertaken by the small team of staff was very impressive and innovative and extended her congratulations for the achievements made. K Palmer also echoed the comments made by the Committee Chair and added she found the list of projects that had been undertaken impressive.

M Penny advised that the work being undertaken was an organisational effort and added that the Team provide support where possible and regularly empower staff, and build up their confidence, to undertake change and improvement projects. Members noted that whilst most staff have the skills, they feel reticent to use them. The Committee Chair expressed the

importance of staff recognising that they have something to offer and encouraging staff to share their opinions and concerns. The Committee Chair advised that she would be interested in attending the ICTM Showcase Event being held in July and M Penny agreed to extend the event invite to Committee Members who were all welcomed to attend.

The Committee Chair sought clarity from M Penny as to whether there were any areas of concern where he would welcome more support from the Committee on. M Penny advised that whilst there was not a specific area that required support from the Committee, the biggest constraint being faced by the Team at present was in relation to operational capacity of staff to undertake improvement pieces of work.

G Dix reflected upon how that ICTM did not exist four years ago and was a vision and Business Case that had been presented to Board for approval. G Dix added that he was incredibly proud of how the service had flourished under the leadership of M Penny and demonstrated how committed the Board were to quality, innovation and improvement. G Dix extended his thanks to M Penny and the team for the significant amount of support they provide to changes in practice and extended his thanks to the Committee Chair for agreeing to receive this presentation at the Committee.

J Denley advised that from an operational perspective this service was valuable and extended an invite to M Penny to attend the launch date for the new Care Groups so that he can raise awareness of the service and what support the Team could offer.

Resolution: The report was NOTED

Action: Invite to the ICTM Showcase Event in July 2024 to be extended to all Committee Members.

8.2 Mental Health Adult Inpatient Improvement Programme

A Llewellyn presented the report and provided committee members with an overview of progress of the Mental Health Adult Inpatient Improvement Programme. The Committee Chair extended her thanks to A Llewellyn for presenting the comprehensive update.

Resolution: The report was NOTED

8.3 Stroke Services Report

O Weeks presented the report and highlighted the key matters for Members attention.

The Committee Chair advised that Stroke had been an area of concern for the Committee for some time and advised that whilst she was pleased to

see the progress being made towards regional working, she was concerned that despite the efforts being made, there continued to be reporting of poor results.

K Palmer also welcomed the progress made despite the significant challenges and sought clarity as to whether engagement had been undertaken with Third Sector organisations and the Stroke Association and whether support from charities had been explored. G Dix confirmed that work had been undertaken with the Stroke Association and added that the Health Board had just been granted a significant amount of research monies to work with the Stroke Network Association in relation to caring for patients with Stroke.

J Denley advised that there were clearly some challenges across the whole system, not just at the front door, and advised that Health Board discharges from dedicated rehabilitation beds were very small, which creates a challenge across the system in terms of patient flow through the stroke pathway.

The Committee Chair extended her thanks to O Weeks for presenting the report and advised that whilst good progress had been made, this still remained an area of significant concern for Committee Members.

Resolution: The report was NOTED

9. CONSENT AGENDA

FOR APPROVAL

9.1.1 Unconfirmed Minutes of the meeting held on 23 January 2024

Resolution: The Minutes were APPROVED.

9.1.2 Unconfirmed Minutes of the In Committee meeting held on 23 January 2024

Resolution: The Minutes were APPROVED.

9.2 FOR NOTING

9.2.1 Action Log

Resolution: The Action Log was NOTED.

9.2.2. Committee Annual Cycle of Business Information

Resolution: The Annual Cycle of Business was NOTED.

9.2.3. Committee Forward Work Programme

Resolution: The Forward Work Programme was NOTED.

9.2.4. Healthcare Inspectorate Wales Action Plan Tracker

This item was moved to the main agenda for discussion.

9.2.5. Clinical Audit Quarterly Report

Resolution: The report was NOTED.

9.2.6. Clinical Audit Forward Plan 2024 - 2025

Resolution: The report was NOTED.

9.2.7. Health, Safety & Fire Sub Committee Highlight Report

Members noted that due to timing of meeting, this Highlight Report will now be received at the May 2024 meeting. There were no matters requiring escalation to the Committee following the meeting held on 4 March 2024.

9.2.8. Radiation Safety Committee Highlight Report

Resolution: The report was NOTED.

9.2.9. Covid 19 Inquiry Preparedness

Resolution: The report was NOTED.

10. CLOSE OUT BUSINESS

10.1 Any other Business

There was no other business to report.

10.2 Highlight report to Board – Verbal

The Committee Chair advised that this would be drafted by the Corporate Governance Team outside the meeting and suggested that concerns raised in relation to boarding of patients needed to be included in the alert/escalate section.

10.3 How did we do in this meeting – Verbal

The Committee Chair advised that she would welcome feedback to be shared outside the meeting as to how Members and attendees felt the meeting went. A Llewellyn shared one reflection in relation to scheduling

of meetings next year and suggested that given the number of non-attendees today as a result of annual leave, it may be beneficial to hold next year's meeting at the start of March.

10.4 Identification of Future Spotlights and Thematic Presentations

Members agreed to consider any themes or discussion points that would support a targeted presentation or a focus at the Committee.

11. PRIVATE/IN COMMITTEE SESSION

The Committee Chair advised that the following items were discussed at the In Committee session held earlier today:

- Listening & Learning story in relation to care provided to a patient with Learning Disability;
- Maternity & Neonatal Incident Cluster Review;
- Review of Health Visiting Services in Bridgend.

12. DATE AND TIME OF NEXT MEETING

The next meeting would be held on Thursday 16 May 2024 at 9:00am.

Agenda Item Number: 9.1.2

Minutes of the Meeting of Cwm Taf Morgannwg University (CTMUHB) Quality & Safety In Committee held on the 14th March 2024 as a Virtual Meeting via Microsoft Teams

Members Present:	
Carolyn Donoghue	Independent Member (Committee Chair)
Kath Palmer	Vice Chair of the Health Board (Vice Chair)
Patsy Roseblade	Independent Member
Dilys Jouvenat	Independent Member
Nicola Milligan	Independent Member
Helen Lentle	Independent Member

In Attendance:	
Greg Dix	Deputy Chief Executive /Executive Director of Nursing
Julie Denley	Deputy Chief Operating Officer/Director of Primary, Community, MH & LD
Dom Hurford	Executive Medical Director (in part)
Sallie Davies	Deputy Medical Director
Hywel Daniel	Executive Director for People
Richard Hughes	Deputy Director for Nursing, Midwifery & Patient Care
Lauren Edwards	Executive Director of Therapies & Health Science
Mandeep Toor	Clinical Practice Educator for MCA, DoLS, & LPS, Safeguarding (in part)
Suzanne Hardacre	Director of Midwifery
Nigel Downes	Assistant Director of Quality & Safety
Andrea Bevan	Senior Nurse, Paediatrics (in part)
Cally Hamblyn	Assistant Director of Governance and Risk
Kathrine Davies	Corporate Governance Manager (Secretariat)

Unconfirmed

Agenda Item

1 PRELIMINARY MATTERS

1.1 Welcome & Introductions

The Chair welcomed everyone to the In Committee meeting of the Quality & Safety Committee.

1.2 Apologies for Absence

Apologies for absence were received from:

- Gethin Hughes, Chief Operating Officer
- Mohammed Elnasharty, Consultant Obstetrician & Gynaecologist

1.3 Declarations of Interest

There were none.

2 MAIN AGENDA

2.1 Shared Listening & Learning Story

M Toor presented the Listening and Learning Story. The Committee were advised of the Learning in relation to the Mental Capacity Act, Deprivation of Liberty Standards and the Court of Protection Process that had arisen following a patient being admitted into a CTM District General Hospital.

The Committee discussed the process for contacting Legal Teams out of hours in relation to the Executive On Call and Senior Manager being clear of the process. G. Padmore-Dix advised that he would pick this up outside of the meeting with regard to training.

The Chair thanked M. Toor for the presentation and commented that it had generated a good debate.

Resolution: The Report was NOTED.

2.2 Maternity & Neonatal Incident Cluster Review

S. Hardacre presented the report which provided the Committee with an update on the four serious adverse incidents that had occurred between December 2023 and January 2024 within Maternity & Neonatal Services that had previously been reported to the Committee in January 2024.

The Committee were advised that Independent, external support had also been sought to review this incident cluster. This will be a separate process from the Root Cause Analysis investigations and will in turn review the incident cluster in its speciality, i.e. The Care Group will receive separate 'speciality' reports reviewing midwifery, obstetric and neonatal care. The rationale for this approach is to:

- Identify any further learning, practice concerns, systems issues or make safes
- Review incidents as a 'cluster', independent of and separate to the multi-disciplinary review process.
- Seek externality and independent expert opinion.

Resolution: The Committee NOTED the steps taken to review the incidents both as separate investigations and as a cluster and would receive the outcome of the incident cluster review once complete.

3. Review of Health Visiting Services (Bridgend)

A Bevan presented the report that informed the Committee on the review that outlined Healthy Child Wales Programme (HCWP) data for Bridgend during 2023 had shown a reduction in health visiting contacts at 15 months, 27 months and 3.5 years compared to previous data returns.

The Committee were advised of the mitigating actions that had been put into place following the review.

Unconfirmed

Resolution: The Report was NOTED

4. ANY OTHER BUSINESS

There was no other business to report.

5. DATE AND TIME OF THE NEXT MEETING

The next In Committee meeting of the Quality & Safety Committee is to be confirmed.

Unconfirmed

Agenda Item
9.1.3

Quality & Safety Committee

Welsh Language Active Offer Policy

Dyddiad y Cyfarfod / Date of Meeting	16/05/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Ben Screen, Welsh Language Lead
Cyflwynydd yr Adroddiad / Report Presenter	Ben Screen, Welsh Language Lead
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Approval

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Welsh Language Steering Group	14/11/2023	Comments and amendments from clinical colleagues

Acronyms / Glossary of Terms	
WNCR	Welsh Nursing Care Record
PREM	Patient Recorded Experience Measure
E-TOC	Electronic Transfer of Care Record

1. Situation /Background

1.1 CTMUHB is required to have a ratified policy in place relating to asking and recording patient language need within in-patient settings (called the Active Offer), in accordance with Welsh Language Standard 24. The policy however will also support the implementation of the More Than Just Words 5-Year Plan 2022-2027 in relation to pro-active bilingual services.

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	22 Jan 2024
Informal Consultation with interested parties	Senior nursing colleagues contacted for input and policy was discussed at the Welsh Language Steering Group.
Formal Consultation	Policy consulted on via CTM UHB's policy SharePoint site between the 5/02/24 and 16/02/24.
Committee – For approval	Quality & Safety Committee

2.2 The policy has been reviewed and is consistent with the approach across NHS Wales / legislation.

2.3 Care Group representatives on the Welsh Language Steering Group have been engaged in the consultation.

2.4 Organisational values and behaviours have been reflected within the policy.

3. Key Risks / Matters for Escalation

3.1 In response to the consultation the following amendments have been made:

- Explanation of acronyms has been added,
- Clearer definition of what in-patient means in the context of the legislation has been added and
- minor typographical amendments have been made.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Living Well
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Wales of Vibrant Culture & Thriving Welsh Language
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Enablers of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Culture and Valuing People
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Domains of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Person Centred
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd?* / Quality *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☒	No: ☐
	Outcome: It is a legal requirement that a policy relating to the Active Offer as relevant to in-patient admission has been written and ratified by the UHB. Non-compliance with requirements under the Welsh Language Standards carry reputational and legal risk as outlined in the Welsh Language	If no, please include rationale below:

	Commissioner's Imposition Policy.	
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 Impact on Age & Disability, Neutral Impact on Gender Reassignment, Marriage & Civil Partnerships, Pregnancy & Maternity, Race, Religion & Belief, Sex and Sexual Orientation. Positive impact on the Welsh Language. Outcome for Welsh Language (delete as appropriate): Positive Impact on Welsh Language	If no, please include rationale below:
Cyfreithiol / Legal	Yes (Include further detail below)	
	It is a legal requirement that CTM UHB has a ratified policy relating to in-patient admission and asking and recording language need, as imposed by Welsh Language Standard 24.	
Enw da / Reputational	Yes (Include further detail below)	
	Lack of compliance with the Welsh Language Standards carries reputational and legal risk to CTM UHB	
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 and Safety Committee are asked APPROVE the Welsh Language Active Offer 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.

IN-PATIENT ACTIVE OFFER POLICY

Document Type:	Clinical Guidelines
Ref:	(For Non-Clinical References – Contact: CTM_Corporate_Governance@wales.nhs.uk For Clinical References – Contact: CTM_ClinicalPolicies@wales.nhs.uk
Author:	Ben Screen, Welsh Language Lead
Executive Sponsor:	Executive Nurse Director
Approved By:	Quality & Safety Committee
Approval / Effective Date:	(14/03/2024)
Review Date:	(14/03/2027)
Version:	1

Target Audience:

People who need to know about this document in detail	All staff on or attending the ward at any time to deliver patient-related interventions, and those Care Group management teams with accountability for in-patient wards
People who need to have a broad understanding of this document	All staff who deal with in-patients in any capacity
People who need to know that this document exists	All staff in the Health Board in patient-facing roles

Integrated Impact Assessment:

Equality Impact Assessment Date & Outcome	Date: 22/01/23 Outcome: Positive Impact on Age & Disability, Neutral Impact on Gender Reassignment, Marriage & Civil Partnerships, Pregnancy & Maternity, Race, Religion & Belief, Sex and Sexual Orientation. Positive impact on the Welsh Language.
Welsh Language Standard	23, 23A & 24
Date of approval by Equality Team:	22/01/23
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

COMPONENTS:

A policy must contain the following components and must also be written to include the values and behaviours of the organisation wherever relevant:

It is accepted that for Clinical Policies and or other Written Control Documents (Procedures, Guidance etc.) the policy components below may not all be relevant.

For guidance on Clinical Policy Development please contact:

CTM_ClinicalPolicies@wales.nhs.uk

For guidance on Non Clinical Policy Development please contact:

CTM_Corporate_Governance@wales.nhs.uk

Or visit the Policy Author Page on SharePoint:

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Introduction and Policy Statement

The purpose of this policy is to ensure an organisation-wide approach to making the Active Offer when admitting in-patients to wards in CTM UHB.

The Active Offer is an example of patient-centred care in a bilingual country, and means that the area and individual clinicians within it pro-actively promote the use of Welsh and ask patient language preference or need, without expecting the patient to tell them.

It serves to ensure there is guidance for staff on what the Active Offer means, when it should be practiced in an in-patient context and where it should be recorded. This includes situations when an in-patient may not be able to communicate their need or preference to use Welsh in whatever capacity with staff for a number of different reasons as explained in the appendix.

Scope of Policy

This policy applies to all in-patient wards at CTM UHB and all admitted in-patients who have been admitted for at least one night.

Aims and Objectives

The aim of the policy is to ensure that:

- In-patients receive the Active Offer of provision in Welsh, whether on admittance to the ward or at a later time if it is not possible or appropriate to ask the patient on admittance and
- That this language preference or need is recorded for other staff.

Responsibilities

- Staff are responsible for ensuring that they are aware of this policy, and act in accordance with it;
- Care Group management teams and ward managers with accountability for in-patient wards are responsible for ensuring their staff are aware of the policy, complete language awareness training where the Active Offer features and record language preference on the systems available to them for doing so, such as the e-whiteboards (using the Welsh flag symbol), E-TOC system, Welsh Nursing Care Record (WNCR) and others as relevant.

Implementation

Appendix 1 sets out the rationale for the policy and how it is to be implemented.

Measuring impact

The impact of this policy and adherence to it will be measured in the following ways:

- The data collected via auditing annual e-whiteboard data to gather the number of patients for whom their language need was recorded as Welsh, and on which ward it was recorded,

- Data collected from the WNCR annually on the number of patients whose preferred language was recorded as Welsh,
- Data from PREMs, collected via surveys through the Civica software and its question on whether the patient was able to use their language of need or preference,
- Qualitative patient experiences relayed to the Health Board via the Concerns Team, the Welsh Language Team or others and
- Data from annual audits of compliance with the Welsh Language Standards as recorded in the Welsh Language Development Dashboard.

All of the measures above will be reported in the annual Welsh Language Standards Performance Report and Highlight Reports from the Welsh Language Steering Group to the People & Culture Committee and will be used to steer internal improvement plans where necessary.

Equality Impact Assessment

A summary of the outcome of the EIA must be present on the front cover of the document.

Either

This policy has been screened for relevance to Equality. No potential negative impact has been identified.

Or

This policy has been subject to a full equality impact assessment and some issues have been identified and highlighted to ensure that due regard and weight is given to them in carrying out this policy.

Either statement needs to be approved by a member of the Equality team (CTM_Equality@wales.nhs.uk), and the date this was done noted.

GETTING HELP

Please contact the Welsh Language Team for resources or further advice on using Welsh on in-patient wards:

CTT_WelshLanguage@wales.nhs.uk

RELATED POLICIES

The Welsh Language Policy for CTM UHB is relevant as the overarching policy for bilingual services in the Health Board.

INFORMATION, INSTRUCTION AND TRAINING

ESR Welsh Language Awareness e-learning to be completed every 3 years by all staff will support an understanding of the broad aims of this policy. Bespoke and local awareness sessions are also offered by the Welsh Language Team.

MAIN RELEVANT LEGISLATION

The policy enacts a core aim of the More Than Just Words 5-Year Plan from the Welsh Government, which is that patients in Wales receive the Active Offer increasingly throughout the healthcare system in Wales underpinned by a culture of awareness and understanding of the importance of being pro-active in bilingual services provision.

The policy also enacts a core aim of the Duty of Quality, under the Health and Social Care (Quality and Engagement) (Wales) Act 2020, where services in Welsh are offered pro-actively and where the availability of services in Welsh is viewed through the lens of quality rather than solely compliance.

It is required that CTM UHB has a written and ratified policy as imposed in CTM UHB's compliance notice under section 44 of the Welsh Language Measure (Wales) 2011, and specifically Standard 24 in relation to those in-patients unable to communicate their language need or preference themselves. This policy is written to satisfy that requirement, however its messages around the importance of asking and recording patient language need or preference are relevant to all patient-clinician interactions throughout CTM UHB.

Welsh Language Measure (Wales) 2011. Available at:
https://www.legislation.gov.uk/mwa/2011/1/contents/enacted

Welsh Language Compliance Notice under Section 44 of Welsh Language Measure (Wales) 2011 as imposed on Cwm Taf Morgannwg University Health Board. Available at:
https://www.welshlanguagecommissioner.wales/media/viflpcyt/20191119-hysbysiad-cydymffurfio44-bwrdd-iechyd-prifysgol-cwm-taf-morgannwg-en.pdf

Welsh Government (2022), More Than Just Words 5-Year Plan 2022-27. Cardiff: Welsh Government. Available at:
https://www.gov.wales/sites/default/files/publications/2022-07/more-than-just-words-action-plan-2022-2027.pdf

Welsh Government (2023), The Duty of Quality Statutory Guidance. Cardiff: Welsh Government. Available at:
https://www.gov.wales/sites/default/files/publications/2023-04/duty-of-quality-statutory-guidance-2023_0.pdf

Cymraeg

Appendix 1 to the In-Patient Active Offer Policy:

The Why, the How and the What

of the Active Offer in in-patient settings at CTM UHB

Y Gymraeg yn CTM
Welsh at CTM
Cymraeg

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

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What is the Active Offer

The Active Offer is a really simple concept with a big impact. It means asking the patient their language need, rather than expecting the patient to tell you, Welsh speakers wearing 'Iaith Gwaith' lanyard/embroidered scrubs with the Cymraeg logo, and ensuring a bilingual environment by following this guide. Being pro-active about what language a patient needs to use is also important if they're unable to note this themselves due to their condition.

In short, think **Surrounding - Asking - Recording**

SURROUNDING

ASKING

RECORDING

Why is it important to use Welsh in healthcare

All of our patients have the right to receive appropriate care in an environment most suited to their needs and for those in our communities whose main language is Welsh, this can mean that patients may need to use Welsh with those caring for them. But is there any evidence at all that this really matters? Can't people who speak Welsh use English as well? Bilingualism is a lot more complex than this. Here are some basic facts about bilingualism.

People when in emotional distress, when facing difficult periods or when in pain will often prefer to use the language they are most comfortable in as a source of familiarity and comfort to them during this difficult and confusing time. A word often used by Welsh-speakers to describe this feeling is 'cartrefol' [a feeling of being 'at home'[1]

Bilingual people can sometimes be more confident in one language than the other, depending on whether they're speaking or writing and what they're communicating about, and for these individuals, pain, discomfort and emotional distress can affect their ability to use the weaker language. This can in turn affect their ability to express themselves fully and authentically[2]

Some conditions affect the part of the brain that has been found to be really important to language. Some of these neurodegenerative disorders include Stroke, Dementia and Parkinson's disease. Bilingual people with aphasia may also struggle to use English if their first language before being becoming aphasic was Welsh.[3]

Those with mental health conditions reliant on talking therapy to get a diagnosis and to alleviate mental health problems will be reliant on their ability to use language effectively. For bilinguals, this can mean needing to use the language they are most comfortable in and the language of their internal monologue or inner cognitive world, to avoid having to translate these thoughts into another language to express them[4]

Using Welsh with bilinguals is a Welsh-specific form of culturally congruent care, and can strengthen the therapeutic and clinical relationship between clinician and patient even where bilinguals can effectively use English. Early research has shown that this cultural closeness can support patients to recover more quickly and feel more at ease, improving the patient's overall satisfaction with their care[5]

OK, but why do we need to ask?

So there's a strong clinical rationale for using Welsh, but why do we need to ask language preference rather than expecting the patient to tell us? There are many reasons for this.

1. The belief that a Welsh-language service may not be available even having asked. See the video on the Welsh Language SharePoint page here; 'I would like a Welsh language service, but I know it's challenge for them'. This was a from a mother who hadn't long given birth. Welsh speaking service users will often put the perceived challenges you face using Welsh before their own communicating in a second language;
2. The fear of prejudice from clinicians were they to ask or some other negative impact such as a delay in care;[6]
3. The tendency for people to follow default options despite their need or preferences, and in services where English is the default and where no Active Offer is made this will mean 'going with the flow' to avoid effort and conflict;
4. Where services in Welsh are pro-actively offered, on admission or later when appropriate for the patient, research has shown that uptake is much higher;[7]
5. Children from Welsh-speaking homes may not have the same amount of vocabulary or expressive ability in English as they do in Welsh until a little later in their development compared to monolingual children. It is likely these children will need to use Welsh and given their vulnerability, we shouldn't expect them to tell clinicians what their language preference or need is especially in the absence of a parental guardian;[8]
6. Those with learning disabilities may not know how to express which language they need to use assuming they have a functional grasp of English to allow them to communicate their needs;
7. Patients who may be admitted unconscious will not be able to communicate any need including language need and so this will need to be asked when appropriate as part of routine admittance procedures or during other interactions with the patient or their next of kin. The injury having caused the person to be unconscious may also affect their cognitive ability and therefore their ability to use their second language;[9]
8. Those who are deaf or mute may struggle to express themselves without adequate communication support and it is important not to assume deaf or mute people do not wish to use Welsh in other ways meaningful to them;
9. Those with speech and language conditions affecting their ability to communicate may not be able to communicate anything at all or without effort, and this would include language need and their need to use Welsh in other ways aside from speaking.

How do I make the Active Offer?

There's a rationale for using Welsh and there's really good reasons for asking the patient what their language need is as well. But how can I do this? Think **Surrounding – Asking – Recording**

Surrounding

- **Displaying the Iaith Gwaith poster at the entrance to the ward and/or at reception**
  The Iaith Gwaith poster (on page 14) is a well-recognised sign around Wales and displays the orange 'Cymraeg' symbol to show that the area welcomes the use of Welsh. It is a practical, visual way of promoting Welsh at the first point of contact for staff, patients and visitors. It can be printed from this document and they are also available from the Welsh Language Team.

- **Use the Welsh you have**
  Did you know there's no universal definition of the word 'fluent'? Think about when you were last in hospital or went for an appointment. Did you want the clinician to talk to you in medical language or did you also appreciate the words of comfort and reassurance in 'everyday' language? Use the Welsh you have, nobody wants to be talked at in jargon and a little bit goes a long way!

- **Posters and resources to encourage the use of Welsh**
  The Health Board has created a Welsh Language Wards and Services Resource Pack. They include the 'Give It a Go' poster which can be displayed to encourage staff to use some Welsh, along with cards with basic Welsh phrases on them and their phonetic spellings so that staff can use basic greetings with patients. They also include a 'Welsh Speaker/Claf Cymraeg' card, which could be used on beds or at the bedside to denote Welsh-speaking in-patients but also as a method of eliciting language need or preference from patients unable to convey this orally. These packs are available from the Welsh Language Team.

- **Adding the Iaith Gwaith symbol to ID badges and uniforms**
  The form for ID badges asks staff whether they are a Welsh speaker and if so they are able to have the 'Welsh speaker' symbol added to their ID badge. Adding this to ID badges is a simple way of informing service users and staff members that the wearer speaks Welsh. Lanyards are also available from the Welsh Language Team to convey this. The same is also true for uniforms and order forms allow staff to have the same logo embroidered onto uniforms where staff aren't able to wear lanyards. It's important that ward managers ask their team often who in their team speaks Welsh and to encourage staff to wear the logo. Use the Welsh you have is the message – nobody wants to be talked at in jargon and even a little bit can make a big difference.

- **Bilingual signage**
  Bilingual signs are a clear visual commitment to bilingualism on the ward. This is true for all signage, but especially any 'welcome' sign to the ward; this is the first thing patients and visitors will see.

- **Using Welsh in activities and patient entertainment**
  On wards or in units where there are programmes of activities or entertainment for patients, including Welsh or Welsh-language elements into these is a really positive thing to do. This could be 1:1 or group activities. Having Welsh books and magazines available can also add to the overall cultural environment for the patient and their family.

- **In-patient advice booklets or information**
  If the ward has welcome booklets, including the names of Welsh speaking staff and an explanation that staff wearing the orange 'Cymraeg' symbol are happy to speak Welsh can be another useful way of promoting the use of Welsh pro-actively.

- **Who's who/named nurse poster**
  If you have named the ward manager, sister or senior nurse on posters or displays, or have any display explaining who's who on the ward, this is another opportunity to inform patients which staff can speak Welsh.

- **Encourage Welsh language champions**
  Why not ask staff with a passion for Welsh to be a Welsh Language Champion or Link Nurse for Welsh? The person specification and the resources available to support this including how it can be linked to core competencies for career development is available on **SharePoint**.

- **Staff language awareness and training**
  The awareness staff have of what the Active Offer means and how it is practiced is really important. One way of doing this is just completing the ESR Welsh Language Awareness Course. Internal guidance and language awareness materials lead with the Active Offer concept and the effect of bilingual care on local people from CTM UHB, and this can easily be found; just search 'Welsh Language' on **SharePoint**. The corporate induction also leads with this concept. The corporate PDR template includes prompts that could facilitate a discussion on patient-centred and linguistically and culturally sensitive care and managers are encouraged to discuss the Welsh language aspects of this with staff, including any training needed to enable this.

Asking and Recording

AT ADMISSION

Patient arrives and information gathered

- Welsh Nursing Care Record has made this really easy – it contains a question on language need so it just needs to be asked.
- If the patient can't speak or convey language need for reasons explained above, then:
  - Next of kin should be asked when contacted, as source of preference for this information as other healthcare providers may not have asked;
  - Check medical notes or information that may already be held in the Welsh Nursing Care Record;
  - Social Care or Community Teams or the patient's GP should be asked if there is no next of kin or they are uncontactable
- It should also be noted that information from patients, their next of kin or other social care providers is always gathered in one way or another for in-patients. This means there should always be an opportunity for language need to be gathered.

Information recorded in national systems

- Information then recorded as relevant on the Welsh Nursing Care Record.
  - WNCR prompts staff to ask patients' 'first language' and 'preferred language'. Staff are also prompted to ask the patient 'Do you want this admission in Welsh ?' (YES?NO), with a free text box to record the action taken if 'Yes' is selected.
  - The language preference field is mandatory within the 'Communication Needs' section of the assessment.
  - Staff can save assessments that are incomplete in a 'draft' format if they are called away, or need further information from next of kin, but all questions within the section need to be completed to mark a section as 'complete'.
  - Other national systems also contain information on the patient's language preference including the Welsh Clinical Portal and Welsh Patient Administration System, although where this has not been noted on the system for a patient this should not be taken to mean that they don't speak Welsh as previous clinicians may not have asked.

Information recorded on the local e-whiteboard system

- CTM UHB has made it easy to record language need internally on wards. The 'Welsh Speaker' symbol (Welsh flag currently) can be found on the left hand side of the e-whiteboard screen.
  - Noting this is important as this is the easiest way of notifying rotating medical and therapies staff that a patient is a Welsh-speaker. It may be that the ward does not currently employ Welsh speakers or that there is no Welsh speaker on shift. Recording and displaying language need internally notifies other staff of this rotating through wards who do speak Welsh.

- The Welsh Language Ward and Service Packs also contain a magnet and a card with 'Welsh speaker/Claf Cymraeg' on them that can also be displayed on the bed/at the bedside to note a patient is a Welsh speaker.

Nurse assigned

- Where a Welsh-speaking in-patient has been admitted and the ward has Welsh-speaking staff a Welsh-speaking nurse should be assigned to this patient for the duration of their stay if specific nurses are being assigned to patients.
  - Where nurses are assigned to areas or specific beds within a ward, as opposed to specific patients, the research described above in the policy should be borne in mind and flexibility allowed to ensure a patient's communication needs are taken into account in their care
  - Other staff other than registered nurses have a significant impact on an in-patient's stay and HCSWs who speak Welsh could also be asked to take particular care of any patient whose language need is Welsh
  - In situations where no ward staff can speak Welsh at all, support is available to support staff to learn Welsh or to help them gain confidence to do so, just reach out to the **Welsh Language Team**. When recruiting, this will also need to be a consideration as per the processes in place when assessing vacant posts.

DURING ADMISSION

- Multi-disciplinary Team Meetings/Case reviews
  - MDT/Case review meetings are an important opportunity to discuss communication needs and to ensure services to which in-patients may be referred are also aware that the patient needs or would prefer to use Welsh.
- Hand-over
  - An holistic hand-over process includes informing in-coming staff for that shift of all relevant communication needs of patients which includes whether or not a patient is a Welsh-speaker
- Continuity of care
  - It is important ward managers know who their Welsh speakers are to inform rota planning on e-rostering, so that Welsh speaking staff are always available. This could be any staff group on the ward, not solely registered nurses. Ideally, all shifts should have at least one Welsh speaker on the ward performing a clinical role in some capacity, so that Welsh speaking in-patients are able to interact with clinical staff in their language of need.
  - Depending on period of rotas and skills in team, consideration could be given to amending shift patterns with consent of staff to allow for continuity of care of Welsh-speaking in-patients if their communication needs are acute. This is especially true where wards may not have a large enough cohort of Welsh-speaking staff so that at least one is statistically always likely to be on rota per shift.

DISCHARGE

- Discharging home
  - Language need or preference should have been noted as above so that it doesn't need to be asked at the next interaction the patient has with the Health Board.
- Discharging to community teams
  - Community teams should be informed the patient is a Welsh-speaker when discharge planning and community teams should note this in notes and systems used by them.
- Discharging to Social Care
  - CTM UHB has developed the E-TOC system, or electronic transfer of care record which is completed when discharging patients to Social Care. This system contains a question on language need and must be completed before the form can be submitted.

Case Studies

Paediatric In-patient wards, Ward 17/18 RGH and Ward 30/31 PCH

Here are some of the ways two paediatric in-patient wards have embedded the Active Offer in CTM UHB:

- Right from the beginning, parents and children know that Welsh is part and parcel of care on the ward and that using the language preferred by the child and family is important. The 'Parent/Care Information Guide' explains, in the beginning, what the orange 'Iaith Gwaith' symbol means so that Welsh-speaking staff can be identified. The guide also commits staff to making the Active Offer and recording this on admission. Bilingual patient and carer information is also promoted in the guide.
- Signage around the wards is bilingual ensuring that the environment around patients respects both languages and reflects Wales as a bilingual country
- In the play room there are Welsh books and Welsh activity and colouring sheets so that children can take part in play in either language

Patients with learning difficulties, Dr David Samuel Consultant Gastroenterologist

Recently, a parent of a patient with additional learning needs wrote to the Health Board to thank one of our consultants, Dr David Samuel for the exemplary care that their son received. They wrote: "The fact that he [Dr David Samuel] is also a Welsh language speaker has also supported Iwan in understanding what is happening to him. This is most commendable."

Iwan, 21 at the time, who has Down's Syndrome and Crohn's Disease, was fully supported in his communication needs and the patient's parent commended the Health Board for using Welsh with Iwan.

The parent added: "Many young adults with a learning disability would find it incredibly challenging to stay overnight in hospital which is an unfamiliar environment without their parents or carers."

This feedback brings it home that for those patients who may not be able to communicate their language preference, or who may not be aware that there's an inappropriate expectation that they tell us, using Welsh can be really important. It really is about more than just words.

Ward Manager and Welsh Language Champion Active Offer Policy Checklist

Surrounding

- ☐ We've displayed the Iaith Gwaith (Working Welsh) poster at the entrance to the ward and/or at reception, with the orange 'Cymraeg' speech bubble logo available on Page 14 and also from the Welsh Language Team
- ☐ We have the Welsh Language Resource Pack available from the Welsh Language Team, including the staff guide and resources to facilitate the use of Welsh and adherence to the Welsh Language Standards
- ☐ We've added the Iaith Gwaith symbol to ID badges and/or uniforms
- ☐ Our signs are bilingual
- ☐ We think about how we can plan using Welsh as well as English in activities and patient entertainment
- ☐ Our in-patient advice booklets include the names of Welsh speaking staff and an explanation that staff wearing the orange 'Cymraeg' symbol are happy to speak Welsh
- ☐ If you have named the ward manager, sister or senior nurse on posters or displays, or have any display explaining who's who on the ward, we've said which staff members are Welsh-speaking
- ☐ We have a Ward Welsh Language Champion
- ☐ Staff have completed their Welsh Language Awareness Training on ESR and/or have had a session on Welsh with the Welsh Language Team

Asking

- ☐ All staff at all levels know what the Active Offer concept means and we ask patients their language preference on admission or when appropriate
- ☐ All staff are aware of this Active Offer Policy and what the expectations are within it

Recording

- ☐ We know that the e-whiteboard system can record patient language preference and know which symbol is used for this on the system
- ☐ Staff know where and how to record language preference in patient records if necessary and on the relevant national system
- ☐ When we have Welsh-speaking patients, we routinely ensure that rotating staff and staff coming in on shift know this if language need is particularly acute as well as noting language need on the relevant digital system

End Notes

[1]Welsh Government and Care Council for Wales 2011, Welsh Speakers Experience of Health and Social Care Services. Available: https://www.iaith.cymru/uploads/generaluploads/welsh_speakers_experiences_of_health_and_social_care.pdf (Accessed: 15/08/2023)

[2]Baker, Colin & Wayne E. Wright 2017, Foundations of Bilingual Education and Bilingualism. Bristol: Multilingual Matters ;Grosjean, Francois 2021, Life as a bilingual, Cambridge: Cambridge University Press.

[3]Morgan, Tracey & Ruth Crowder 2003, Mini Mental State Examinations in English: Are they Suitable for People with Dementia Who are Welsh Speaking? in Dementia 2(2), pp. 267-272; El-Gabalawi, Fayez & Hani Khouzam, The Effect of Mental Illnesson Language Regression to the Mother Tongue in Bilingual Teenagers 2009, The Journal of Neuropsychiatry and Clincal Neurosciences 21(1), pp.88-91; Martin, Conor, Bob Woods and Siôn Williams 2019, Language and Culture in the Caregiving of People with Dementia in Care Homes - What Are the Implications for Well-Being? A Scoping Review with a Welsh Perspective in J Cross Cult Gerontol 34(1), pp. 67-114; Costa, Albert 2019, The Bilingual Brain. Penguin Random House: Dublin

[4]Madoc-Jones, Iolo 2004, Linguistic sensitivity, indigenous peoples and the mental health system in Wales in International Journal of Mental Health Nursing 13, pp. 216-224; Marquine MJ & Jimenez D 2020, Cultural and linguistic proficiency in mental health care: a crucial aspect of professional competence. Int Psychogeriatr. 32(1), pp. 1-3; El-Gabalawi & Khouzam, 2009

[5]Hemberg, Jessica and Emelie Sved 2021, The significance of communication and care in one's mother tongue: Patients' views in Nordic Journal of Nursing Research 41(1), pp. 42-53. Available at: https://journals.sagepub.com/doi/10.1177/2057158519877794 (Accessed: 14 August 2023); Whalen, D.H., Lewis, M.E., Gillson, S. et al. Health effects of Indigenous language use and revitalization: a realist review. Int J Equity Health 21, 169 (2022)."

[6]Welsh Language Commissioner 2014, My Language My Health: Welsh Language Commissioner's Inquiry into the Welsh Language in Primary Care. Cardiff: Welsh Language Commissioner

[7]Evas, Jeremy & Daniel Cunliffe 2017, Behavioural economics and minority language e-services: The case of Welsh in Mercedes Durham & Jonathan Morris (eds.), Sociolinguistics in Wales. London: Palgrave Macmillan, pp. 61-91; Vaughan-evans, Awel 2022, External non-linguistic cues influence language selection during a forced choice task, Bilingualism: Language and Cognition, pp. 1-19.

[8]Gathercole, V. C. M., Enlli Môn Thomas & Emma Hughes 2008, Designing a normed receptive vocabulary test for bilingual populations: A model from Welsh, International Journal of Bilingualism and Bilingual Education 11 (6), pp. 678-720; Clayden, Jonathan D et al 2023, The Impact of Multiple Language Exposure on Cognition During Childhood: Evidence from the UK Millennium Cohort Study, Frontiers in Psychology 14, n. pag. Web; Siow, Seren, Irina. Lepadatu, Nicola Gillen and Kim Plunkett 2022, UK Bilingual Toddlers Show a lag in Vocabulary Size Relative to Monolinguals in Both Comprehension and Production, Proceedings of the Annual Meeting of the Cognitive Science Society, 44. Available at: https://escholarship.org/content/qt988252g8/qt988252g8_noSplash_f52c3f7459dfc17dcd053df330a5032e.pdf (Accessed: 15/08/2023); Binks, Hannah & Enlli Môn Thomas 2023, Welsh–English bilingual adolescents' performance on verbal analogy and verbal classification tasks: the role of language exposure and use on vocabulary knowledge, International Journal of Bilingual Education and Bilingualism, pp.1-16.

[9]Barwood, Caroline & Bruce Murdoch 2013, Unravelling the influence of mild traumatic brain injury (MTBI) on cognitive-linguistic processing: A comparative group analysis, Brain Injury 27(6), pp. 671-676; Wong, Min Ney, Bruce Murdoch & Brooke-Mai Whelan 2009, Language disorders subsequent to mild traumatic brain injury (MTBI): Evidence from four cases, Aphasiology 24(10), pp. 1155-1169; Costa, The Bilingual Brain

Defnyddiwch eich **Cymraeg** pan welwch yr arwydd hwn

Use your **Welsh** whenever you see this sign

Am ragor o fanylion neu i archebu nwyddau ewch i **comisiynyddygymraeg.org**

For further details or to order items visit **welshlanguagecommissioner.org**

Comisiynydd y Gymraeg
Welsh Language Commissioner

Agenda Item
9.1.4

Quality & Safety Committee

QUALITY & SAFETY COMMITTEE ANNUAL REPORT 2023 - 2024

Dyddiad y Cyfarfod / Date of Meeting	16/05/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Emma Walters, Head of Corporate Governance & Board Business
Cyflwynydd yr Adroddiad / Report Presenter	Carolyn Donoghue, Chair of the Quality & Safety Committee
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	Endorse for Board Approval

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

Acronyms / Glossary of Terms	

1. Situation /Background

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

1.2 This annual report from the Quality & Safety Committee details the activities and performance for the Committee for the reporting period 2023-2024.

2. Specific Matters for Consideration

2.1 The Committee Annual Report at Appendix 1, summarises the key areas of business activity undertaken by the Committee from April 2023 – March 2024 and highlights activity for further consideration over the next 12 months.

3. Key Risks / Matters for Escalation

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

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Living Well
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Enablers of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Learning, Improvement & Research
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Domains of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Safe
	If more than one applies please list below:
	No - Not Applicable

Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* Quality *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not applicable for this report
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: Not applicable for this report
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

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

6. Next Steps

6.1 Once endorsed, the Annual Report will be submitted to the Board meeting being held on 30 May 2024 for approval.

Appendix 1

Quality & Safety Committee

Committee Annual Report 2023-2024

DRAFT

QUALITY & SAFETY COMMITTEE
ANNUAL REPORT 2022-2023

1. FOREWORD

I am pleased to be able to commend to you this annual report, which has been prepared for the attention of the Board and reviews the work of the Committee for the financial year 2023-2024.

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

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

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

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

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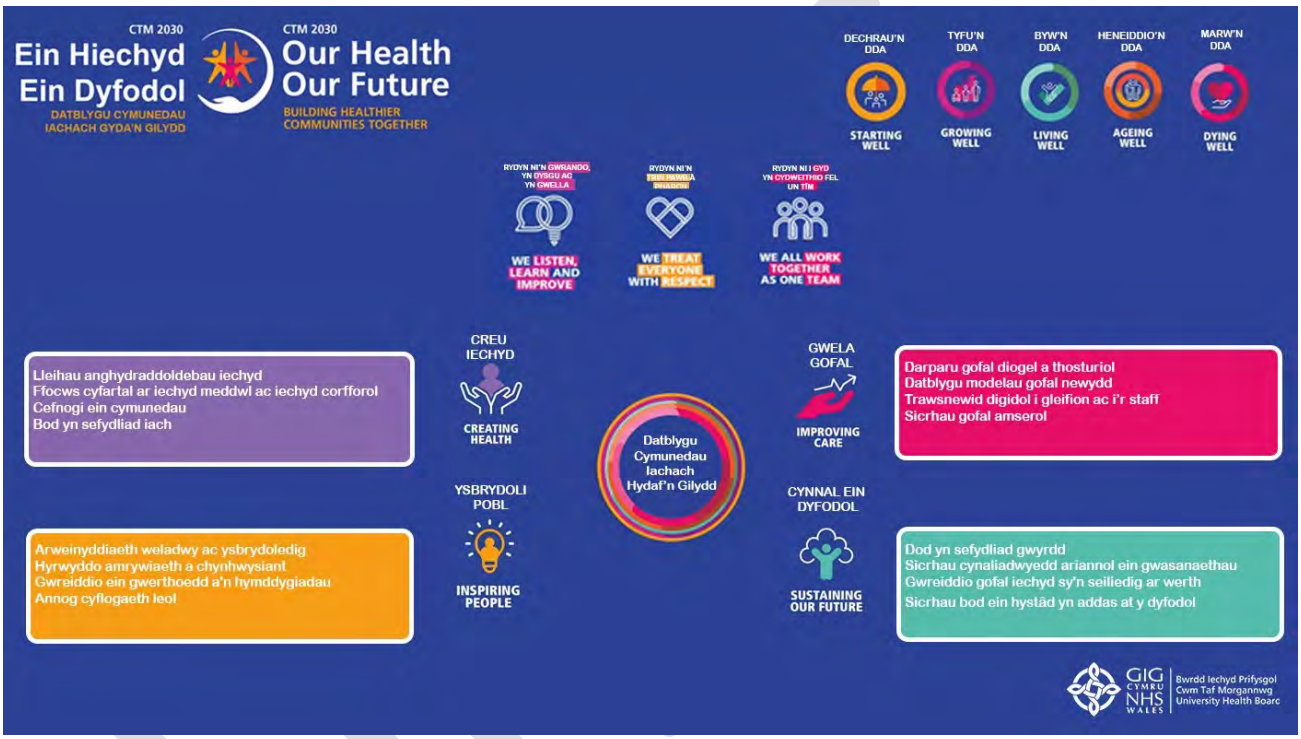
2. INTRODUCTION

The purpose of the Quality & Safety Committee "the Committee" 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.

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



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

A key area of the Quality Improvement work continues to be focussed on the Health Board's response to the concerns raised in 2019 regarding failings in maternity services. The service and Maternity Improvement Team has continued to deliver improvements during 2023-2024 with a regular report on improvement activity received by the Committee. It was agreed at the September 2023 meeting that progress in relation to Maternity & Neonates would be reported via the Children's & Families Care Group Highlight Report from November 2023 given the de-escalation of the service.

During 2023-2024, continued focus was paid to Ty Llidiard service improvements following concerns raised by the Welsh Health Specialised Services Committee on Mental Health Services following reviews undertaken by Healthcare Inspectorate Wales. In relation to Ty Llidiard, it was agreed that following de-escalation, progress updates would be reported via the Mental

Health & Learning Disabilities Care Group Highlight Report from November 2023 onwards.

The Committee were also sighted on programmes of improvement in relation to Stroke Services.

3. ROLE, MEMBERSHIP, ATTENDEES AND COMMITTEE ATTENDANCES

3.1 ROLE

The role of the Committee is to advise and assure the Board on whether there are effective Quality & Safety arrangements in place – through the design and operation of the Health Board system of assurance – to support it in its decision taking and in discharging the accountabilities for securing the achievement of the Health Board objectives in accordance with the standards of good governance determined for the NHS in Wales.

The Committee's Terms of Reference are reviewed annually and are available via the following link: https://cwmtafmorgannwg.wales/how-we-work/standing-orders/

3.2 MEMBERSHIP

The membership of the Quality & Safety Committee comprises of six Independent members, enabling the Committee to provide robust scrutiny and assurance to the Board independently of the management decision-making processes.

A summary of the Independent membership during 2023-2024 is outlined in table 1 below:

Table 1 – Composition & Membership of the Quality & Safety Committee Apr 2023-March 2024

Name	Period
Members	
Jayne Sadgrove (Committee Chair until June 2023) (Committee Member until July 2023) Independent Member	April 2023 – July 2023
Carolyn Donoghue (Committee Chair from July 2023) Independent Member	April 2023 – March 2024
James Hehir Independent Member	Apr 2023 - September 2023
Nicola Milligan Independent Member	Apr 2023 – March 2024
Dilys Jouvenat	April 2023 - March 2024

Independent Member	
Patsy Roseblade Independent Member	April 2023 – March 2024
Helen Lentle Independent Member	January 2024 – March 2024
Kath Palmer Vice Chair	November 2023 – March 2024

3.3 ATTENDANCE AT QUALITY & SAFETY COMMITTEE 2023-2024

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

Table 2 - Meetings and Member Attendance 2023-2024

Public Meeting - In Attendance	24 May 2023	25 July 2023	21 Sept 2023	21 Nov 2023	23 Jan 2024	14 Mar 2024	Total
Independent Members							
Jayne Sadgrove (Chair of the Committee until June 2023)	✓	✓					2 / 2
Carolyn Donoghue - Independent Member (Chair of the Committee from July 2023)	✓	✓	✓	✓	✓	✓	6 / 6
Kath Palmer Vice Chair/Independent Member (from November 2023)				✓	✓	✓	3 / 3
Dilys Jouvenat – Independent Member	✓	✓	✓	✓	✓	✓	6 / 6
Nicola Milligan – Independent Member	✓	x	✓	✓	✓	✓	5 / 6
James Hehir – Independent Member (until September 2023)	✓	✓	✓				3 / 3
Patsy Roseblade Independent Member	✓	✓	✓	✓	✓	✓	6 / 6
Helen Lentle – Independent Member (from January 2024)					x	✓	1 / 2

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In Committee Meeting - In Attendance	31 May 2023	25 July 2023	21 Sept 2023	23 Jan 2024	14 Mar 2024	Total
Independent Members						
Jayne Sadgrove (Chair of the Committee)	✓	✓				2 / 2
Carolyn Donoghue - Independent Member (Chair of the Committee from July 2023)	✓	✓	✓	✓	✓	5 / 5
Dilys Jouvenat – Independent Member	✓	✓	✓	✓	✓	5 / 5
Nicola Milligan – Independent Member	x	✓	x	✓	✓	3 / 5
James Hehir – Independent Member (until September 2023)	✓	✓	x			2 / 3
Patsy Roseblade Independent Member	x	x	✓	✓	✓	3 / 5
Helen Lentle - Independent Member (from January 2024)				x	✓	1 / 2

3.4 ATTENDEES

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

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4. QUALITY & SAFETY COMMITTEE BUSINESS

The Quality & Safety Committee provides an essential element of the Health Board's overall assurance framework. All meetings continued to be held virtually via Microsoft Teams during 2023/2024 with continued use of the Consent Agenda. Any items included on the consent agenda were considered by Members prior to each meeting, with Members provided with the opportunity to raise questions prior to the meetings regarding the reports. All reports included on the Main Agenda were discussed during each meeting. The Quality & Safety Committee agenda broadly follows a standard format, comprising of specific sections, and the activity of the Committee during 2023/2024 is outlined in Appendix 1 of this report.

Links with Other Committees/Boards

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

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

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

During the course of 2023-2024, there were no items referred to the Quality & Safety Committee from other Committees

5. ACTION LOG

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

6. GOVERNANCE

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

- Annual Review of the Terms of Reference & Operating Arrangements
- Committee Annual Report
- Highlight Reports from the Committee to the Health Board meetings
- Annual Committee Effectiveness Self-Assessment Survey
- Annual Cycle of Committee Business

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

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Committee Annual Self-Assessment

The Committee is in the process of completing its Annual Self-Assessment for 2023-2024, any learning and themes identified following the assessment will be presented to the Committee for review and consideration.

7. ASSURANCE TO THE BOARD

The Quality & Safety Committee considers that on the basis of the work completed by the Committee during 2023 - 2024, there are effective measures in place that have delivered against its agreed Terms of Reference.

The forward work programme for 2024-2025 and beyond, ensures that the Committee retains scrutiny on key areas of activity, not exclusive to but including the following:

- Listening and Learning Stories (Patient and Staff)
- Learning lessons and sharing best practice
- Maternity & Neonate Services oversight and scrutiny (via the Childrens and Families Care Group Highlight Report)
- Quality Governance arrangements
- Compliance with the Nurse Staffing Levels (Wales) Act
- Quality improvement initiatives
- Scrutiny of any Regulatory and Inspectorate Body reports
- Consideration of the Audit Wales Structured Assessment feedback to consider how best to manage and prioritise the volume of the Committees business.
- Monitoring the activity considered by the Health, Safety & Fire Sub Committee established in August 2019

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

The Annual Cycle of Committee Business has continued to be presented to each meeting of the Committee during 2023/2024, alongside the Forward Work Programme. This supports and helps identify the key areas of focus for the Committee and is one of the key components in ensuring that the Committee is effectively carrying out its role. It also facilitates the management of agendas and Committee business.

8. LINKS WITH OTHER COMMITTEES

The Quality & Safety Committee will continue to have close links, and share risks with other Committees of the Board, particularly the Audit & Risk Committee, Planning, Performance & Finance Committee and the People & Culture Committee.

As a Sub Committee of the Quality & Safety Committee, regular highlight reports are received from the Health Safety & Fire Sub Committee.

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

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APPENDIX 1

1. Consent Agenda

During 2023 – 2024 the following items were received on the Consent Agenda for Approval/Endorsement:

- Quality & Safety Committee Annual Report 2022-2023;
- Ratification of Urgent Committee Chairs Action – Policy Approval;
- All Wales Model Policy for Consent to Examination for Treatment;
- Policy for the Provision of Intraoperative Cell Salvage;
- Volunteer Service Policy;
- Concerns Policy;
- Rapid Tranquilisation Policy;
- Cwm Taf Morgannwg Carers End of Year Progress Report 2022/23;
- Medicines Policy;
- Safeguarding Policy;
- Clinical Policies Approval Process;
- Violence Against Women, Domestic Abuse and Sexual Violence Policy;
- Measles Policy;
- Meningitis Policy;
- Safeguarding Annual Report;
- Quality & Safety Committee Terms of Reference.

During 2023 – 2024 the following items were received on the Consent Agenda for Noting/Information:

- Action Log;
- Committee Annual Cycle of Business;
- Committee Forward Work Programme;
- Human Tissue Act Compliance and Progress Reports;
- Welsh Health Specialised Services Committee Quality & Patient Safety Chairs Reports;
- Infection, Prevention & Control Mid Year Update, End of Year Update and Annual Reports;
- Quality Governance – Regulatory Review Recommendations and Progress Updates;
- Cancer Services Annual Report;
- RADAR Committee Highlight Reports and Annual Report;
- Putting Things Right Annual Report;
- Clinical Audit Quarterly Updates and Forward Plan 2024-2025;
- Radiation Safety Committee Mid Year and Annual Updates;
- Nosocomial Investigation Update Report;
- Recovery Plan Hep B and Hep C;
- Welsh Risk Pool Claims Final Internal Audit Report and Action Plan;
- Concerns Final Internal Audit Report and Action Plan;
- Cwm Taf Morgannwg Individual Patient Funding Requests (IPFR) Annual Report 2022/23;
- Public Services Ombudsman For Wales A Year of Change – A year of Challenge Annual Report and Accounts 2022/2023;
- Incident Management Internal Audit Report;

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- A National Review of Consent to Examination & Treatment Standards in NHS Wales - Final Welsh Risk Pool Report;
- Public Services Ombudsman for Wales Groundhog Day 2: An opportunity for Cultural Change in Complaints Handling?;
- Prescribing Annual Report;
- Clinical Education Annual Report;
- Organ Donation Committee Annual Report;
- Cwm Taf Morgannwg Maternity Metrics - An update in comparison to Welsh Government (WG) Maternity and Birth Statistics 2022;

2. Main Agenda

During 2023 – 2024 the following items were received:

- Patient Experience/Listening & Learning Stories;
- Spotlight Presentations on:
    - Planned Care – Focus on Cancer Services;
    - Primary & Community Care;
    - Emergency Department – A Review of Falls and Pressure Ulcers;
    - Diagnostic, Therapies, Pharmacies and Specialties;
    - Planned Care - Focus on Ophthalmology Backlog;
    - Frailty;
    - Sepsis;
    - Acute Oncology Service;
- Organisational Risk Register – Risks Assigned to the Quality & Safety Committee;
- Healthcare Inspectorate Wales Action Plan Tracker reports;
- Maternity & Neonates Services Improvement Programme reports – including final closure report;
- Maternity & Neonatal Metrics;
- Maternity Quality Improvement Annual Update 2022-2023;
- Ty Llidiard Progress Reports;
- Mental Health In-Patient Improvement Progress Reports;
- Patient Safety & Quality Dashboard Reports;
- Lessons Learnt – Learning and Actions following a death in Maesteg Hospital;
- Report from the Chief Operating Officer;
- Learning from Events Backlog – Progress Reports;
- Development of a CTM Allied Health Professionals & Healthcare Science Strategy;
- Stroke Services Progress Reports;
- Datix Cymru – Assurance Report;
- Mortality Indicators and Mortality Reviews Assurance Reports;
- Liberty Protection Safeguards Progress Reports;
- Covid 19 Inquiry Preparedness (also received via the consent agenda on occasion);
- CTMUHB Staff Process for Raising Concerns;
- CTMUHB Nosocomial Covid-19 Incident Management Programme Delivery Unit Interim Learning Report;
- Quality & Safety Committee Annual Self Effectiveness Survey;

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- Summary of Irradiated Blood Alerts incorrectly added to Digital Patient Records;
- National Collaborative Commissioning Unit (NCCU) Quality Improvement and Assurance Service Annual Position Statement;
- Report from the Clinical Executives;
- Update on Mental Capacity Work;
- Health, Safety & Fire Sub Committee Highlight Reports (also received via the consent agenda when no items requiring escalation);
- Incident Management Framework;
- Emergency Ambulance Services Committee (EASC) Quality & Safety Highlight Report;
- Quality Strategy Annual Plan;
- Continuing Healthcare (CHC) and Funded Nursing Care (FNC) Activity Annual Report;
- ICTM Annual Report.

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

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

The following reports were received at the In Committee Sessions:

- External Review of Practice into Care of Ms. R by Cwm Taf Morgannwg Health Board and Rhondda Cynon Taf County Borough Council – Verbal Update;
- Controlled Drugs Local Intelligence Network (CDLIN) Annual Report: April 2022 – March 2023;
- Critical Care Reconfiguration;
- MBRRACE-UK Perinatal Mortality Report: 2021 Births;
- Stillbirth Thematic Review 2022;
- Internal Data 'Deep Dive' in to Neonatal Morbidity and Mortality At Cwm Taf University Health Board;
- Nationally Reportable Incidents (NRI)/Maternity Incident Cluster Reports;
- Review of Health Visiting Services (Bridgend);

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ACTION LOG QUALITY & SAFETY COMMITTEE					
Minute Reference	Date of Meeting Action Originated	Issue	Lead Officer	Timescale for Action to be completed	Status of Action (as at May 2024)
7.1	November 2021 January 2022	Quality Dashboard Future hot topics to be presented to the Committee via the Quality Dashboard in relation to Pressure Ulcers and the Deep Dive being undertaken on Thrombosis. Spotlight report to be presented to the July meeting in relation to Medication Errors	Assistant Director of Quality & Safety	January 2024	Partially Complete - One action in Progress Spotlight report on Community Acquired Pressure Damage presented to the March 22 meeting. Completed. Spotlight report on Patient Falls presented to the May 22 meeting. Completed. Spotlight Report on Medication Errors included in the Quality Dashboard report to the July 22 meeting. Completed. Spotlight on Thrombosis to be agreed. In Progress
2.1	24 January 2023	Listening & Learning Story Presentation to be shared at a future meeting in relation to the wider piece of work being undertaken in relation to the Volunteer Service.	Director of Nursing	January 2024	In progress Date to be agreed. Being considered alongside other Listening & Learning stories that need to be scheduled into the programme.
6.5	21 September 2023	CTMUHB Nosocomial Covid-19 Incident Management Programme	Head of Covid19 Nosocomial	16 May 2024	On agenda

		Delivery Unity Interim Learning Report Outcome of the Demand & Capacity work to be presented to a future meeting of the Committee	Investigation Team		Closure report being presented to the 16 May 2024 meeting
7.3	23 January 2024	CTM Quality Strategy Work Plan Update Consideration to be given outside the meeting as to whether the work being undertaken on Healthcare Pathways and the Ward Accreditation Programme needed to be added to the plan as positive examples Review to be undertaken as to the most appropriate time to present the next update to the Committee	Executive Director of Therapies & Health Sciences	16 May 2024 Now 15 July 2024	In progress Work ongoing to improve routes of reporting into Quality Strategy Annual Plan. Updated Annual Plan to be presented to the Quality & Safety Committee in July by the Assistant Director of Therapies & Health Sciences
2.1	14 March 2024	Listening & Learning Story – Acute Oncology Service Inequity of service across sites to be considered as part of the work being undertaken in relation to the development of the Acute Clinical Services Plan	Executive Director of Nursing/Deputy Chief Operating Officer	16 May 2024	In progress Awaiting response from Deputy Chief Operating Officer
2.1	14 March 2024	Listening & Learning Story – Acute Oncology Service	Executive Director of Nursing/Deputy	16 May 2024	In progress

		Team to attend a future meeting of the Operational Management Board to discuss the operational issues experienced in detail.	Chief Operating Officer		Awaiting response from Deputy Chief Operating Officer
5.1	14 March 2024	Clinical Executives Report Concerns raised in relation to issues being experienced in relation to Boarding of patients to be escalated to the Board via the Committee Highlight report.	Committee Chair	30 May 2024	In progress Verbal update provided to the Board by the Committee Chair at the March meeting. Issue will be reported in the Committee Highlight Report to May Board

PREVIOUSLY REPORTED Completed Actions					
Minute Reference	Date of Meeting Action Originated	Issue	Lead Officer	Timescale for Action to be completed	Status of Action (as at May 2024)
6.4	21 September 2023	Learning From Events Reports Further update on progress to be presented to the January meeting of the Committee as an appendix to the Quality Dashboard report.	Assistant Director of Concerns and Claims	23 January 2024 Now 14 March 2024	Completed Update received as an appendix to the Quality Dashboard report at the meeting held on 14 March 2024
5.2c	23 January 2024	Children & Families – Care Group Highlight Report Deep Dive to be presented to a future meeting outlining the outcome of the review into Health Visiting issues experienced in the Bridgend areas.	Director of Midwifery	14 March 2024	Completed Report received and discussed at the In Committee Quality & Safety Committee held on 14 March 2024
7.2	23 January 2024	Emergency Ambulance Services Committee (EASC) Quality & Safety Highlight Report Future reports to include some graphs which showed WAST lost hours and the planned and actual production hours to provide a holistic view of the position	Chief Ambulance Services Commissioner	11 July 2024	Completed Reports to be received bi-annually. Added to Annual Cycle of Business

5.2a	14 March 2024	Mental Health & Learning Disabilities Care Group Highlight Report Presentation on Right Care, Right Person, which was previously shared at the Mental Health Act Monitoring Committee, to be shared with Quality & Safety Committee Members for information	Care Group Nurse Director, Mental Health & Learning Disabilities	16 May 2024	Completed Presentation shared by email on 14 March 2024
8.1	14 March 2024	ICTM Annual Report Invite to the ICTM Showcase Event in July 2024 to be extended to all Committee Members	Director of Improvement and Innovation	16 May 2024	Completed Details of the event shared with Members by email on 14 March 2024
2.1	14 March 2024	Listening & Learning Story – Acute Oncology Service Discussion to be held outside the meeting in relation to resourcing issues within the Acute Oncology Service in terms of Specialist Nurse support, particularly at the Princess of Wales Hospital	Care Group Nurse Director, Planned Care	16 May 2024	Completed and Ongoing Care Group Nurse Director, Planned Care has made contact with the Macmillan Lead Nurse regarding issues being experienced and will continue to discuss moving forwards.
7.1	14 March 2024	Patient Safety, Quality & Experience Dashboard Review of the statement contained on page 9 of the report in relation to incidents that had been care planned/not care planned	Assistant Director of Quality & Safety	16 May 2024	Completed An explanation has been included in the report being presented to the May meeting.

Agenda Item
9.2.2

Quality & Safety Committee

Quality & Safety Committee Annual Cycle of Business

Dyddiad y Cyfarfod / Date of Meeting	16/05/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Emma Walters, Head of Corporate Governance & Board Business
Cyflwynydd yr Adroddiad / Report Presenter	Cally Hamblyn, Assistant Director of Governance & Risk
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For 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. Situation /Background

1.1 The Quality & Safety Committee should, on annual basis, receive a Cycle of Business which identifies the reports which will be regularly presented for consideration. The annual cycle is one of the key components in ensuring that the Committee is effectively carrying out its role.

1.2 The Cycle of Business covers the period 1 January 2024 to 31 December 2024.

1.3 Any changes made to the Annual Cycle of Business since the last meeting will be identified in red moving forwards.

2. Specific Matters for Consideration

2.1 The Cycle of Business has been developed to help plan the management of Committee matters and facilitate the management of agendas and Committee business.

3. Key Risks / Matters for Escalation

3.1 Please refer to Appendix 1 – Quality & Safety Committee Cycle of Business for further detail. Any changes have been identified in red.

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	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:	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.
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: 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.	
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 Committee are asked to NOTE the Annual Cycle of Business for 2024.

Quality & Safety Committee

Cycle of Business

(1st January 2024 – 31st December 2024)

The Quality & Safety Committee should, on annual basis, receive a cycle of business which identifies the reports which will be regularly presented for consideration. The annual cycle is one of the key components in ensuring that the Committee is effectively carrying out its role.

The Cycle of Business covers the period 1st January 2024 to 31st December 2024.

The Cycle of Business has been developed to help plan the management of Committee matters and facilitate the management of agendas and committee business.

The principal role of the Committee is set out in the Standing Orders 1.0.1.

Quality & Safety Committee Cycle of Business (1st January 2024 – 31st December 2024)

Item of Business	Executive Lead	Reporting period	23 Jan 2024	Feb 2024	14 Mar 2024	April 2024	16 May 2024	June 2024	11 July 2024	Aug 2024	12 Sep 2024	Oct 2024	14 Nov 2024	Dec 2024
SHARED LISTENING & LEARNING														
Shared Listening & Learning Story	Executive Director of Nursing	All regular meetings	⚑		⚑		⚑		⚑		⚑		⚑	
Thematic Spotlight Presentation	Lead Clinical Executive	All regular meetings	⚑		⚑		⚑		⚑		⚑		⚑	
SETTING THE SCENE – SERVICE DELIVERY														
Report from the Clinical Executives	Clinical Executives	All regular meetings	⚑		⚑		⚑		⚑		⚑		⚑	
Care Group Highlight Reports	Executive Director of Nursing	All regular meetings	⚑		⚑		⚑		⚑		⚑		⚑	
GOVERNANCE, RISK AND ASSURANCE														
Organisational Risk Register – Risks Assigned to Quality & Safety Committee	Director of Corporate Governance/ Board Secretary	All regular meetings	⚑		⚑		⚑		⚑		⚑		⚑	
Healthcare Inspectorate Wales Action Plan Tracker	Executive Director of Nursing	All regular meetings	⚑		⚑		⚑		⚑		⚑		⚑	
Mortality Indicators and Mortality Reviews	Executive Medical Director	Bi-annually	⚑						⚑					
National Collaborative Commissioning Unit Quality Improvement and Assurance Service Annual Position Statement	Director of Nursing, Performance and Quality, NCCU	Annually									⚑			
Continuing Healthcare (CHC) and Funded Nursing Care (FNC) Activity.	Executive Director of Nursing	Annually	⚑ Defer to Mar 24		⚑									
Infection, Prevention & Control Report (Annual Report and Mid-Year Update) Exception reports will be presented as and when required	Executive Director of Nursing	Bi-Annually					⚑ End of year update				⚑ Annual Report		⚑ Mid Year update	
DELIVERING OUR PLAN														
Quality Dashboard Report	Executive Director of Nursing	All regular meetings	⚑		⚑		⚑		⚑		⚑		⚑	
EASC Quality & Safety Highlight Report	Chief Ambulance Services Commissioner	Bi-Annually	⚑						⚑					
DELIVERING OUR IMPROVEMENT PROGRAMMES														
Stroke Services Progress Report	Executive Director of Therapies and Health Sciences	Quarterly			⚑				⚑				⚑	
Mental Health In-Patient Improvement Progress Reports	Executive Director of Therapies and Health Sciences	All regular meetings	⚑		⚑		⚑		⚑		⚑		⚑	
CONSENT AGENDA ITEMS – FOR APPROVAL/NOTING														

Item of Business	Executive Lead	Reporting period	23 Jan 2024	Feb 2024	14 Mar 2024	April 2024	16 May 2024	June 2024	11 July 2024	Aug 2024	12 Sep 2024	Oct 2024	14 Nov 2024	Dec 2024
Minutes of the previous meeting	Director of Corporate Governance	All regular meetings	⚑		⚑		⚑		⚑		⚑		⚑	
Action Log	Director of Corporate Governance	All regular meetings	⚑		⚑		⚑		⚑		⚑		⚑	
Committee Annual Cycle of Business	Director of Corporate Governance	All regular meetings	⚑		⚑		⚑		⚑		⚑		⚑	
Committee Forward Work Plan	Director of Corporate Governance	All regular meetings	⚑		⚑		⚑		⚑		⚑		⚑	
Committee Annual Report	Director of Corporate Governance	Annually					⚑							
Quality & Safety Committee Terms of Reference	Director of Corporate Governance	Annually	⚑ Defer to July 24						⚑					
Quality & Safety Committee Annual Self-Assessment	Director of Corporate Governance	Annually							⚑					
WHSSC Quality & Patient Safety Committee Chairs Report	Director of Corporate Governance	Bi-monthly	⚑				⚑				⚑			
Putting Things Right Annual Report	Director of Corporate Governance	Annually							⚑					
Organisational Wide Policies for Approval	Director of Corporate Governance	As and when they arise												
Clinical Policies Highlight Report	Executive Medical Director	Bi-Annually					⚑						⚑	
Safeguarding & Public Protection Annual Report	Director of Nursing	Annually											⚑	
Welsh Ambulance Services NHS Trust Patient Experience Report Update has been included in the Unscheduled Care Group Highlight Report for July 2023	Director of Nursing	Quarterly	⚑				⚑		⚑				⚑	
Controlled Drugs Local Intelligence Network (CDLIN) Annual Report	Medical Director	Annually					⚑							
Cancer Services Annual Report	Medical Director	Annually					⚑							
Prescribing Annual Report	Medical Director	Annually											⚑	
RADAR Committee Highlight Reports (Annual Report and Mid-Year Update) – to include updates on Sepsis Compliance – Quality Improvement	Medical Director	Bi-Annually					⚑ Now July 24		⚑				⚑	
Clinical Audit Quarterly Report	Medical Director	Quarterly			⚑				⚑				⚑	
Clinical Audit Annual Plan	Medical Director	Annually			⚑									
Clinical Education Annual Report	Director of Nursing	Annually											⚑	

Item of Business	Executive Lead	Reporting period	23 Jan 2024	Feb 2024	14 Mar 2024	April 2024	16 May 2024	June 2024	11 July 2024	Aug 2024	12 Sep 2024	Oct 2024	14 Nov 2024	Dec 2024
Individual Patient Funding Request Annual Report	New Chair being appointed	Annually									⚑			
Health, Safety & Fire Sub Committee Highlight Reports	Executive Director for People	Quarterly			⚑				⚑				⚑	
Radiation Safety Committee Annual and Mid-Year Updates	Director of Therapies & Health Sciences	Bi-Annually			⚑								⚑	
Covid 19 Inquiry Preparedness	Director of Nursing	Bi-Annually			⚑								⚑	
Nosocomial Investigation Update Report	Director of Nursing	Bi-Annually	⚑ Defer to May 2024				⚑		⚑					
Ombudsman's Annual Letter and Annual Report	Director of Nursing	Annually									⚑			
Human Tissue Authority Act Progress Report	Chief Operating Officer	Bi-Annually					⚑						⚑	
CWM TAF Morgannwg Carers End of Year Progress Report 2022/23	Director of Nursing	Annually							⚑					
Organ Donation Committee Annual Report	Medical Director	Annually											⚑	
Access to Medicines Committee	Medical Director	Annually											⚑	

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

QUALITY & SAFETY COMMITTEE – FORWARD WORK PLAN				
Origin of Request	Category of Report / Presentation (Deferred Item / Additional Item / Ad-Hoc Item)	Item Title	Lead Officer	Intended Meeting Date
Request made by the Quality & Safety Committee Chair	Additional Item	Annual Quality Work Plan	Director of Nursing	Discussion held at agenda planning. Noted that an Annual Quality Report would need to be produced as opposed to an Annual Quality Work Plan. Date for presentation of the Annual Quality work plan to be confirmed
Request received from the Head of Nosocomial Investigation Team	Additional Item	CTMUHB Nosocomial Covid 19 Incident Management Programme - Delivery Unit (NHS Executive) Interim Learning Report	Executive Director of Nursing	On agenda Closure report being presented to the meeting being held on 16 May 2024
Email Request received from the Senior Nurse Community Children's Nursing Services	Additional Item	Was Not Brought Policy – For Approval	Director of Nursing	Was planned for 21 November 2023 – To be deferred – date to be confirmed
Email Request received from the Head of Safeguarding	Additional Item	Deprivation of Liberty Protection Safeguards Policy	Director of Nursing	Was planned for 21 November 2023 – To be deferred – date to be confirmed

Origin of Request	Category of Report / Presentation (Deferred Item / Additional Item / Ad-Hoc Item)	Item Title	Lead Officer	Intended Meeting Date
Email request received from the Medical Directorate Business Manager	Additional Item	New NICE Guidance Process	Medical Director	Was planned for 14 March 2024 – Now 16 May 2024 – On agenda
Email request received from the Welsh Language Services Manager	Additional Item	Welsh Language Active Offer Policy	Executive Director of Nursing	Was planned for 14 March 2024 – Now 16 May 2024 – On agenda
Request made by Executive Director of Nursing at agenda planning session for this item to be added to the agenda	Additional Item	NHS Wales Joint Commissioning Committee	Executive Director of Nursing	Planned for 16 May 2024 – On agenda
Request made by Executive Director of Nursing at agenda planning session for this item to be added to the agenda	Additional Item	Infection, Prevention & Control Strategy	Executive Director of Nursing	Planned for 16 May 2024 – On agenda
Request made by Executive Director of Nursing at	Additional Item	Nursing & Midwifery Plan	Executive Director of Nursing	Planned for 16 May 2024 – On agenda

agenda planning session for this item to be added to the agenda				
Email request received from the Executive Medical Director	Additional Item	Body Store Recommendations from Welsh Government	Executive Medical Director	Planned for 15 July 2024
Email request received from the Assistant Director of Concerns, Legal Services, Clinical Audit & Informatics	Additional Item	Organisational Learning Policy	Executive Director of Nursing	Planned for 15 July 2024
Email request received from the Deputy Chief Operating Officer	Additional Item	Parc Prison Health Care - A Year on Report	Deputy Chief Operating Officer	Planned for 15 July 2024

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Completed Activity From the Forward Work Programme:

Origin of Request	Category of Report / Presentation (Deferred Item / Additional Item / Ad-Hoc Item)	Item Title	Lead Officer	Intended Meeting Date
Email request received from the Director of Improvement & Innovation	Additional Item	ICTM Annual Report	Director of Improvement & Innovation	Completed Received and discussed at the meeting held on 14 March 2024
Suggested as an item for discussion at the September 2023 Board meeting	Additional Item	Consequences of Endoscopy Delays from a Quality & Safety Perspective	Chief Operating Officer	Completed Agreed at agenda planning that given the improvement in Endoscopy Delays it was felt that this matter no longer needed to be received as a spotlight report.
Email request received from the Assistant Director of Concerns, Legal Services, Clinical Audit & Informatics	Additional Item	Enhanced Learning Programme	Executive Director of Nursing	Completed No longer a need for this report to be presented to the Quality & Safety Committee

Agenda Item
9.2.4

Quality & Safety Committee

Clinical Policies Highlight Report

Dyddiad y Cyfarfod / Date of Meeting	16/05/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Dr Esther Flavell, Assistant Medical Director Quality & Clinical Effectiveness Abbie Jenkins, Medical Directorate Support Manager
Cyflwynydd yr Adroddiad / Report Presenter	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
New structure details shared with all care group leaders	January 2024	New structure accepted at Operational Management Board

Acronyms / Glossary of Terms	

1. Situation /Background

1.1 Since September 2023, a new process for the approval of Clinical Policies has been implemented. The new approach allows Care Groups to review and approve policies first, and then present directly to Operational Management Board for approval without further delay.

1.2 Approved policies that have been taken to the Operational Management Board are collated by the Assistant Medical Director for Quality and Safety and presented to Quality & Safety Committee. They are also added to SharePoint.

1.3 The Care Groups have more ownership of the development of policies rather than having to attend the Clinical Policies Group as previously.

1.4 The purpose of this report is to provide the committee with an outline of the policies approved at Operational Management Board in the last six months.

2. Specific Matters for Consideration

2.1 This is a new structure and there are few policies to report from the last six months.

2.2 In relation to the process put into place for the approval of clinical policies, the following policies have been approved during the period October 2023 to April 2024:

- Policy for the Safe Administration of Eye Drops by Unregistered Healthcare Practitioners (appendix 1)

3. Key Risks / Matters for Escalation

3.1 The number of policies approved at Operational Management Board is expected to increase in number and we will continue to report twice a year.

3.2 We have identified some policies that have been approved at Care Group Operational Management Board meetings, but have now asked the authors to take them to the Health Board Operational Management Board meeting in line with the new process.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below:

Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	Not Applicable
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Enablers of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Not Applicable
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Domains of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Effective
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd?* / Quality *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg?* / Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below:
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	

Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.
Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.

5. Recommendation

5.1 The Committee are asked to NOTE the contents of this report

6. Next Steps

6.1 Six monthly report to Quality & Safety Committee November 2024.

Safe Administration of Eye Drops By Unregistered Healthcare Practitioners

Document Type:	Clinical Policy
Ref:	CLP 145
Author:	Zahra Rasheed, Clinical Optometrist
Executive Sponsor:	Executive Nurse Director
Approved By:	Operational Management Board
Approval / Effective Date:	29/11/2023
Review Date:	29/11/2026
Version:	1

Target Audience:

People who need to know about this document in detail	Ophthalmology Teams, Ophthalmology Clinical Leads, Head of Optometry, Head of Orthoptics, Ophthalmology Nurse Manager, Medical Illustration Manager
People who need to have a broad understanding of this document	Clinical Directors Head & Neck, Outpatients Head of Nursing, Ophthalmology Locality Manager, Head of Medicines Management, Quality and Safety Committee
People who need to know that this document exists	Medicines Management Committee, Senior Leaders, all employees within CTM Ophthalmology Department

Integrated Impact Assessment:

Equality Impact Assessment Date & Outcome	Date:
	Outcome:
Welsh Language Standard	No
Date of approval by Equality Team:	(00/00/0000)
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

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Abbreviations

The following abbreviations are used throughout this document:

AHP – Allied Health Professional
IP - Independent Prescriber
MHRA – Medicines and Healthcare Products Regulatory Agency
PGD – Patient Group Directions
PSD – Patient Specific Directions
RCO – Royal College of Ophthalmologists
RP - Registered Practitioner

UHP – Unregistered Healthcare Professional

1. Policy Statement

This policy outlines the legal and quality assurance framework within which unregistered healthcare practitioners (UHPs) can safely administer specified diagnostic eye drops without a prescription or patient-specific directive (PSD), in specific clinics and defined circumstances, within the Ophthalmology Department in CTMUHB. It outlines the necessary training, competencies and revalidation required to ensure the safe administration of these ophthalmic medications by this subgroup of staff.

2. Scope of Policy

This document serves to define the specific drugs and clinics this procedure applies to. All patients (both new and follow-up) in these selected clinics follow a standard patient care pathway - each patient receives the same diagnostic eye drops at each visit to that clinic, barring the contraindications listed in Appendix A. Essentially, a patient having an appointment in these clinics shall serve as the directive that the patient should have these drops instilled, exclusions withstanding. It is the responsibility of the supervising consultant in charge of such clinics to ensure that patients booked into these clinics are clinically suitable for instillation of drops by the UHP acting under this policy, including the use of any prescription medications.

In these specific clinics only, UHPs may instil the specified eye drops following the guidelines as documented below and taking into account the exclusion/inclusion criteria in Appendix A. Registered practitioners (RPs) are exempt from the training requirements of this protocol.

As part of this protocol, a cross-site Pathway Implementation Lead will be identified to ensure overall SOP adherence, oversee audit cycles, and act as a single point of contact that any clinician can raise concerns regarding staff/pathway performance to. A clear route of reporting concerns is particularly important as UHPs in Ophthalmology are a cross-professional group with different line managements.

This document is to be used in conjunction with the HB's Standard Operating Procedure for the Instillation of Eye Drops policy[3]. The medications and clinics within the scope of this policy are defined below.

Designated Clinic	Eye drops to be instilled, in order
Virtual or face-to-face diabetic retinopathy clinics	1. Tropicamide 1% both eyes 2. Phenylephrine 2.5% both eyes
Intravitreal injection clinics	1. Tropicamide 1% both eyes
Virtual or face-to-face glaucoma clinics	1. Lidocaine 4%/Fluorescein 0.25% 2. Tropicamide 1% both eyes
Colour fundus photo or fluorescein angiography clinic	1. Tropicamide 1% both eyes 2. Phenylephrine 2.5% both eyes
Virtual or face-to-face macular/ medical retina clinics	1. Tropicamide 1% both eyes 2. Phenylephrine 2.5% both eyes

Table 1: Clinics currently included in this protocol, and the specified eye drops required for each

Ophthalmic medications for administration

The following ophthalmic diagnostic drugs may be administered by the UHP in line with this policy:

- Tropicamide 1% Eye Drops (Minims)
- Phenylephrine 2.5% Eye Drops (Minims)
- Lidocaine hydrochloride 4%/ Fluorescein sodium 0.25% Eye Drops (Minims)

Further details on these medications and their use in clinic are provided in Appendix A. The specific combination & order of eye drops will be dependent on the clinic the patient is attending, as set out in Table 1. For example, a UHP working in a virtual diabetic retinopathy clinic will instill one drop in each eye of tropicamide 1%, then phenylephrine 2.5% in all patients (unless exclusion criteria are present). Unless a reason can be clearly identified e.g. an artificial eye, the required drops shall be instilled in both eyes for all patients.

Ophthalmology clinics in which this policy shall apply

1) <u>UHP authorised to instil under this protocol</u>

The table above specifies the clinics this protocol applies to, and the drugs required for patients attending these clinics, including the order of instillation. Appropriate clinic documentation will be completed at every visit, clearly indicating the drops instilled, batch number, expiry date and the designation of the healthcare professional instilling them. All clinics will be operating on hospital sites within CTMUHB, during normal working hours. Drugs will be securely stored in the Ophthalmology department, as per the HB Medicines Storage in Hospitals Procedure.

Implementing this policy will likely facilitate the development of new patient pathways, as clinics make further use of the expanded role of UHPs. The above clinic list therefore is not exhaustive or final. The corresponding instructions for any future clinics that this protocol is applicable to (i.e. a clinic with a uniform patient care pathway in which all patients receive the same diagnostic eye drops at every visit), will be added to Table 1 as a minor amendment.

2) UHP acting under supervision of an RP

In all other CTMUHB Ophthalmology clinics (e.g. clinics not listed in Table 1), the case mix of patients is such that the input of an RP is needed to determine which, if any, diagnostic eye drops are to be instilled, by evaluating each patient's case. Any eye drops required are prescribed by a doctor/IP/AHP with exemptions, via prescription or PSD. Instillation of these eye drops can be delegated to a UHP, acting on the valid prescription and subject to the conditions in this policy. A PGD however, does not allow for delegation of tasks (see Section 3 below).

3. Aims and Objectives

Ophthalmology is the highest volume outpatient specialty in the NHS and is subject to long-standing capacity issues, leading to nationwide instances of patient harm and vision loss. Demand for ophthalmic services is growing, particularly with an ageing population and an increasing incidence of diabetes. The effects of the COVID-19 pandemic have further exacerbated this. Sustainably increasing clinic capacity and throughput, whilst prioritising patient safety and experience, is thus a vital priority for the department.

Upskilling of the multidisciplinary workforce is a proven method of meeting the demand-capacity gap, and it is prudent for this Ophthalmology workforce to be working towards the top of their skill mix. UHPs are an important part of the multi-disciplinary workforce in Ophthalmology, and with the appropriate training and education, are able to deliver safe and high-quality care in selected and defined tasks previously provided by RPs. This subsequently releases RPs to provide higher levels of patient care, as per their skill mix. Additionally, successful clinical delegation pathways enhance team cohesion, and job satisfaction/staff retention[5].

Recommendations for the implementation of more efficient models of ophthalmic care, including non-medical led clinics and virtual clinics, rely on standardised pathways for subspecialty cohorts that typically require the use of the same common diagnostic eye drops for each patient/visit. Prescriber delegation of the administration of diagnostic eye drops is an appropriate and well-established method of freeing up senior clinicians for more complex tasks; the task itself is relatively low-risk and frequently repeated. Delegation requires a prescription, PSD or PGD. A PGD allows for RPs to administer eye drops, but does not allow for delegation of the task of instillation to UHPs, which is a bottleneck to workforce and clinic efficiency. A UHP can

instil drops using a prescription or PSD, but this generates a volume of repetitive administration for senior prescribing clinicians, for large patient groups that are relatively homogenous in terms of ophthalmic disease, and are following standardised clinic pathways. In modern ophthalmic services with new, efficient models of care and high volume clinics, this has created a barrier to increasing clinical capacity.

Upskilling UHPs to safely carry out diagnostic eye drop administration in selected clinic care pathways without a prescription will significantly improve Ophthalmology clinic capacity, reducing harmful patient delays. High quality care provision by this underutilised subgroup of the workforce can be achieved through competency-based training/accreditation, a comprehensive SOP, and ongoing audit and revalidation, as set out in this pathway.

4. Definitions

Supervising Consultant

The named ophthalmology consultant responsible for the clinic/care pathway, identified at the top of each clinic sheet/proforma. Supervision can refer to indirect clinical oversight; the consultant may not be on site at the particular times of these clinics, but they are available to give advice/assistance remotely, with contingency plans if they are not available.

Registered Practitioner (RP)

An accredited healthcare professional e.g. nurse, doctor (all grades), orthoptist or optometrist, who is registered with a regulated professional body.

Unregistered Healthcare Professional (UHP)

A non-registered healthcare worker e.g. health care assistant, ophthalmic technician, medical illustrator, or nursing support worker, who is not part of a regulated body or on an accredited register.

Allied Health Professional (AHP) with exemptions

Orthoptist professionals with a higher post-registration qualification in medicine exemptions are able to supply and administer certain medicines, including those listed in this policy. Appropriate delegation of instillation is within their professional remit.

Independent Prescriber (IP)

Ophthalmic nurse and optometrist professionals with a higher post-registration qualification in independent prescribing are able prescribe, supply and administer ophthalmic medicines including those covered by this policy. This includes appropriate delegation of instillation.

Senior Clinician

The named RP (ophthalmologist/nurse/optometrist/orthoptist) responsible for the specified non-consultant clinic, identified at the top of each clinic sheet/proforma.

Virtual Clinics

Patients attend a hospital site for a diagnostic data collection and imaging appointment, the results of which are later clinically assessed, and managed, remotely by an RP.

Face-to-Face Clinics

Traditional consultations where the patient is assessed and receives treatment or a management plan within the same consultation.

Delegation

The process of an RP appropriately allocating a specific clinical task to a competent UHP, in a specified situation.

5. Responsibilities

Responsibilities with respect to this policy are delineated below:

Supervising consultant
Overall responsibility for the instillation of drops by UHP lies with the named ophthalmology consultant in whose clinic they are operating. This will be the case whether the consultant is present physically in the clinic or not (newer patient pathways such as virtual clinics may not have a doctor physically in attendance). They also retain responsibility for ensuring patients booked into these clinics are appropriate in terms of risk profile, including the suitability of each patients' prescription medication and the diagnostic drugs covered by this policy (see Appendix L).

Registered practitioner (RP)
In clinics where an RP (eg. nurse, doctor, orthoptist, or optometrist) is working with the UHP, the RP has a responsibility to have determined that the UHP has the knowledge and skill level required to perform the task competently to the required standard e.g. confirming UHP has valid competence in instilling drops.

Unregistered Healthcare Professional (UHP)
The UHP accepts responsibility to perform the task competently and is responsible for maintaining the level of knowledge and skills required to perform the task correctly and safely as per HB policies and procedures. In order to administer ophthalmic medications, the UHP must complete the required training, and achieve and maintain competency on an ongoing basis. They must follow the procedures and contingencies detailed here, and not make standalone clinical judgements even when working independently.

Senior Clinician

Where there is no supervising consultant e.g. non-consultant-led clinic, the overall responsibility for the instillation of drops by UHPs lie with the named RP in whose clinic they are operating. This will be the case whether the RP is present physically in the clinic or not (newer patient pathways such as virtual clinics may not have a doctor physically in attendance).

Workplace Mentor

As an RP knowledgeable in medicines management, they are responsible for helping to assess UHP's competency in eye drop administration technique. They provide advice and guidance specific to this task, and help ensure trainee adherence to the training/renewal pathway.

Pathway Implementation Lead

Responsible for ensuring overall SOP adherence across the department, and overseeing the audit cycles. They provide a lead mentor role that any clinician can contact to raise concerns regarding staff/pathway performance.

6. Training Pathway

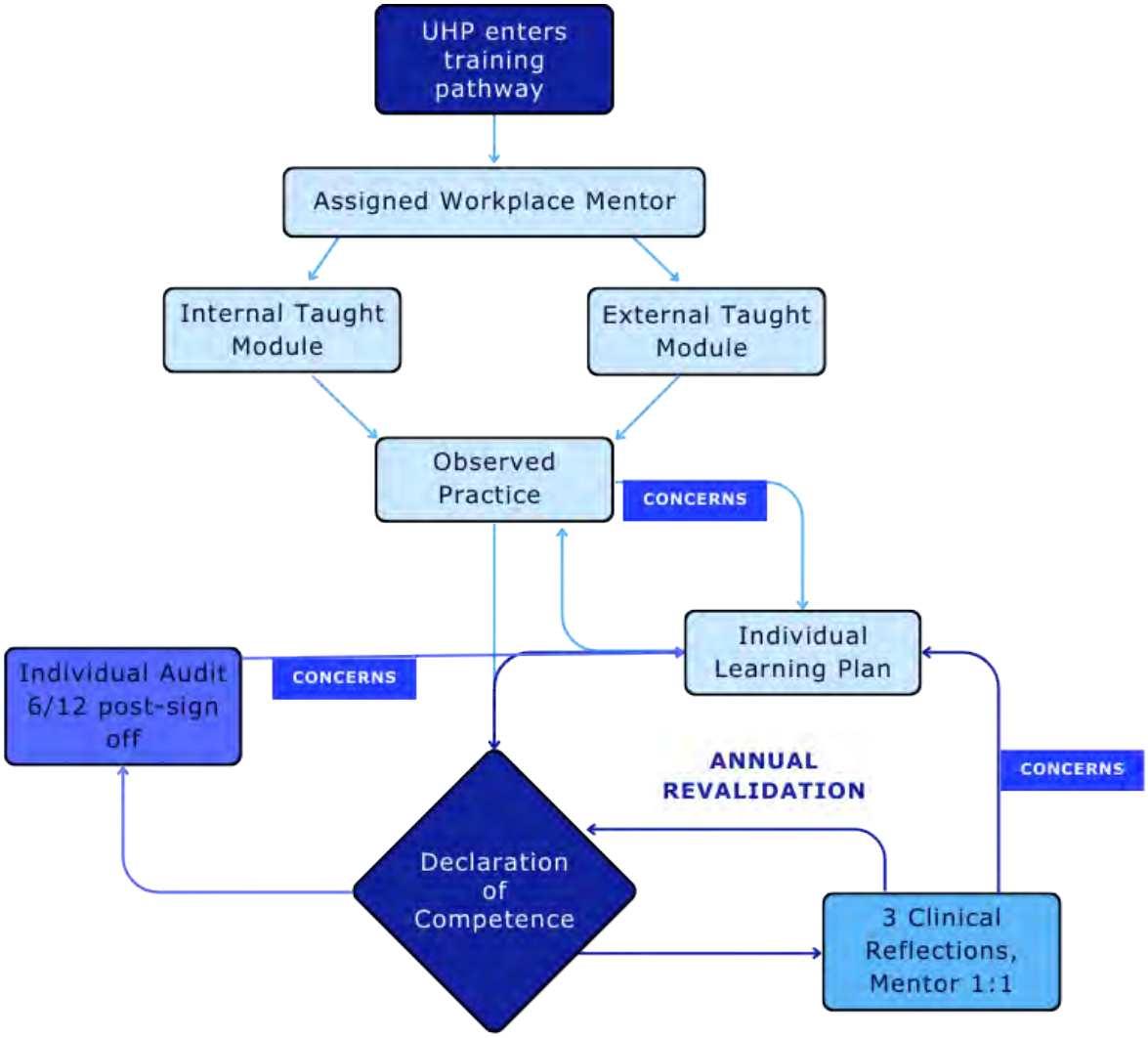


Fig. 1: Summary of Training Pathway

Entry Qualifications

- Employed by CTMUHB Ophthalmology at Band 3 or above, with this task within the sphere of their job description.
- Written line manager authorisation to work under this policy
- Completed HB mandatory training in Infection Prevention & Control, Safeguarding Adults and Basic Life Support and Anaphylaxis management (Resuscitation).
- Assigned a departmental Workplace Mentor for this task

Training

- Complete the relevant taught module (either internal or external)
- Complete required independent observed practice (target defined by either internal or external training)
- Complete Declaration of Competence (Appendix I)

Taught Module

The UHP will undertake either:

- Department-specific training in the safe instillation or eye drops, conducted by an appropriate RP with knowledge of HB medicines management. This RP is responsible for ensuring the UHP has achieved a satisfactory knowledge base and competencies with which to perform this task safely. OR
- External training module provided by an accredited institution. Examples of this include Agored Cymru's "Administer Eye Drops to Individuals within the Health Care Sector" module, or Pearson Qualifications' "Preparing For Diabetic Retinopathy Screening" module.

Access to two taught options within this policy allows the department to benefit from the robustness of externally validated education and training whilst also being able to utilise high-quality local training even when funding for external training courses is not available. It also gives the department the opportunity to modify training bespoke to audit results/departmental outcomes, if necessary; this has been a hallmark of successful clinical delegation programmes elsewhere[5].

In addition to the practical skill of drop instillation, both taught programmes include:

- Identifying a valid prescription
- Medication characteristics, including dose, frequency, side-effects, inclusion and exclusion criteria for the administration of eye drops in line with this policy
- Risks and issues around administering the medication e.g. Acute angle closure, anaphylaxis signs, and where to seek assistance if required
- Professional reflective practice
- Importance of auditing practice

See Appendix G for in-house teaching programme and learning objectives.

Observed Practice

This includes a log of directly observed, independent practice, of a set number of instillations of eye drops, supervised by an RP (see Appendix H). The supervisor will evaluate the trainee's technique and provide feedback. The number of required patients logged depends on the training route:

- Internal course – 10 patients
- External course – as per course requirements (e.g. Agored Cymru require 4 hours of clinical shadowing followed by 4 supervised instillations)

The mentor will address any competence concerns identified by supervisor feedback via 1:1 targeted instruction/learning plan, which will involve repeating some or the entire observed log, as appropriate.

Declaration of Competence

Following completion of the UHPs competency assessment documentation the trainer and the UHP will both sign the Declaration of Competency (Appendix I), valid for 12 months. Copies will be filed in the UHPs personal file, ESR, archived, and given to the UHP.

Revalidation Process

Ascertaining competence requires annual revalidation, consisting of:

- 3 clinical reflection exercises, demonstrating understanding and use of this policy, to be discussed with mentor
- Mentor discussion with trainee ascertaining any competence concerns

  Mentor discussion with trainee's line manager, relevant senior clinicians, and any relevant Datix reports to establish if there are any concerns in this area.

7. Standard Operating Procedure

This is detailed in Appendix C, which aligns with the department's existing Standard Operating Procedure For The Instillation Of Eye Drops for RPs[3].

8. Documentation and Audit

Clinical Record Keeping

The following information is to be contemporaneously included in every patients' medical records:

- Drug name
- Dose
- Eye administered
- Date and time of administration
- Batch Number
- Expiry date
- Details of any adverse effects, action taken and outcome
- Printed name, signature and position of person administering medication

For ease and consistency, pre-printed stickers/stamps for written clinical records will be made available for each drug covered in this pathway. The above notation will be

replicated in the clinic templates used for any electronic patient record that supercedes written records.

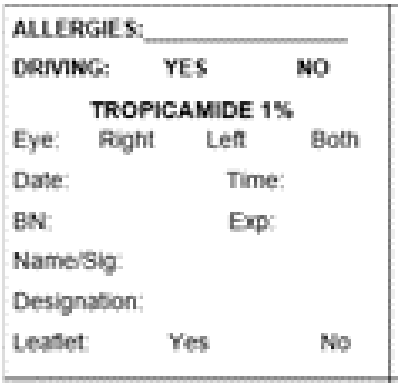


Fig. 2: Example of Tropicamide 1% sticker for clinical notes.

Training Records

Completed training documentation (Appendices H-K) will be stored in UHPs personnel files, with a copy of completed annual validation recorded on the ESR Compliance and Competency portal, with a 12-month expiry. This will allow for clear notice of approaching expiry, and allow line managers to monitor compliance at appraisal etc.

Audit

New Trainees

Each UHP will have their initial notes reviewed by their mentor or clinical manager after 6 months of working under this policy. This will include paperwork reviews from at least 10 completed cases, to identify any learning needs and ensure safe practice and protocol adherence. Any concerns raised with regard to knowledge or clinical skills will be managed by the development of an individual learning plan, with action points including supervision, observation and reassessment of knowledge and skills as needed.

Annual Audit

There will be an annual departmental audit of 30-50 cross-clinic sample cases to ensure procedures are adhered to, documentation is clear and legible, and the correct pathways have been followed. These audits will be managed by the Pathway Implementation Lead for this protocol, and reported to the Ophthalmology Nurse Manager, Head of Optometry and Head of Orthoptics in CTMUHB. Any problems identified via clinical incident monitoring (Datix) or patient surveys will be discussed with the relevant UHP's clinical manager and/or the supervising consultant/doctor in charge immediately.

9. Patient Safety, Adverse Events and Escalation Procedures

Action if patient declines or is excluded

If the drug is contraindicated e.g., the patient intends to drive home, or refuses eye drops, the UHP must seek advice from an RP regarding how to proceed. This could be the supervising consultant, or other ophthalmology RP present on site. Clinics may run at locations where RPs are not on site, but senior advice and instruction will always be readily available. If there is no RP on site, the UHP will telephone the senior clinician/RP for that clinic, for advice and instruction; if they are not available, the ophthalmology doctor in Eye Casualty will be contacted via telephoning 01443 443443 Ext.6061 (Royal Glamorgan Hospital) or 01656 753979 (Princess of Wales Hospital). If they are not available, the supervising consultant will then be telephoned for advice.

If tropicamide or phenylephrine eye drops are definitely contraindicated, the patient may proceed through the clinic pathway without dilation, and required clinical imaging will be acquired without dilating drops in this case. Images may be sufficient for clinical decision-making, preventing the need for a short follow-up appointment interval. There is no risk of patient harm in image acquisition.

If lidocaine/fluorescein eye drops are definitely contraindicated, the UHP will seek guidance for alternatives as above. In the unlikely event of not being able to contact an RP, the patient will be rebooked into an appropriate RP face-to-face clinic.

Pregnancy/Breastfeeding

UHPs will seek out a doctor/IP/AHP with exemptions to assess the need for eye drops in pregnant or breastfeeding patients, who will then write a PSD or prescription if drops are indicated.

Adverse events

Prior to eye drop instillation, the UHP will counsel each patient on the potential risks versus benefits of the drug, as per Appendix A. Each patient will also be provided with the relevant Patient Information Leaflet, reiterating the warning signs of an adverse reaction, and advice on seeking medical assistance if these occur once they have left the clinic (see Appendix D). Identifying adverse events, and escalation procedures, will be covered in depth in training.

Anaphylaxis

All UHPs acting under this policy will have completed mandatory training in Basic Life Support and Anaphylaxis management.

Cases of suspected anaphylactic shock (collapse, swelling around the mouth and tongue, wheeze/difficulty breathing or any other symptoms of anaphylaxis) will be managed in line with Health Board guidelines on the management of anaphylaxis (see Appendix F). If a reaction is suspected, the UHP will:

- Call for help – pull alarm bell in clinic room/call 2222.
- Call doctor/nurse in clinic for immediate assistance.
- Lay patient flat/raise patient's legs, and stay with the patient.
- At sites such as YCR/YCC/Maesteg, where there is no resuscitation team, call 999 for an ambulance.
- Once the patient is under medical care, document the episode and record the suspected allergen clearly in the notes.
- Contact the named Senior Clinician responsible for the clinic who will inform next of kin, inform the GP of the suspected allergen and complete a Datix and MHRA Yellowcard report.

Acute Angle Closure Glaucoma

If the patient shows signs of acute angle closure following the instillation of dilating drops (painful, red eye, blurred vision with nausea, severe eye/head-ache), the UHP will immediately alert a senior ophthalmic clinician, who will review the patient to determine if they are in angle closure and treat accordingly. If there is no clinician on site, the UHP will contact the on-call ophthalmology doctor immediately on 01443 443443 Ext 6061, who will arrange for urgent transfer and review. Once the patient is under medical care, they will document the episode, and contact the Senior Clinician responsible for the clinic; the latter will complete a Datix and MHRA Yellowcard report as appropriate.

Other Adverse Reactions

If a patient experiences a mild local allergic reaction around the eye (including mild redness/itching/swelling around the eyes), the UHP can advise cold compress therapy at home (a low risk but effective intervention for symptom relief). The UHP will document the suspected reaction & their advice in the patient's notes, and instruct the patient to see a local optometrist if it does not resolve or improve in 24 hours. If there is any doubt in signs observed or advice to give, the UHP will immediately seek advice from an RP or the senior clinician.

See Appendix E for a reference guide to the escalation procedure for suspected adverse reactions.

Medication Errors

If a UHP instills the incorrect drug/dosage or in the wrong eye, they will immediately report this to the RP in the clinic, as well as document the error in the clinical notes. The RP will assess the patient for any necessary clinical management, inform them of the error, and complete clinical incident reporting where required. This will be an auditable measure with a target of zero errors.

Safety Profile of Mydriatics

There is a low risk of inducing acute angle closure glaucoma from a single diagnostic application of the mydriatics included in this protocol, namely tropicamide 1% and phenylephrine 2.5%. The RCO framework[6] summarises the clinical literature regarding this risk below:

> "There have been a number of large reviews of the use of pupil dilating drops and an overview paper in the British Medical Journal in 2006 summarised these:
>
> *'A systematic review reported that out of an estimated 600 000 individuals who received mydriatic eye drops, 33 (0.006%) developed acute angle closure glaucoma, giving an estimated risk of 1 in 20 000. The same review found that in almost 4000 people whose pupils were dilated using tropicamide, none developed acute glaucoma as a result of the dilatation. We are aware of only two cases of tropicamide-induced angle closure glaucoma from the published literature. Thus, these studies place the risk of acute angle closure glaucoma caused by pharmacological pupil dilation at 1 to 6 per 20 000 people in the general population.*
>
> This review concluded that *pupil dilation is important for thorough fundoscopy, and the risk of precipitating acute angle closure glaucoma with routine use of mydriatics is close to zero.'"*

A local audit of pupil dilation in the eye department at St Thomas' Hospital showed one documented case of angle closure between 2007 and 2016, giving an approximate risk of less than 1 in 400,000. As such, the risk to patients can be summarised as low. Moreover, the instillation of these eye drops by a non-registered practitioner does not increase this risk.

There is also a low but theoretical risk of inducing adverse hypertensive effects when using phenylephrine eye drops in patients using tricyclic antidepressants and/or monoamine oxidase inhibitors. This risk is not established, and given the extensive longstanding use of phenylephrine 2.5% routinely in ophthalmic care worldwide with no reported serious adverse effects, appears minimal. The HB ophthalmology consultant body have deliberated on this low theoretical risk, and have ratified an agreement to allow instillation of phenylephrine 2.5% in the presence of contraindicated prescription medication (tricyclic antidepressants, monoamine oxidase inhibitors and antihypertensive medications – see Appendix L). This is also

explored in more detail in Appendix B, with the appropriate countermeasures implemented within this protocol to ensure patient safety is prioritised.

10. Procedure Compliance

All UHPs involved in the instillation of eye drops must be aware of their responsibility for the implementation of this procedure. This is a key element in achieving a consistent approach to the instillation of eye drops across the HB, and ensuring patient safety through high-quality standardised practice. Failure to adhere to this procedure may leave the HB vulnerable to challenge. Compliance with this procedure will be monitored via annual appraisals, annual audit and any clinical incidents or complaints. Failure to comply may be regarded as a disciplinary matter and will be dealt with under the appropriate policy.

11. Equality Impact Assessment Statement

This policy has been screened for relevance to Equality. No potential negative impact has been identified.

12. Related Policies

This procedure is designed to be used in conjunction with the department's Standard Operating Procedure For The Instillation Of Eye Drops[3].

13. Main Relevant Legislation

In response to the urgent need to redesign patient pathways and the key role of unregistered professionals in this endeavour, the Royal College of Ophthalmologists (RCO) and the UK Ophthalmic Pharmacy Group has produced specific guidance on the subject[6]. This guidance describes how instillation of drops without a prescription by unregistered health professional is possible and legal under the current regulatory framework, and has been endorsed by the MHRA Policy Division. The guidance reports:

"In summary, to facilitate the smooth and safe running of the service, unregistered health professionals may administer eye drops without a prescription provided they have been lawfully obtained by a healthcare body"

The guidance goes on to emphasise that despite a prescription not being necessary to administer appropriate drops in an eye clinic setting, it is vital that a detailed HB specific direction exists to allow the safe administration of eye drops for these patients. The Medicines Act Article 9 of the 1997 Order No 1830 states that restrictions on who can administer prescription-only medication do not apply to non-parenteral administration i.e. eye drops[4]. Eye drop instillation as a task fits within the

responsible delegation guidance provided by the College of Optometrists and the Nursing & Midwifery Council[1,5].

Deploying UHPs to instil eye drops in this way in Ophthalmology clinics is analogous to patients currently attending community diabetic retinopathy screening, with its longstanding practice of all patients receiving tropicamide 1% eye drops without a prescription, administered by UHPs. MHRA have previously stated that neither a prescription nor a patient group directive is required for retinal screeners employed by an NHS organisation[4].

14. References

1. College of Optometrists (2021) *Guidance for Professional Practice.* Delegating the instillation of eye drops. Available at: Instilling eye drops - College of Optometrists (college-optometrists.org). [Accessed 6 April 2023]
2. Cwm Taf Morgannwg University Health Board (2018) *Medicines Storage in Hospital Procedure.* Available at: Medicines Storage in Hospitals Procedure.docx [Accessed 25 September 2023]
3. Cwm Taf Morgannwg University Health Board (2023) *Standard Operating Procedure for the Instillation of Eye Drops.* Available at: Eye Drop Installation Standard Operating Procedure [Accessed 25 September 2023]
4. Medicines and Healthcare products Regulatory Agency (2007) *Advice on administering eyedrops in retinal screening programmes*. Available at:http://www.mhra.gov.uk/home/idcplg?IdcService=SS_GET_PAGE&nodeI (scot.nhs.uk). [Accessed 6 April 2023]
5. Nursing and Midwifery Council (2018) *The Code. Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates.* Delegation and accountability supplementary information to the NMC code. Available at: delegation-and-accountability-supplementary-information-to-the-nmc-code.pdf. [Accessed 5 Feb. 2023]
6. Royal College of Ophthalmologists (2020) *Ophthalmic Services Guidance:* Eye Drops Instillation by Unregistered Health Care Professionals for use within NHS Ophthalmic Services. Available at: https://www.rcophth.ac.uk/wp-content/uploads/2021/12/Eye-Drops-Instillation-by-Unregistered-Health-Care-Professionals-for-use-within-NHS-Ophthalmic-Services.pdf [Accessed 5 Feb. 2023].
7. Shore, C. B., Maben, J., Mold, F., Winkley, K., Cook, A., & Stenner, K. (2022). *International Journal Of Nursing Studies* Delegation of medication administration from registered nurses to non-registered support workers in community care settings: A systematic review with critical interpretive synthesis. 126:104121.

APPENDIX A - Medicine Characteristics

Drug name	Tropicamide 1%
Purpose	An antimuscarinic used to temporarily paralyze the iris sphincter muscle to allow dilation of the pupil, facilitating funduscopy & retinal imaging.
Indications	• All adult patients attending clinic for ophthalmic assessment or diagnostic investigation. • Pregnant patients may receive dilating drops by the UHP only after being prescribed.
Contraindications/exclusion criteria	• Patient or carer is unwilling to consent to dilation and/or assessment • Individuals aged 18 years and over and assessed as not competent to consent using the Mental Capacity Act Guidelines • Patient with raised intra-ocular pressure >21mmHg • Patient who require visual field testing or refraction imminently • Patients with a known allergy to dilating eye drops • Patients whose medical notes are not available in clinic • Patients known to have narrow angle glaucoma or where the filtration angle is known to be narrow. • Patients with an anterior chamber intraocular lens implant. • Pregnant patients in the absence of a valid prescription
Legal classification	Prescription-only medication (POM)
Formulation	1% minims, preservative-free
Dosage	One drop instilled into the lower fornix of each eye. If both dilating drops have been requested, Tropicamide 1% Eye drops will be administered PRIOR to Phenylephrine 2.5% Eye drops. A period of approximately 20 seconds should be allowed between each different medication to be administered.

Adverse reactions	Frequency not known: Erythema, irritation, pain, headache, nausea, blurred vision, Photophobia; Rarely: syncope. There is a small (0.006%) risk of precipitating acute angle closure glaucoma with pharmacological dilation. Patients are to be advised of this risk, the associated warning signs to monitor for (painful red eye/headache/blurred or loss of vision/haloes/nausea), and the importance of raising this in clinic immediately if it occurs, or seeking immediate assistance in A&E if they have symptoms at home. UHP will follow escalation procedure if these symptoms occur in clinic. Pregnant or breastfeeding patients may receive dilating drops by the UHP only after being prescribed. If known hypersensitivity, seek medical advice from senior clinician for prescription for alternative drug.
Advice/information to patient/carer	• Patient to remove contact lenses prior to instillation, advise patients not to wear them for an hour after administration. • Initial stinging on administration is likely, and temporary blurring of vision will last approx. 4-6 hours. • Patients should not drive or operate machinery for 6 hours, until vision is clear. • Dark sunglasses are recommended in bright sunlight. • Risk of acute angle closure glaucoma as above.
Storage/Handling	Store in a dry secure location at room temperature below 25°C. Protect from light.
Record Keeping	The following information must be included in every patients' medical records: • Drug name. • Dose. • Eye administered. • Date and time of administration. • Batch Number.

	• Expiry date. • Details of any adverse effects, action taken and outcome. • Printed name, signature and position of person administering medication

Drug name	Phenylephrine 2.5%
Purpose	A sympathomimetic that stimulates the radial iris muscles, used in conjunction with tropicamide 1% to achieve pupil dilatation, facilitating funduscopy & retinal imaging.
Indications	• All adult patients attending clinic for ophthalmic assessment or diagnostic investigation. • Pregnant patients may receive dilating drops by the UHP only after being prescribed.
Contraindications/exclusion criteria	• Patient or carer is unwilling to consent to dilation and/or assessment • Individuals aged 18 years and over and assessed as not competent to consent using the Mental Capacity Act Guidelines • Patient with uncontrolled hypertension or cardiac disease, or tachycardia • Patient with raised intra-ocular pressure >21mmHg • Patient who require visual field testing or refraction imminently • Patients with a known allergy to dilating eye drops • Patients whose medical notes are not available in clinic • Patients known to have narrow angle glaucoma or where the filtration angle is known to be narrow. • Patients with an anterior chamber intraocular lens implant. • Pregnant patients in the absence of a valid prescription
Legal classification	Pharmacy medication (P)
Formulation	2.5% minims, preservative-free
Dosage	One drop instilled into the lower fornix of each eye. Systemic absorption may be reduced by compressing the lacrimal sac at the medial canthus for a minute during and following the instillation of the drops. (This blocks the passage of the drops via the naso-lacrimal duct to the wide absorptive area of the nasal and pharyngeal mucosa).

	If both dilating drops have been requested, Tropicamide 1% Eye drops will be administered PRIOR to Phenylephrine 2.5% Eye drops. A period of approximately 20 seconds should be allowed between each different medication to be administered.
Adverse reactions	Frequency not known: Erythema, irritation, pain, headache, nausea, blurred vision, Photophobia; Rarely: syncope. There is a small (0.006%) risk of precipitating acute angle closure glaucoma with pharmacological dilation. Patients are to be advised of this risk, the associated warning signs to monitor for (painful red eye/headache/blurred or loss of vision/haloes/nausea), and the importance of raising this in clinic immediately if it occurs, or seeking immediate assistance in A&E if they have symptoms at home. UHP will follow escalation procedure if these symptoms occur in clinic. Pregnant or breastfeeding patients may receive dilating drops by the UHP only when prescribed. If known hypersensitivity, seek medical advice from senior clinician for prescription for alternative drug.
Advice/information to patient/carer	• Patient to remove contact lenses prior to instillation, advise patients not to wear them for an hour after administration. • Initial stinging on administration is likely, and temporary blurring of vision will last approx. 4-6 hours. • Patients should not drive or operate machinery for 6 hours, until vision is clear. • Dark sunglasses are recommended in bright sunlight. • Risk of acute angle closure glaucoma as above.
Storage/Handling	Store in a dry secure location at room temperature below 25°C. Protect from light.

Record Keeping	The following information must be included in every patients' medical records: • Drug name. • Dose. • Eye administered. • Date and time of administration. • Batch Number. • Expiry date. • Details of any adverse effects, action taken and outcome. • Printed name, signature and position of person administering medication

Drug name	Lidocaine hydrochloride 4%/ Fluorescein sodium 0.25%
Purpose	A combined diagnostic stain and topical anaesthetic used in the measurement of intraocular pressure by Goldmann tonometry.
Indications	• All adult patients attending clinic for glaucoma diagnostic investigation or follow-up assessment.
Contraindications/exclusion criteria	• Patient or carer is unwilling to consent to assessment • Individuals aged 18 years and over and assessed as not competent to consent using the Mental Capacity Act Guidelines • Patients with a known allergy to lidocaine, fluorescein, or amide-type local anaesthetics • Patients with very inflamed red eyes. • Patients whose medical notes are not available in clinic • Patients who do not consent to have anaesthetic eye drops administered.
Legal classification	Prescription-only medication (POM)
Formulation	4%/0.25% minims, preservative-free
Dosage	One drop instilled into the lower fornix of each eye. If insufficient corneal anaesthesia once contact tonometry attempted, a further drop can be instilled.
Adverse reactions	Very rare: allergic reactions, ranging from local (allergic conjunctivitis, peri-orbital oedema) to systemic (anaphylactic reaction, urticaria, skin rash). UHP will follow escalation procedure if these symptoms occur in clinic. Use with caution in an inflamed eye as hyperaemia greatly increases the rate of systemic absorption through the conjunctiva. If known hypersensitivity, seek medical advice from senior clinician for prescription for alternative drug.

Advice/information to patient/carer	• Patient to remove contact lenses prior to instillation, advise patients not to wear them for an hour after administration. • Initial stinging on administration and temporary blurring of vision likely. • Patients should not rub eyes • Dark sunglasses are recommended in bright sunlight. • Serious allergic reactions are very rare, but patients should seek immediate medical attention if they develop symptoms (feeling faint, difficulty breathing, mouth/throat swelling, collapse) after leaving the clinic.
Storage/Handling	Store in a dry secure location at room temperature below 25°C. Protect from light.
Record Keeping	The following information must be included in every patients' medical records: • Drug name. • Dose. • Eye administered. • Date and time of administration. • Batch Number. • Expiry date. • Details of any adverse effects, action taken and outcome. • Printed name, signature and position of person administering medication

Further product information for each drug is available in the British National Formulary (BNF) or the Summary of Product Characteristics (SPC).

This Appendix will be provided to each UHP prior to commencing their observed training log, and a copy will be available in each clinical area.

APPENDIX B – Phenylephrine 2.5% Safety Profile

Phenylephrine 2.5% has a long history of routine ophthalmic use worldwide, including in elderly populations with an increased risk of hypertensive crisis. Ophthalmic solutions of phenylephrine are available from 1-10%, making it difficult to isolate the specific risks of potential ADRs at lower concentrations.

The benefits of maximum pupil dilation (and peripheral retinal view) via dual-dilation must be considered against the potential ADRs of phenylephrine. In medical retina clinics where missed pathology in the retinal peripheries can lead to irreversible sight loss, and many patients are predisposed to recalcitrant pupils, dual-dilation is medically justified. In glaucoma clinics where this is less of a risk, only tropicamide is indicated for dilation as per this policy (see Table 1).

The Summary of Product Characteristics for Phenylephrine 2.5% eye drops include contraindications for its use in patients with cardiac disease and hypertension, due to suspected effects on increasing blood pressure and heart rate seen at higher concentrations or via oral/IV routes[4]. A large-scale systematic review in 2015 found Phenylephrine 2.5% eye drops did not cause any significant changes to blood pressure or heart rate, and is thus safe to use routinely as a diagnostic tool[3].

A further cited contraindication/suspected drug interaction by the manufacturer is its use in patients using monoamine oxidase inhibitors (MAOIs) and/or tricyclic antidepressants (TCAs), due to serious cardiovascular reactions seen with higher doses/other drug routes[4]. This risk has not been confirmed, with no case studies in the literature (see detailed Medicines Information response below). Taking drug/medical histories and assessing for potential drug interactions is outside the scope of job descriptions/clinical responsibilities for UHPs, and given the limited evidence for this suspected interaction, is not necessary for this protocol. However, several compensatory measures detailed below have been included in this protocol to ensure any potential risks to patients are minimised.

Plasma concentrations of phenylephrine reach their maximum 20 minutes after drop instillation[2]. This would be within the approximate window of appointment duration so any potential crises would be escalated/managed via the ADR procedures detailed in this policy. The patient information leaflet provided also advises patients to seek medical attention if they feel unwell (Appendix D).

To attempt to offset the low but potential risks of 2.5% phenylephrine, the following countermeasures have been included in the policy and technique training materials:

1. Conjunctival hyperaemia – conjunctival vessel dilation is a risk factor for increased systemic drug absorption[4]. Therefore, marked red eyes are a contraindication for UHPs to instil phenylephrine under this SOP, without alerting a senior clinician (who can then override this via a signed PSD if indicated)
2. Closed eye and nasolacrimal occlusion – pressure over the medial canthal area, to occlude the nasolacrimal duct, demonstrably reduces systemic absorption. Drug absorption via the highly vascularised nasal mucosa allows it to enter the venous system directly without being metabolised by the liver[1]. UHPs will thus instruct patients to keep their eyes closed post-phenylephrine instillation (which

also has been shown to reduce systemic absorption levels) and press their finger gently into the medial canthus for at least 1-2mins to reduce their risk of potential systemic ADRs.

3. No repeat drops – this protocol limits the use of phenylephrine to 1 drop in each eye, even when it is suspected that instillation was incorrect e.g. patient moved unexpectedly. This ensures dosages are controlled to the lowest possible, despite the drug license allowing for a further drop if needed.
4. Wiping excess spillage – immediately wiping away excess drops from the cheeks and periorbital area can prevent accidental swallowing and minimise any cutaneous absorption.

By incorporating these measures, both patient safety and clinical efficiency are prioritised, to the benefit of patients.

References

1. Flach AJ (2008) *Transactions of the American Ophthalmological Society* The importance of eyelid closure and nasolacrimal occlusion following the ocular instillation of topical glaucoma medications, and the need for the universal inclusion of one of these techniques in all patient treatments and clinical studies. 106:138-45.
2. Kumar V, Schoenwald RD, Barcellos WA, Chien DS, Folk JC, Weingeist TA. Aqueous vs Viscous Phenylephrine: I. Systemic Absorption and Cardiovascular Effects. *Arch Ophthalmol.* 1986;104(8):1189–1191.
3. Stavert B, McGuinness MB, Harper CA, Guymer RH, Finger RP (2015) Cardiovascular Adverse Effects of Phenylephrine Eyedrops: A Systematic Review and Meta-analysis. *JAMA Ophthalmol.* 133(6):647-52
4. Summary of Product Characteristics – Minims Phenylephrine Hydrochloride 2.5%w/v Eye Drops, Solution. Bausch & Lomb U.K Limited. Accessed via Minims Phenylephrine Hydrochloride 2.5%w/v Eye Drops, Solution - Summary of Product Characteristics (SmPC) - (emc) (medicines.org.uk) on 02/06/23 [date of revision of the text March 2016].

04/04/23 Correspondence from CTMUHB Medicines Information, Pharmacy Department re: evidence for an interaction between phenylephrine hydrochloride 2.5% eye drops and monoamine oxidase inhibitors (MAOIs) or tricyclic antidepressants (TCAs).

As you are aware, the manufacturers of Phenylephrine Hydrochloride 2.5%w/v Eye Drops, contraindicate their use in patients on monoamine oxidase inhibitors and tricyclic antidepressants (and anti-hypertensive agents including beta-blockers).[1] This is because of an increased risk of adrenergic reactions when used simultaneously with, or up to three weeks after, the administration of MAOIs and a possible increase in the pressor response to adrenergic agents and the risk of cardiac arrhythmia in patients receiving tricyclic antidepressants.[1] This contraindication appears to have

been extrapolated from evidence of an interaction between oral or intravenous phenylephrine with MAOIs and intravenous phenylephrine with TCAs as detailed below. Whether the effects of phenylephrine eye drops are also enhanced is uncertain, but some caution would be prudent until they have been shown to be safe.[2]

Phenylephrine can be absorbed systemically from the eye with the extent of ocular penetration determined by the condition of the cornea. A healthy cornea presents a physical barrier, in addition to which, some metabolic activity may occur. Where the corneal epithelium is damaged, the effect of the barrier and the extent of metabolism are reduced, leading to greater absorption.[1] *Serious cardiovascular reactions including arteriospasm coronary, ventricular arrhythmia and myocardial infarction have occurred following topical use of 10% phenylephrine (frequency not known). These sometimes fatal reactions have usually occurred in patients with pre-existing cardiovascular disease.*[1] *Palpitations, tachycardia, extrasystoles, arrhythmias are also listed as undesirable effects by the manufacturers of phenylephrine eye drops (frequency not known).*[1]

MAOIs
The concurrent use of oral phenylephrine and MAOIs can result in a potentially life-threatening hypertensive crisis. The interaction between the MAOIs and oral phenylephrine is established, serious and potentially life-threatening: concurrent use, or use within 14 days of stopping an MAOI, is generally contraindicated. The effects of parenteral phenylephrine may be approximately doubled by MAOIs.[2]

TCAs
Tricyclic antidepressants might enhance the effects of phenylephrine on blood pressure. Limited evidence suggests that they may increase the risk of arrhythmias developing.[2]

Summary
In summary, the manufacturers of Phenylephrine Hydrochloride 2.5%w/v Eye Drops, contraindicate their use in patients on monoamine oxidase inhibitors and tricyclic antidepressants. Evidence for the interaction is limited and has been extrapolated from information on interactions between oral or intravenous phenylephrine with MAOIs and intravenous phenylephrine with TCAs. An interaction between topical preparations of phenylephrine and MAOIs or TCAs has not been established but some caution would be prudent.

References

1. *Summary of Product Characteristics – Minims Phenylephrine Hydrochloride 2.5%w/v Eye Drops, Solution. Bausch & Lomb U.K Limited. Accessed via Minims Phenylephrine Hydrochloride 2.5%w/v Eye Drops, Solution - Summary of Product Characteristics (SmPC) - (emc) (medicines.org.uk) on 27/02/23 [date of revision of the text March 2016].*
2. *Baxter K, Preston CL (eds). Stockley's Drug Interactions [online] London: Pharmaceutical Press <http://www.medicinescomplete.com> [Accessed on 2023 Feb 27].*

APPENDIX C – Standard Operating Procedure for Instillation of Eye Drops

1. Preparation

Have the following basic equipment to hand:

- Correct clinic proforma, stating patient & clinic pathway details, including Senior Clinician responsible
- Correct minim of medication
- Low-linting swab or facial tissue
- Hand hygiene facilities

If the patient requires an eye toilet procedure, the following will also be required:

- Sterile water
- Sterile dressing pack

2. Pre-administration checks

1. Check patient details (name, address, DOB) verbally against ID sticker. If patient does not have capacity, check with carer.
2. Check & document allergy status.
3. Check & document driving status.
4. Check whether patient is wearing contact lenses, and if so ask them to remove them.
5. Check clinic proforma is as expected.
6. Check minim packaging against clinic proforma, including drug name, which eye, expiry date and any noticeable tampering/discolouration.
7. Explain & discuss what you are going to do, the purpose of the drops, likely effects & potential adverse reactions with the patient. This ensures that the patient understands the procedure and gives their valid informed consent.
8. Provide patient with single use soft tissue/s.

Eye drop administration

	Instruction	Rationale
1.	If the eye is clean there is no need to clean the eye and surrounding area prior to drop administration	*To minimise unnecessary intervention.*
2.	If there is any discharge from the eye, proceed as for eye swabbing/ eye toilet procedure.	*To remove any infected material and thus ensure adequate absorption of the drops*
3.	Assist the patient with the correct position i.e. head well supported and tilted back	*To ensure that drops are instilled beneath the lower lid into the fornix and to avoid excess solution running down the patient's cheek*
4.	Wash hands thoroughly using a bactericidal soap and water, or bactericidal alcohol hand rub, and dry them	*Asepsis is essential, particularly when the patient has a damaged eye or has just had an operation on the*

		eye. Infection can lead to loss of an eye
5.	Place a low-linting swab or tissue on the lower lid against the lid margin	*To absorb any excess solution which may be irritating to the surrounding skin*
6.	Ask the patient to look up immediately before instilling the drop, gently pull down the lower lid and instill one single drop in the lower fornix.	*This opens up the eye and allows the drop to be instilled into the outer side of the lower fornix. If done too soon the patient may blink as the drop is instilled*
7.	Ask the patient to close the eye. Keep the tissue on the lower lid and wipe any excess fluid.	*To ensure absorption of the fluid and to avoid excess running down the cheek*
8.	For Phenylephrine, instruct patient to keep eye closed and occlude punctae (using tissue/gentle pressure) for 1-2mins.	*To reduce nasolacrimal drainage and systemic absorption*
9.	Check that the patient is comfortable	*To ensure that the patient has experienced no adverse effects from the procedure*
10.	Remove and dispose of equipment safely	*To comply with UHB policy regarding the safe disposal of equipment*
11.	Wash hands with bactericidal soap and water or bactericidal alcohol hand rub	*To avoid cross-infection*
12.	Record the procedure in the clinic proforma, below the following prompts: drug name, dose, eye administered, date & time of administration, batch number, expiry date, details of any adverse effects, & printed name, signature and position of person administering medication.	*To aid continued patient care and comply with HB record keeping policies*

3. Post-administration checks:

Patients are advised on warning symptoms of adverse reactions prior to eye drop instillation, and the need to alert staff members if they occur in clinic. They are provided with the relevant completed Patient Information Leaflet (Appendix D). Indirect observations are also incorporated throughout the patients' clinic journey. For example, noticing a patient vigorously rubbing an itchy red eye in the waiting room, or struggling to get up when called because they are suddenly feeling faint, are symptoms that will necessitate further questions, and likely action/advice. If an adverse drug reaction is suspected, follow the ADR Escalation Procedure below.

Appendix D – Draft Patient Information Leaflets

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

OPHTHALMOLOGY DEPARTMENT
Dilation Eye Drops

Eye Drops Instilled ☐ Tropicamide 1% ☐ Phenylephrine 2.5%

Date & Time of Instillation _____

These eye drops make your pupils wider, to allow your eye clinic professional to gain a better view of the inside of your eye. The drops take about 15 to 30 minutes to work and the effect may last for up to six hours (or occasionally until the next day).

Do not undertake hazardous activities such as driving, cycling or operating heavy machinery while your vision is affected. Having large pupils will make you more sensitive to light, especially if it is sunny, and your vision will be blurred.

In the unlikely event that you experience any unusual symptoms such as feeling unwell, or pain and redness in or around your eyes, or your vision seems misty, please contact your local optometrist or seek urgent medical advice. You might be experiencing an adverse reaction to the drops. Take this note with you.

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

OPHTHALMOLOGY DEPARTMENT
Anaesthetic Eye Drops

Eye Drops Instilled ☐ Lidocaine 4%/Fluorescein 0.25%

Date & Time of Instillation _____

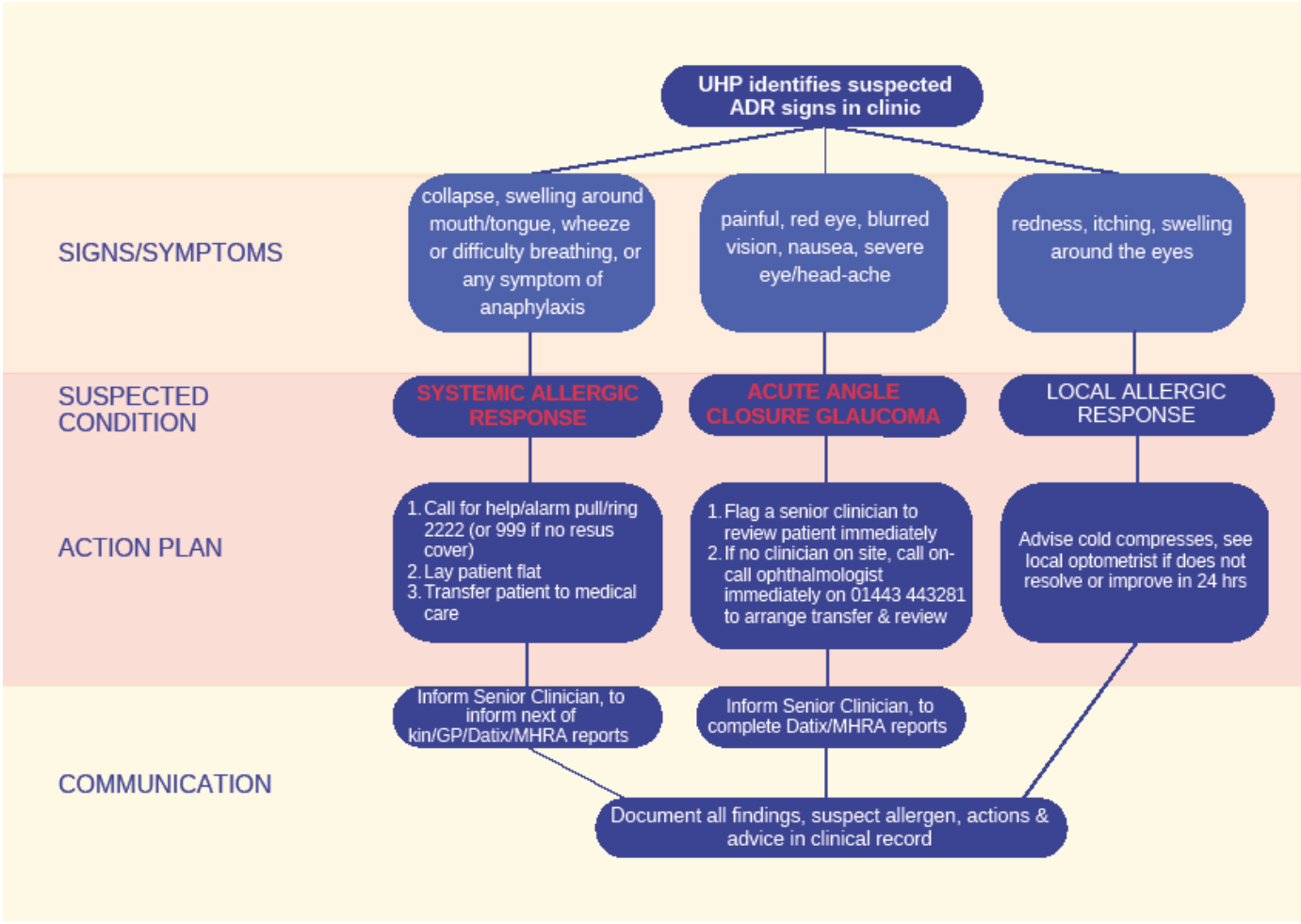
Local anaesthetics allow your eye clinic professional to measure eye pressure painlessly by numbing the surface of the eye. The drops take about 60 seconds to work and the effect may last for up to 25 minutes. They may sting briefly at first.

Until the drops have worn off:

- Do not rub your eyes.
- Avoid getting dust or grit in your eye.
- If you wear contact lenses do not put them back in for at least 1 hour.

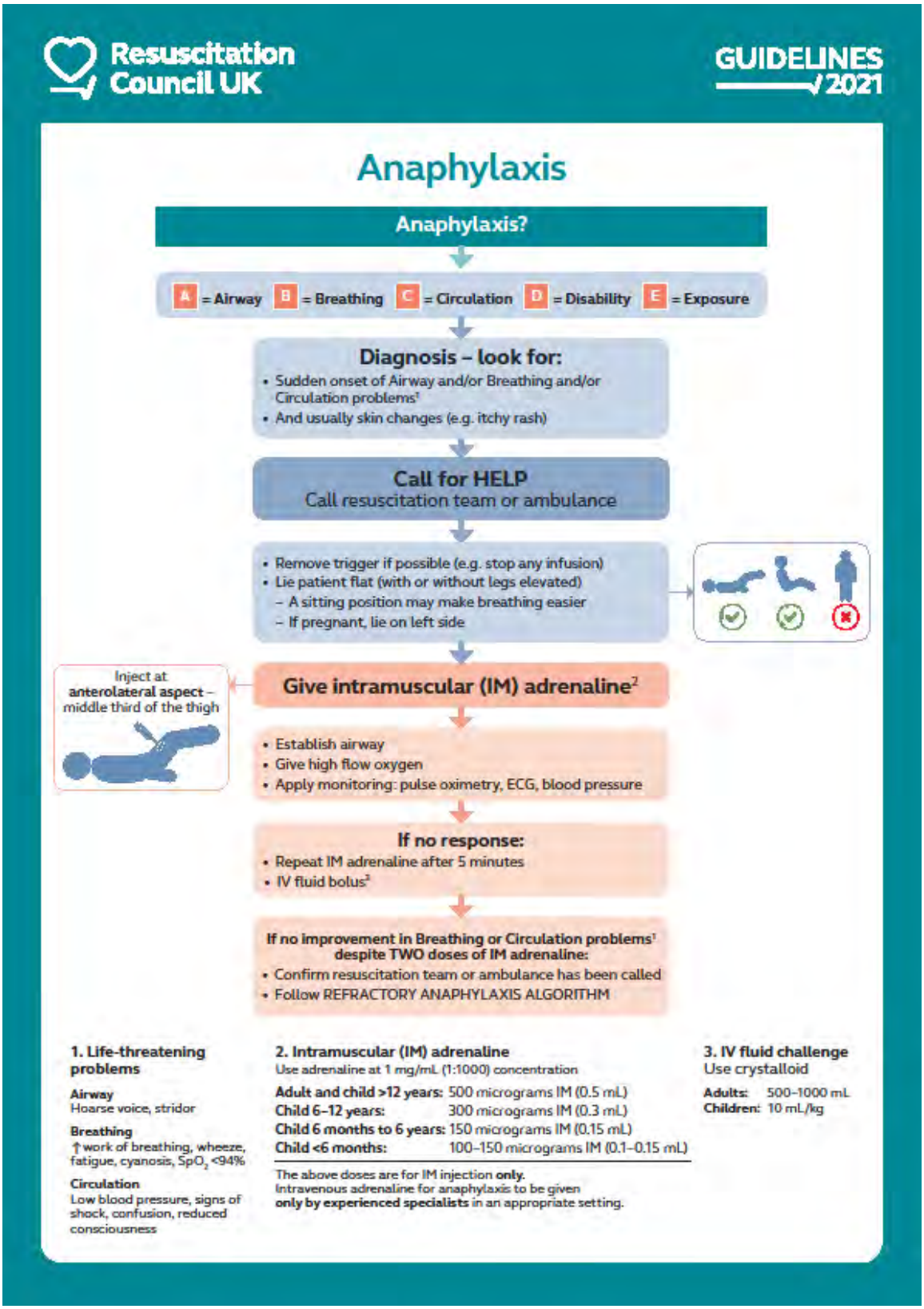
In the unlikely event that you experience any unusual symptoms such as pain or soreness in or around your eyes or your vision seems blurred, contact your local optometrist, or seek urgent medical advice as you might be experiencing an adverse reaction to the drops. Take this note with you.

Appendix E - Escalation Procedure for Adverse Drug Responses



Each UHP will receive their own copy, and a laminated version will be available on clinic room noticeboards.

APPENDIX F - Anaphylaxis Management Guidelines



APPENDIX G - Proposed Programme of Learning

Course Content:

- Medicines legislation
- Medicine characteristics of the 3 common eye drops used in OPD
- Basic anatomy and physiology of the eye
- Infection control
- Patient consent & advice
- Pre-administration drug checks for safe eye drop administration
- Standard Operating Procedure for eye drop administration
- Record keeping
- Adverse drug reactions & Escalation procedures
- Safe medication storage & disposal
- Training & Competency sign-off processes

Learning Outcomes:

- Identify the basic anatomy and physiology of the eye
- Identify the 2 dilating & 1 anaesthetic drops commonly used in Ophthalmology
- Understand the purpose of these drops, their indications/contraindications, & known adverse reactions
- Apply this understanding to provide appropriate patient advice
- Recognise the common signs of local allergy, drug anaphylaxis & closed-angle glaucoma
- Demonstrate how to accurately record drop instillation, including adverse effects/refusals
- Demonstrate an understanding of who & how to refer to if problems occur, & how soon
- Demonstrate how to carry out a safe and effective drop administration technique
- Understand drug storage regulations & record-keeping policies

APPENDIX H – Training Log

RECORD OF TRAINING FOR INDEPENDENT OBSERVED PRACTICE FOR THE INSTILLATION OF EYE DROPS BY UNREGISTERED HEALTH PRACTITIONERS

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Trainee Name: _____ Workplace Mentor: _____

Job Title: _____Workplace Mentor Email: _____

Supervision can be completed by any HB registered practitioner (doctor/nurse/optometrist/orthoptist)

Trainee feedback to be based on supervisor evaluation of the following:

- Excellent communication skills
- Correct checking of medication
- Correct patient positioning
- Excellent hand hygiene
- Use of good technique
- Knowledge of drug side effects
- Safe disposal of equipment
- Excellent record keeping

Medications to be used:

- **Tropicamide 1% Eye Drops (Minims)**
- **Phenylephrine 2.5% Eye Drops (Minims)**
- **Lidocaine hydrochloride 4%/ Fluorescein sodium 0.25% (Minims)**

	Date	Patient Hospital Number	Independent Observed Practice	Comments	Signature of Practitioner	Signature & Print of Supervising RP
1						
2						
3						

	Date	Patient Hospital Number	Independent Observed Practice	Comments	Signature of Practitioner	Signature & Print of Supervising RP
4						
5						
6						
7						
8						
9						
10						

APPENDIX I – DECLARATION OF COMPETENCE

DECLARATION OF COMPETENCE FOR THE INSTILLATION OF EYE DROPS FOR UNREGISTERED HEALTH PRACTITIONERS

Valid for 12 months from signing date

Name of Practitioner: _____

Job Title: _____

Line Manager: _____

This document certifies that the individual named above has:

- ☐ Completed a competency-based training package on eye drops
- ☐ Observed the correct procedure for eye drop instillation
- ☐ Read and understood the Eye Drop Instillation SOP and Medications Characteristics Appendix detailed in the training protocol
- ☐ Understood the procedure and has practiced it to a safe and competent standard whilst supervised

(Internal Training: 10 patients External Training: ___ patients *as per course requirements*)

Training Course Name: _____

Course Completion Date: _____

Competency Completion Date: _____

Next Review Date: _____

The practitioner understands they are responsible for:

- Compliance with HB policies
- Engaging actively with the training
- Keeping up to date
- Keeping accurate training records
- Ensuring they act within their sphere of competence
- Completing accurately the relevant parts of the medical records
- Following Standard Operating Procedures (SOPs)
- Reporting adverse events and safety concerns to their mentor, consultant or line manager

Signed:

_____ PRACTITIONER SIGNATURE

_____ MENTOR SIGNATURE

_____ PRACTITIONER NAME

_____ MENTOR NAME

3 Copies: UHB, UHP's Personal File, Department Archive

APPENDIX J – CLINICAL REFLECTION TEMPLATE

Practitioner Name: Date of Episode:

Mentor Name: Date of Submission:

1. Identify an event involving your instillation of eye drops in the clinics you work in. What was the nature of the event or experience?
2. How did you respond?
3. Would you call this a positive or challenging event?
4. What did you learn from this experience & your reflection on it? Outline how you have used this learning to make an improvement in the way you learn, work, or how tasks are carried out in your area.
5. Did you have all the support you needed? If not, what would have helped?
6. If there is a similar event in the future, would you do anything differently?

MAINTAIN THE CONFIDENTIALITY OF OTHERS WHEN WRITING THIS STATEMENT

Date discussed with mentor: Mentor signature:

APPENDIX K – RENEWAL OF COMPETENCE

RENEWAL OF DECLARATION OF COMPETENCE FOR THE INSTILLATION OF EYE DROPS FOR UNREGISTERED HEALTH PRACTITIONERS

Valid for 12 months from signing date

Name of Trainee: _____

Job Title: _____

Line Manager: _____

Core Training:

Training Course Name & Date: _____

Initial Competency Completion Date: _____

This document certifies that over the past 12 months, the individual named above has:

☐ Completed, and discussed with mentor, 3 Clinical Reflections (attached) demonstrating their appropriate use & understanding of this policy

☐ Has no concerns in their continued competence in the instillation of eye drops

☐ Has no concerns raised against their continued competence in the instillation of eye drops (the mentor can source this from discussion with clinical leads, above line manager, and Datix reports)

If this is the first renewal document, please include the completion date & findings of the initial 6-month audit:

_____

Renewed Competency Date: _____

Next Review Date: _____

The practitioner responsibilities detailed in the initial Declaration of Competency continue to apply.

Signed:

_____ _____

PRACTITIONER SIGNATURE MENTOR SIGNATURE

_____ _____

PRACTITIONER NAME MENTOR NAME

3 Copies: UHP, UHP's Personal File, Department Archive

APPENDIX L – CONSULTANT POSITION STATEMENT

CTMUHB Ophthalmology Consultant Body Position Statement On The Use Of Topical Phenylephrine 2.5% And Risk Of Drug-Drug Interactions

1) Phenylephrine is an alpha adrenoceptor agonist and is used systemically in the treatment of hypotension or for nasal decongestion. The vasopressor effect of phenylephrine may be potentiated by the concurrent use of medications such as Monoamine Oxidase Inhibitors or Tricyclic antidepressants. Patients may be at risk of cardiac arrhythmias. The reports of such adverse events are, to the best of our knowledge, limited to systemic (IV, oral) administration and there no severe adverse events related to drug interactions have been reported with topical use of phenylephrine 2.5%.
We note that FDA labelling of phenylephrine for mydriasis does not list use of MAOI or TCAs as a contraindication to use.

2) Topical phenylephrine was first described in the literature in the 1930s and was approved for use in the USA in 1939. It is commonly used in conjunction with tropicamide 1% to provide adequate mydriasis for retinal examination and is standard practice in retinal clinics in UK eye units. In the UK alone, there are 7-8 million ophthalmology outpatient attendances annually, a large proportion of whom will be dilated with phenylephrine 2.5%.
To the best of our knowledge, there are no reported cases of serious drug-drug interactions with topical phenylephrine 2.5% despite nearly a century of use worldwide in an ophthalmic setting.
In clinical practice, phenylephrine is given to all patients in a retinal clinic aside from those with known allergy to phenylephrine. TCA/MAOI use and the other contraindications listed on the SmPC (eg hypertension, cardiac disease, diabetes mellitus) are common in patients attending retinal clinics and are generally considered relative contraindications. In these patients, the use of 10% phenyephrine (not covered by this policy) is to be avoided.

3) It is standard and long-established practice that all patients attending retinal clinics or requiring retinal examination in CTM receive phenylephrine 2.5% (and tropicamide 1%) drops at every visit. Concurrent MAOI/TCA use is not routinely enquired about. In patients taking such medication, the benefits of better pupil dilation and better retinal assessment by using phenylephrine 2.5% outweigh any potential risk of drug-drug interactions.
Whether the drops are instilled by a UHP under this policy, or by a nurse acting under a PGD or prescription, the risk to the patient of drug-drug interactions will be unchanged.
Having a cohort of UHPs able to instill drops under this policy will aid ophthalmic service redesign in order to address the severe capacity challenges the hospital eye service faces. Without it, the risk to patients from delayed appointments and treatment is far greater than the risk posed by drug reactions.

4) In the extremely unlikely event of a case of an adverse reaction, there is a pan-CTM escalation policy to mitigate this risk.

Agreed by CTM Ophthalmology Consultants 06/10/2023

Agenda Item
9.2.5

Quality & Safety Committee

Controlled Drug Accountable Officer (CDAO) Report: April 2023 – March 2024

Dyddiad y Cyfarfod / Date of Meeting	16/05/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Hannah Wilton, Clinical Director Medicines Management
Cyflwynydd yr Adroddiad / Report Presenter	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	
CTMUHB	Cwm Taf Morgannwg University Health Board
CDAO	Controlled Drugs Accountable Officer
CDLIN	Controlled Drugs Local Intelligence Network
CD	Controlled Drug

1. Situation /Background

The introduction of the Controlled Drugs (Supervision of Management and Use) (Wales) Regulations 2008 which came in to force in Wales in January 2009, made provision under the Health Act 2006 to strengthen the systems for managing controlled drugs.

Both Cwm Taf Morgannwg University Health Board (CTMUHB), as a Designated Body and the Controlled Drug Accountable Officer (CDAO) have statutory responsibilities laid out in the regulations to ensure robust arrangements for the management and use of Controlled Drugs (CDs) to minimise patient harm, misuse and criminality across community, primary and secondary care. The CDAO for CTMUHB is Hannah Wilton, Clinical Director of Pharmacy and Medicines Management.

Under the aforementioned regulations, CDAO's are required to establish and operate appropriate arrangements for ensuring the proper sharing of information in accordance with regulation 25 or 26, by their designated body with other responsible bodies regarding the management and use of controlled drugs.

For a CDAO nominated or appointed by a Local Health Board, those arrangements must include establishing a network (a "local intelligence network") for sharing information regarding the management and use of controlled drugs. This network is known as the Controlled Drugs Intelligence Network (CDLIN).

The CDLIN is a multi-agency forum, which each Health Board is required to have, as set out in the Controlled Drugs (Supervision of Management and Use) (Wales) Regulations 2008. It is chaired by the CDAO and includes representation from the police, General Pharmaceutical Council (GPhC), counter fraud, local authority and ambulance service along with primary care contractors and private care providers within the Health Board area. Meetings are held on a quarterly basis and have received excellent attendance. The role of the CDLIN is to share intelligence around the use/misuse of CDs, direct policies and procedures to ensure the safe use of CDs and to minimise risk to patients. The Terms of Reference for the CDLIN can be found in Appendix 1.

This report provides an update of activity undertaken at the direction of the CDAO and CDLIN throughout the last financial year. It also outlines planned activity over the coming year designed to improve CD governance.

2. Specific Matters for Consideration

Areas of CD governance providing a challenge for the CDAO over the last year include:

2.1 Guidance on managing CD incidents

It has been identified that the HB should produce guidance on managing CD incidents to support investigating and managing CD errors. Guidance has been produced on reporting CD incidents for use within secondary care. This document has been approved by Operational Management Board.

2.2 Controlled Drugs Home Office Licenses

A joint letter from Welsh Government and Home Office on 28th February states

> *"Health boards and NHS trusts should as a matter of priority, review all services where they possess controlled drugs and arrangements where they supply controlled drugs to different services within their organisation or to other organisations and assure themselves of compliance with the requirements for controlled drugs licensing".*

The Health Board is therefore ensuring compliance with these requirements

An action tracker has been developed to help give assurance around the status of the CD licensed which will be updated weekly

Application fees for new Home Office Controlled Drug Licenses:

Licensable Activity	Application Fee
Possess controlled drugs	£3,133
Supply, or offer to supply, controlled drugs	£3,655

Renewal fees for an existing Home Office Controlled Drug License:

Compliance Visits	Licence Renewal Fee
No visit required	£326
Visit required	£1,371

Through this review it has been determined, that given current practice, Home Office controlled drug supply licenses would be required for Royal Glamorgan, Prince Charles, Princess of Wales and Ysbyty Cwm Rhondda Pharmacy Departments. Possession licences will then be required for Health Board sites using controlled drugs beyond the main hospital sites.

The table below shows the current status of the licence applications.

Controlled Drug Licenses- Action tracker

Premises	Licence type	Responsible Person	DBS applied	DBS complete	Application submitted	Date of inspection	Licence issued	Date of expiry	Re-Application
RGH	Supply	Kathryn Howard			7.7.23	29.5.24			
PCH	Supply	Rhian Carta			25.7.23	23.1.23	7.05.24		
POW	Supply	David Hughes			22.8.23	22.1.24	07.05.25		
YCR	Supply	Janine Edmunds				14.11.23	Application Pending		
HMP Parc	Possession	Rebecca Hunter				30.01.23	24.2.23	23.2.24	Completed Expiry 20/3/25
Ty Elai	Possession Supply	Martine Randall Andrea Dorrington				23.01.24	15.02.24	15.02.25	
Community Dental Clinics	Possession	Laura Andrews /Sarah Pick			4.8.23	29 & 30.5.24			
CDAT: Dewi Sant	Possession	Emma Weatherall	Yes						
CDAT: Celtic Court	Possession	Emma Draper	Yes						
CDAT: Trealaw	Possession	Eira Morris	Yes	Received					
CDAT: YCC	Possession	Robert Madden	Yes						
CDAT: Kier Hardy	Possession	Keith Morris	Yes	Yes					

In the interim, until the required licences are in place, practice has been changed to ensure compliance with the Medicines Act.

2.3 Management of Controlled Drugs Internal Audit

A review of the management of controlled drugs process was undertaken in line with the 2023/24 Internal Audit Plan for Cwm Taf Morgannwg University Health Board.

'Reasonable' assurance was provided for each of the objectives, and an action plan developed that has been agreed by the Clinical Director of Medicines Management and Assistant Director of Quality and Safety (Appendix 2).

	Objectives	Assurance
1	Policies and procedures are in place.	Reasonable
2	Relevant staff have been a trained.	Reasonable
3	Ordering, delivery and receipt of controlled drugs is in with the procedures.	Reasonable
4	Controlled drugs registers are in place	Reasonable
5	Controlled drugs are securely stored.	Reasonable
6	Appropriate checks and audits are performed.	Reasonable
7	Monitoring and reporting takes place.	Reasonable

2.4 Identification of diversion

A key remit of the CD LIN is the detection and prevention of diversion of controlled drugs. Earlier this year information was shared around the suspected mismanagement of controlled drugs by a community pharmacist. Appropriate action in accordance with the required management process was undertaken providing the Committee with assurance that the mechanisms in place to detect inappropriate use of controlled drugs are effective in the management of such cases.

3. Key Risks / Matters for Escalation

Cross care group collaboration will be required to improve controlled drugs compliance against the action plan developed from the controlled drugs audit. The action plan has been approved by the Audit and Risk Committee, and will now be shared with the Care Group Leadership teams for dissemination.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Creating Health
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Living Well
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Enablers of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Whole-systems Perspective

Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Domains of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Equitable
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd?* / Quality *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☒	No: ☒
	Outcome:	If no, please include rationale below: Not required
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg?* / Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☐
	Outcome for Equality (delete as appropriate): NEUTRAL Outcome for Welsh Language (delete as appropriate): NEUTRAL	If no, please include rationale below: Not required
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol)* / Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

The Quality and Safety Committee is asked to note the content of this report including the progress made and the actions prioritised for the coming year.

6. Next Steps

6.1 The actions identified as part of the action plan to be undertaken

6.2 Over the next 12 months the CDAO, in collaboration with the CDLIN will build on the achievements made to date to further strengthen the arrangements for the safe and secure management of controlled drugs across CTMUHB.

Appendix 1

Controlled Drugs Local Intelligence Network- Terms of Reference

September 2022

1. CONSTITUTION

The Local Intelligence Network (LIN) will be chaired by the Controlled Drugs Accountable Officer (CDAO) for the Cwm Taf Morgannwg University Health Board (CTMUHB) and activity will be reported, via the Quality and safety Committee of the Health Board and monitored by Health Inspectorate Wales (HIW)

The Network will cover Health Board employed staff, primary care contractors, all hospitals, private hospitals, hospices, drug and alcohol agencies and care homes within CTMUHB area.

2. ROLE OF THE LOCAL INTELLIGENCE NETWORK

The purpose of the LIN is to share information about incidents and concerns relating to the use and possible abuse of controlled drugs including potential or actual systems failures.

The Network will:

- agree local principles for sharing controlled drug (CD) intelligence between agencies
- actively share intelligence regarding use and potential abuse of CDs
- agree systems for reporting concerns
- agree procedures for investigation and participate in incident panels
- agree on the management of incidents affecting more than one agency
- receive reports from an investigation subgroup/ Incident Panel and decisions of the LIN Chair
- advise on monitoring processes and audits of CD management
- advise on training requirements for CD handling and undertake joint training
- advise on policy requirements
- update its membership as required

3. MEMBERSHIP

3.1 Membership

Membership will include, but will not be limited to:

- Controlled Drugs Accountable Officer, Cwm Taf Morgannwg UHB (Chair)
- Chief Pharmacist Governance, Cwm Taf Morgannwg UHB
- Chief Pharmacist Primary Care, Cwm Taf Morgannwg UHB
- Pharmacy Team Leader for Medicines Governance and MMPU, Cwm Taf Morgannwg UHB (Deputy Chair)
- Lead Pharmacist Community Pharmacy, Cwm Taf Morgannwg UHB
- Nurse Advisor Medicines Management, Cwm Taf Morgannwg UHB
- Medicines Management Support Officer (CDs & Community Pharmacy), Cwm Taf Morgannwg UHB
- Assistant Director Quality & Patient Experience, Cwm Taf Morgannwg UHB
- Head of Primary Care, Cwm Taf Morgannwg UHB or representative
- Primary Care Development Manager – Dental, Cwm Taf Morgannwg UHB
- Controlled Drugs/Chemical Liaison Officer, S Wales Police
- NHS Wales Shared Services Partnership Counter Fraud Officer

- Area Planning Board (APB) representative
- Health Inspectorate Wales representative
- Care and Social Services Inspectorate Wales (CSSIW) representative
- General Pharmaceutical Council (GPhC) Inspector
- Welsh Ambulance Service representative
- Local Authority Substance Misuse Representative
- CDAT representative Cwm Taf locality
- CDAT representative Bridgend locality
- Neighbouring LIN representatives
    - Cardiff and Vale
    - Swansea Bay
    - Aneurin Bevan
    - Powys
- Kaleidoscope representative
- Velindre representative
- Centre for Reproduction And Gynaecology Wales representative
- Heatherwood Court representative
- Ty Cwm Rhondda representative
- Priory Church Village representative
- Parc Prison representative

Organisations required to have an Accountable Officer will normally be represented by that person.

Representatives from Contractor Bodies will be invited as required (CPW, LMC LDC).

3.2 Nominated Deputies

Members were possible will have a nominated deputy who will attend Network meetings when the representative is in unable to attend and who will be available to action intelligence passed on by the Network.

All participants should be aware of the confidential nature of some of the issues discussed.

The nominated deputy chairperson for the meeting will be the Pharmacy Team Leader for Medicines Governance and MMPU

3.3 Observers

Observers may from time to time be invited to attend but may be excluded where confidential issues are discussed.

3.4 Resignation

Membership may end by resignation at any time by notice to the chair

4. QUORUM

The quorum for the Network is six members, including the Chair or Deputy Chair.

In the event of non-compliance with quorate requirements this will be noted at the start of the meeting and documented in the minutes.

5. FREQUENCY OF MEETINGS

Meetings will be held as and when deemed necessary at the discretion of the Chairperson but no less than four times per year.

6. CONFIDENTIALITY

All members of the Network and their deputies are bound by an agreement of confidentiality to enable the sharing of identifiable information in the assured knowledge that named information or sources will not be revealed outside the network.

7. AGENDAS

The agendas for each meeting will be agreed by the Accountable Officer and will be despatched to all members no later than five days prior to the meeting. The minutes and action log will be completed after each meeting.

Appendix 2.

The table below provides a progress report against actions identified in the previous year as well as new actions identified. Whilst progress has been made in some cases, competing priorities and limited resources have meant that it has not been possible to fully complete in all cases and therefore further action required going forward is noted.

Accountable Officer Action Plan

Action/ regulation	Status	Progress	Further action required
Action: Develop Authorised Witness (AW) Training/ develop cross Health Board Training Standardisation of AW training within Wales	Complete **Ongoing**	Completed and further training scheduled CTMUHB have provided training for neighbouring health boards & trusts	Continue to monitor AW and ensure further training required as per AW agreement. All Wales work for standardisation. AW training and reciprocal arrangements within Wales
Action: Review CD policies/procedure	**Ongoing**	Current policies in date	Current policies in date but will need review before October 2024
Action : Bi-annual CDAO newsletter	**Ongoing**	Newsletter published annually - Further newsletters to be produced and disseminated	
Action : Management of controlled stationery procedure for CTMUHB.	In progress	To have a CTMUHB wide procedure for the management of controlled stationary. To work with counter fraud to ensure it is fit for purpose.	**ongoing**
CD Incident Reporting Standard Operating Procedure to be approved by Operational Management Board.	Complete	Accepted by April OMB	

Action/ regulation	Status	Progress	Further action required
Management will ensure Pharmacy audit checks are performed quarterly in line with the SOP	**Ongoing**	Underway	To be reported via Medicines Management Planning and performance meeting
Consideration will be given to reviewing and monitoring the use of controlled drugs distribution across the site. This will support in reviewing patterns, themes, or periodic changes a period.	**Not yet started**		**Meeting to discuss strategy**
Consideration to be given to using ESR to retain training records of staff who have undertaken Controlled Drugs training and refresher training	**In progress**	Discussions started with learning and development to add the training dates on to ESR where all bookings will be added and confirmation of attendance will be kept through this rather than on the current paper documentation.	

Agenda Item
9.2.6

Quality & Safety Committee

CANCER SERVICES ANNUAL REPORT

Dyddiad y Cyfarfod / Date of Meeting	16/05/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Keryn Jones – Directorate Manager for Specialised Services David Williams – Cancer & Outpatients Improvement Manager Dawn Casey – Macmillan Lead Cancer Nurse Rhian Collins – Macmillan AHP lead for Cancer
Cyflwynydd yr Adroddiad / Report Presenter	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

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf Morgannwg University Health Board
SCP	Suspected Cancer Pathway
CWT	Cancer Waiting Times
PTR	Putting Things Right
HB	Health Board
OPA	Outpatient Appointment
MDT	Multi-Disciplinary Team
HEIW	Health Education and Improvement Wales
CNS	Clinical Nurse Specialist
WCISU	Welsh Cancer Intelligence and Surveillance Unit
AHP	Allied Health Professional

1. Situation /Background

1.1 This report provides an annual update on cancer services across CTMUHB.

2. Specific Matters for Consideration

2.1 Impact of non-compliance with the suspect cancer waiting time measure.

3. Key Risks / Matters for Escalation

3.1 Continued failure to meet the suspected cancer waiting time performance measure.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Enablers of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Not Applicable
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Domains of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Not Applicable
	Timely, Safe, Person Centred, Equitable, Efficient, Effective
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* Quality *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality: Outcome for Welsh Language:	If no, please include rationale below:
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	Yes (Include further detail below)	
	Cancer performance is a key Welsh Government priority	
Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	Yes (Include further detail below)	
	Additional funding will be required to meet current cancer waiting time performance target	

5. Recommendation

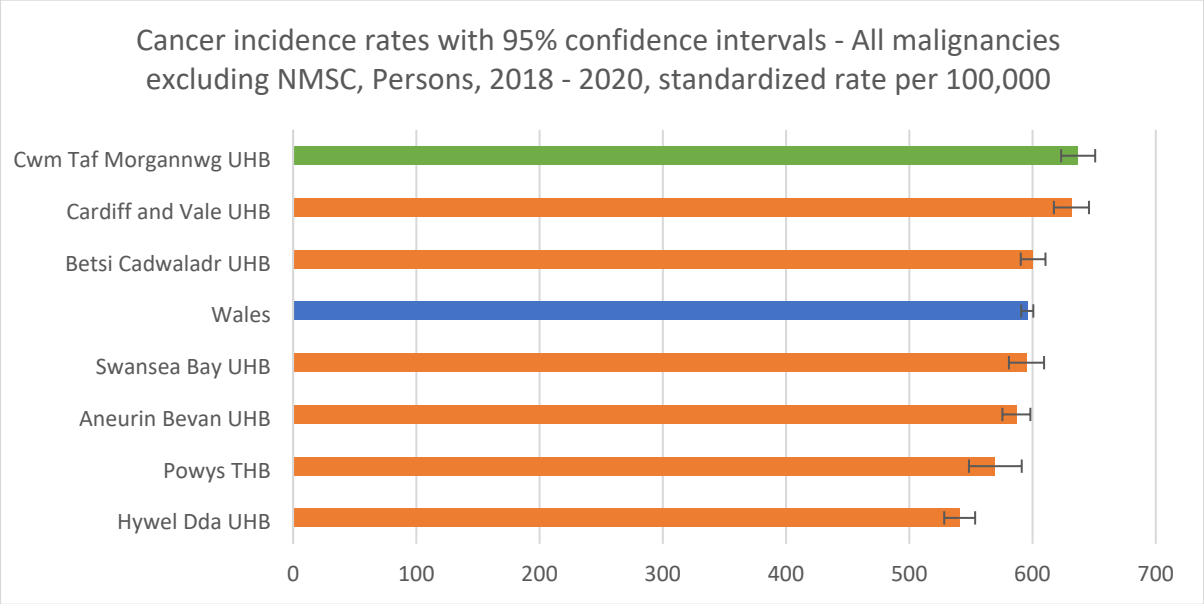
5.1 For NOTING and consideration of the contents of this report.

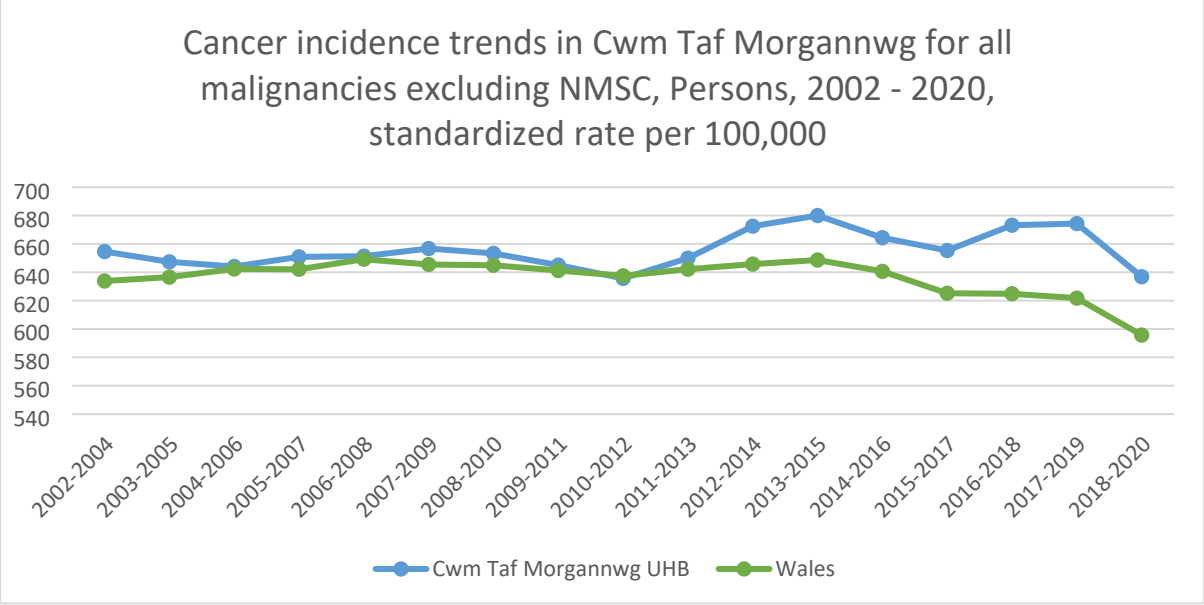
Annual Cancer Report 2023/2024

1.0 Introduction

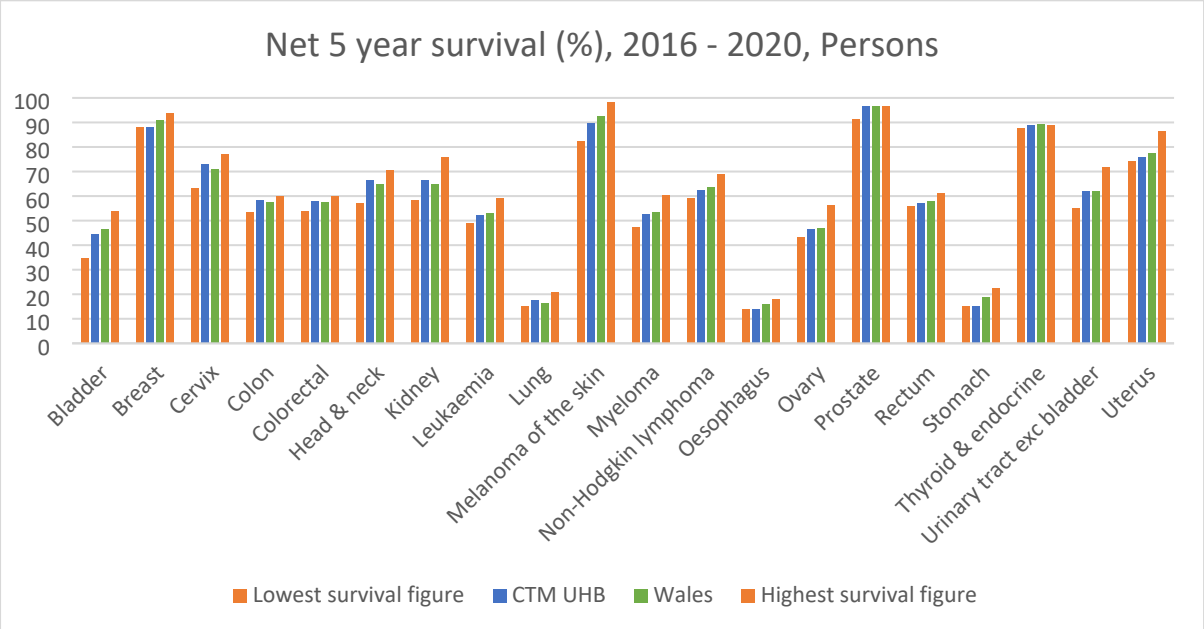
This annual report provides an overview of the challenges faced by our cancer teams, in delivering the National Optimal pathway in this post Covid era and our progress made during this period.

2.0 Cancer landscape across CTMUHB

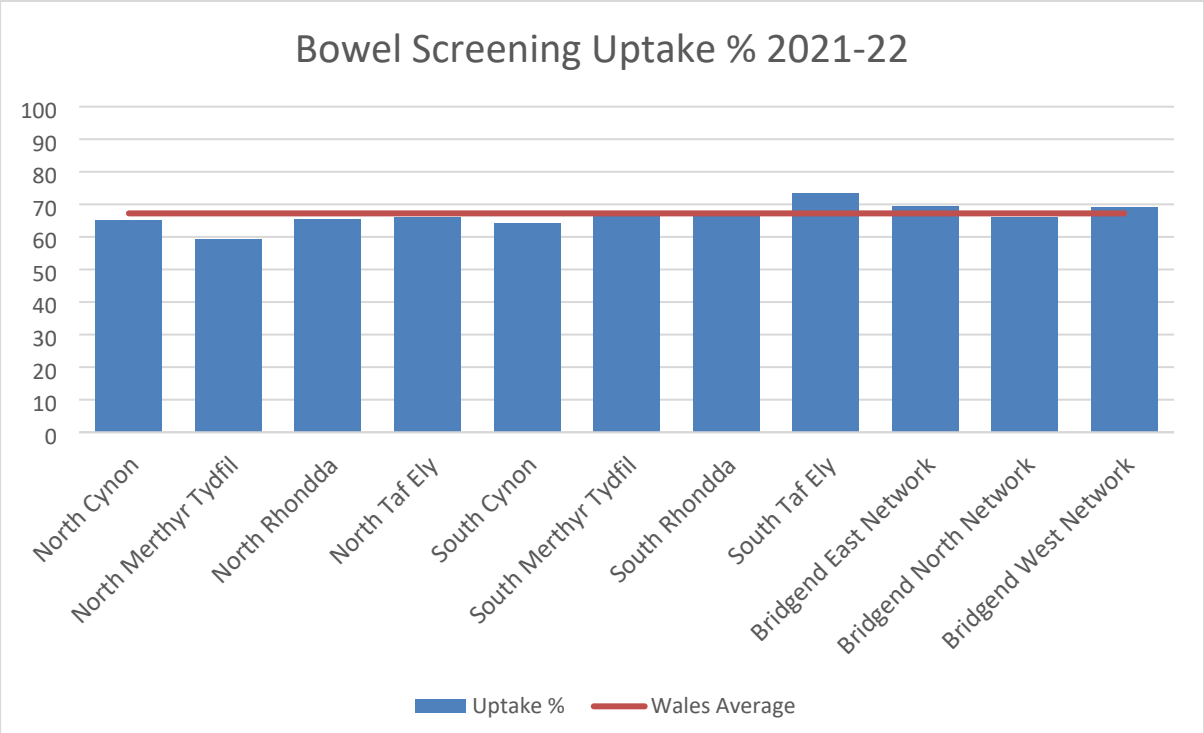




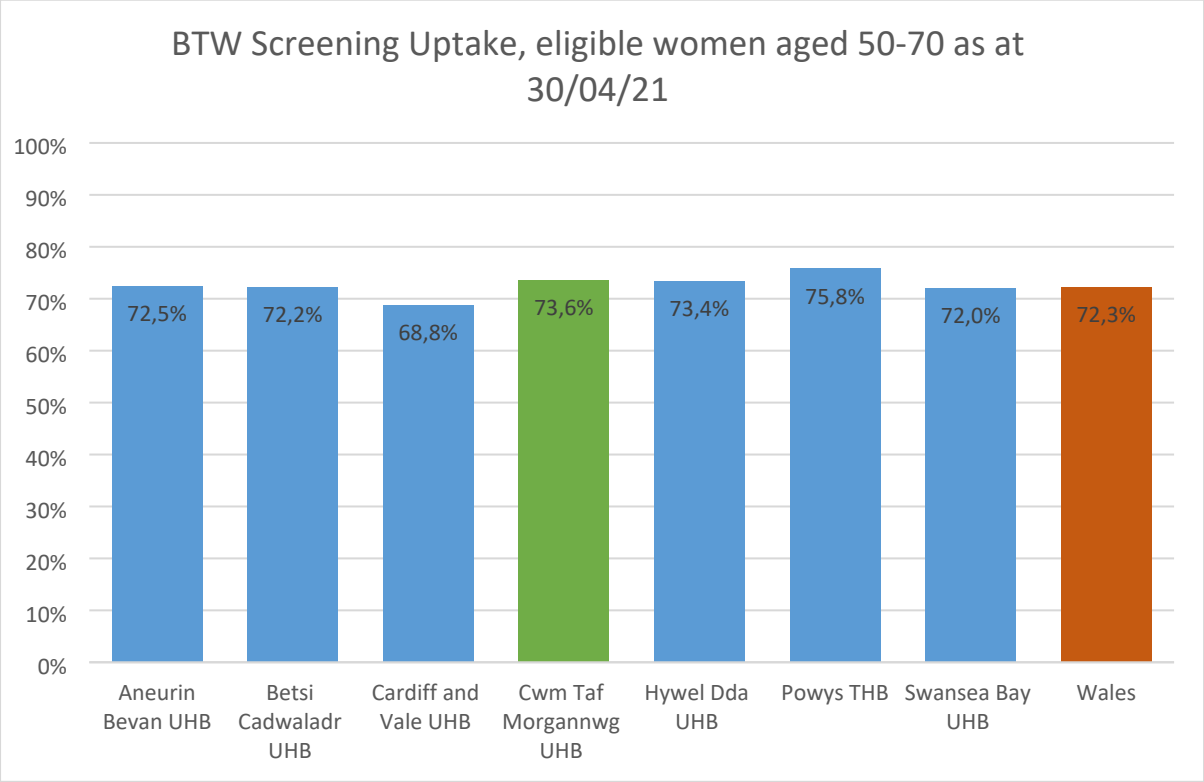
Each year around 3,500 people across CTMUHB are diagnosed with cancer. Cancer incidence has remained at a higher rate in CTMUHB than for Wales, with the rate for Wales decreasing since 2015.



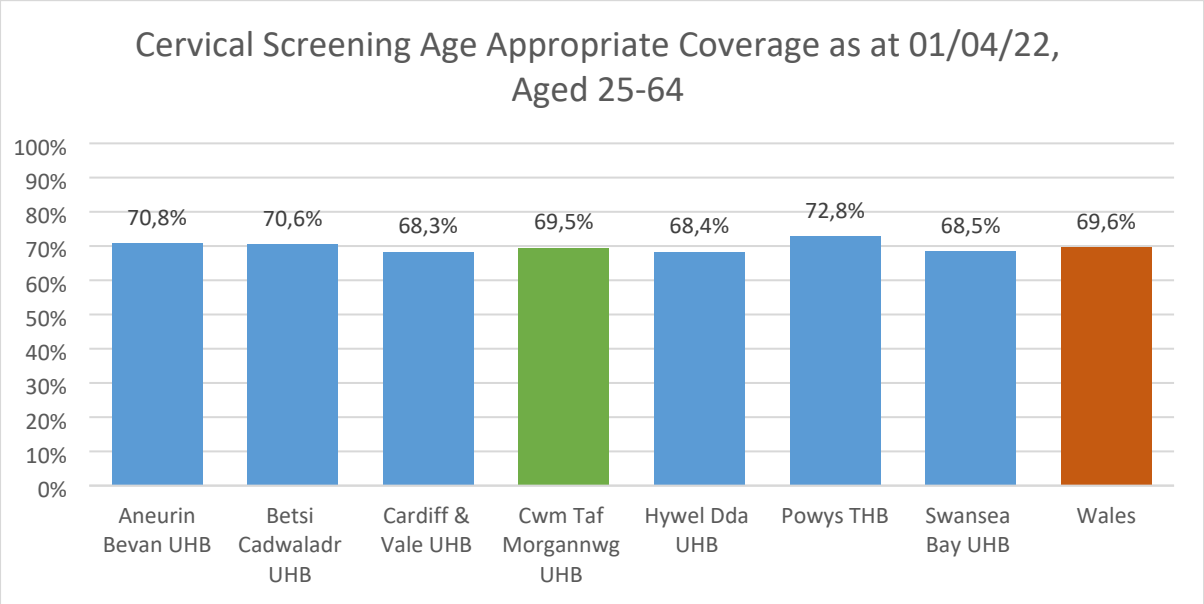
In the latest published cancer survival figures from WCISU, most cancer types across Wales showed a decrease in survival from 2019 to 2020. One-year survival for all cancers combined fell from 75.9% to 71.6%, which was statistically significant. The analysis does not fully account for the changes in background mortality due to the unprecedented impact of Covid-19. The analysis showed that Cwm Taf Morgannwg survival figures were not statistically different to the all Wales figures for any tumour site.



Bowel screening threshold has been lowered and expanded to include 51 - 54 year olds in October 23. CTMUHB had 67.0% uptake overall for Bowel Screening Wales (BSW) during 2021-2022. Variations of uptake is evident across GP clusters.



The uptake of breast screening across Wales increased in the most recently published figures, from 71.7% to 72.3%. Coverage remains above the 70% standard for nearly all health boards.



The cervical screening coverage across Wales stands at 69.6% in the most recently published figures. This figure combines the proportion of 25-49 year olds screened in the previous 3.5 years, and the proportion of 50-64 year olds screened in the previous 5.5 years.

3.0 Performance

Whilst now improving, cancer services within CTMUHB were challenged via the ongoing impact and recovery from Covid–19.

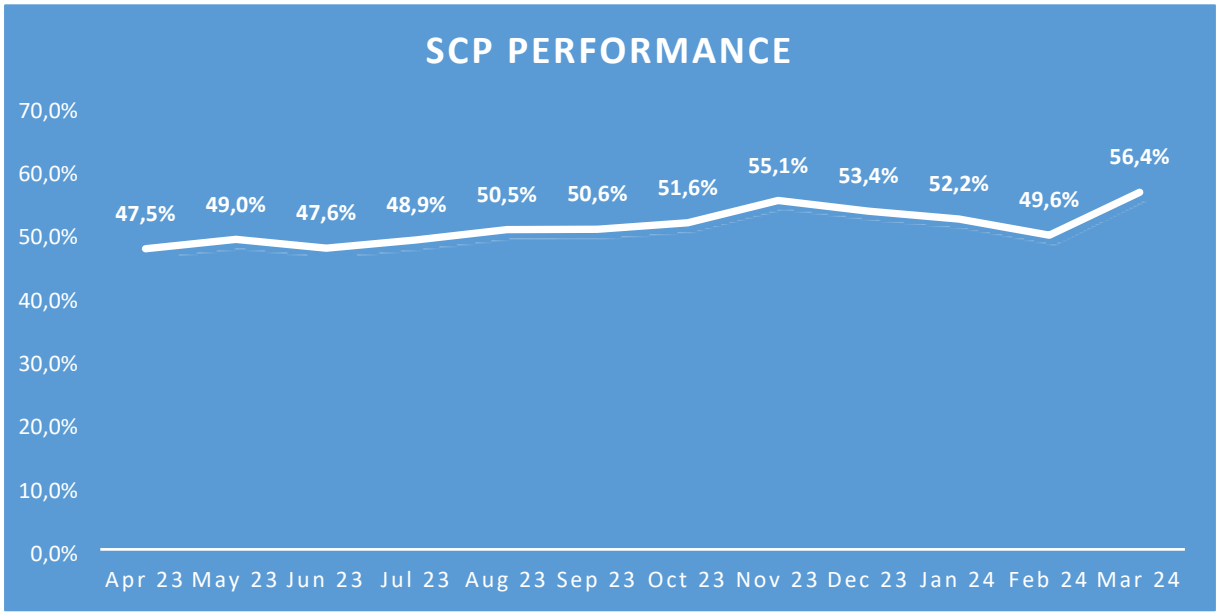
3.1 Referrals

Referral numbers have increased by 5% over the last 12-month period compared to the previous 12 months. The increase in referrals seen in Gynaecological services is in part down to the movement of some services from Swansea Bay to Cwm Taf Morgannwg UHB.

Tumour Site	April 2022 to March 2023	April 2023 to March 2024	Vol Diff	% Diff
Brain/CNS	27	19	-8	-30%
Breast	4,877	5,336	459	9%
Children's	20	23	3	15%
Gynaecological	4,452	5,413	961	22%
Haem (exc acute leukaemia)	555	421	-134	-24%
Head and neck	3,491	3,646	155	4%
Lower GI	5,631	4,993	-638	-11%
Lung	1,278	1,232	-46	-4%
Other	3,584	3,368	-216	-6%
Sarcoma	30	36	6	20%
Skin (exc BCC)	4,888	5,612	724	15%
Upper GI	3,273	3,177	-96	-3%
Urological	4,169	4,893	724	17%
Total	**36,275**	**38,169**	**1,894**	**5%**

3.2 Cancer Performance

The current CWT target is 75%. The planned care recovery plan established a new target of 80%, to be reached by 2026.



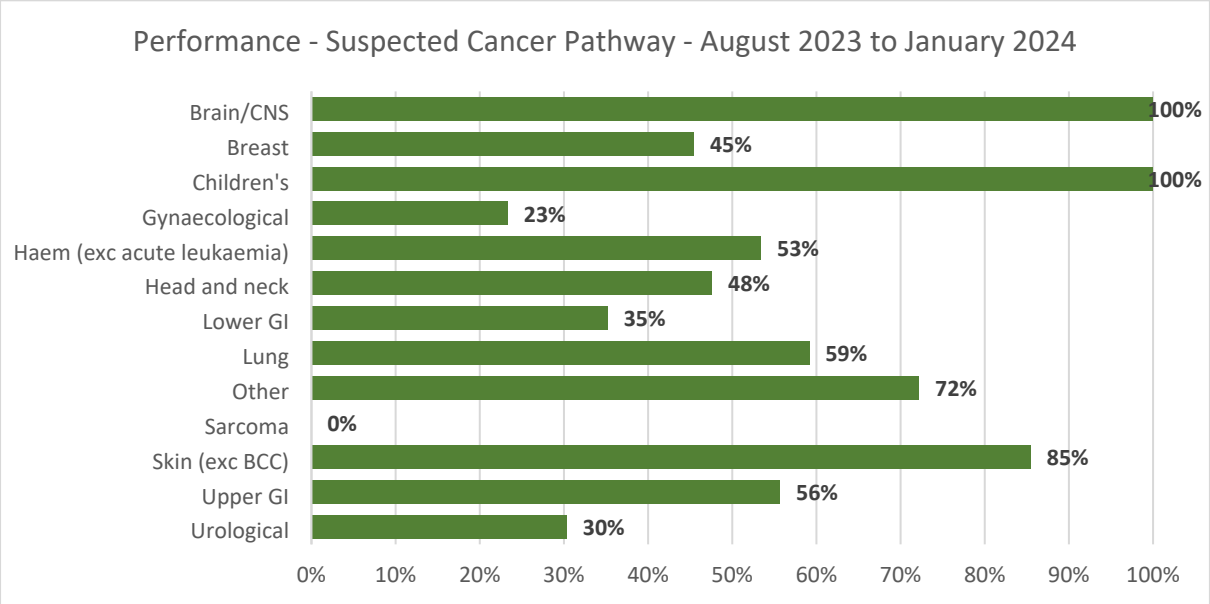
**March performance unvalidated*

CTMUHB has not achieved the SCP CWT target in any month over the last 12-month period.

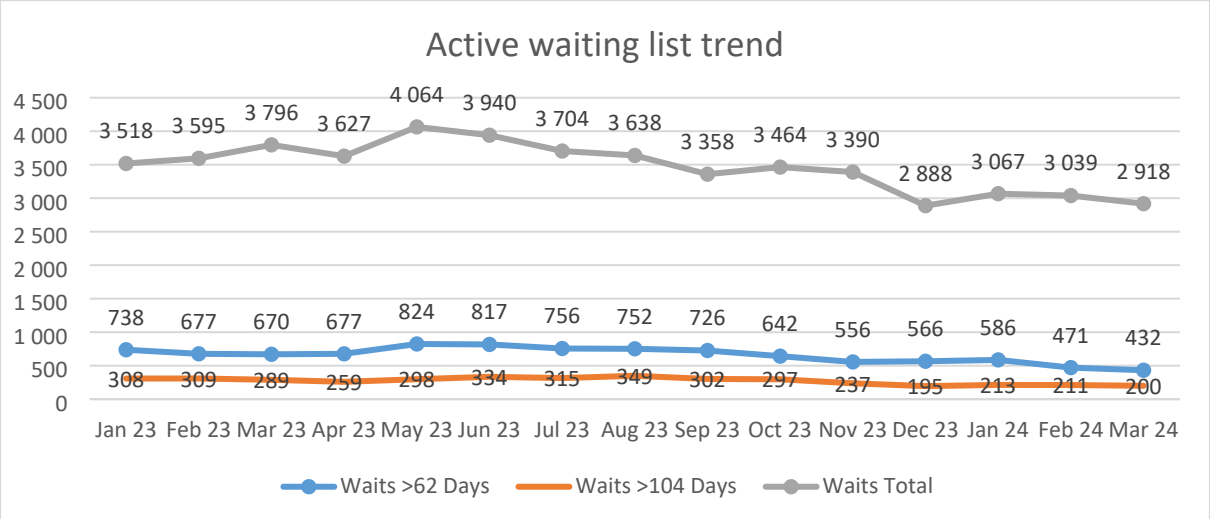
In November 2022 concerns surrounding quality and patient experience were raised by the Minister for Health & Social Services in a number of areas within the HB, cancer being one. Subsequently cancer was placed in targeted intervention.

CTMUHB's performance has gradually increased over the last 12 months, seeing an increase in performance for the August to January period from 45.8% to 51.9% for 2023/24. In comparison to all other acute HB's throughout Wales, CTMUHB has moved from being the lowest performing Health Board to the fourth highest.

Performance - Suspected Cancer Pathway - August 2023 to January 2024	
Betsi Cadwaladr	58.8%
Hywel Dda	48.6%
Aneurin Bevan	58.7%
Cardiff & Vale	63.6%
Cwm Taf Morgannwg	51.9%
Swansea Bay	51.5%
All Wales	**55.8%**



The only major tumour site to achieve the SCP CWT target is skin. All other tumour sites have failed to achieve it; although performance varies, as illustrated above.



The waiting list and backlog volumes have generally declined over the last 12 months. In comparison to all other acute HB's throughout Wales CTMUHB are ranked 3rd in having the highest volume of active patients on the SCP.

Bottlenecks specifically at radiology, endoscopy and pathology account for the bulk of the diagnostic challenges.

Fundamental to improving cancer performance is investment in diagnostics and the continuation of backlog clearance.

4.0 Quality Assurance of Cancer

4.1 Quality Assurance Framework

The quality assurance framework is now available as a dashboard and is being reviewed on a quarterly basis and reported to the cancer programme board. The trends are noted and an additional deep dive is undertaken when changes are identified.

A change in the trend for patients readmitted within 48 hours of treatment was noted and explored. This confirmed there were no concerns. Also a review of patients who were treated for cancer within 12 months of a cancer downgrade was undertaken. As a result, it was found no cancers had been missed.

Challenges around the key worker reporting have been identified as a result of the move to the new cancer module from CANISC. These have been raised with the NHS Executive.

4.2 Cancer Harm reviews

Cancer harm reviews were introduced within CTMUHB in quarter 4 of 2019 as a pilot. As a result of the work that CTMUHB and Betsi Cadwaladr University Health Board (BCUHB) had undertaken, Welsh Government trialed them across Wales, in 2021. Welsh Government subsequently extended the reporting period from 104 days to 146 days. The Welsh Government no longer requires a separate process. Reverting to the standard duty of candour process. The current process requires a large amount of administrative support and until now has not found any serious harm that hadn't already been reported. It has identified minimal moderate harm.

A paper has been written to propose that the HB stops undertaking routine cancer harm reviews, focusing on clinicians reporting via the normal route if they identify a concern.

Below is the breakdown of review outcomes since the process started;

Level of harm	No/Low	Moderate	Serious
Total	757	4	3 (1 no learning)

4.3 Ongoing reviews of CTMUHB corporate cancer risk

As described earlier, there has been considerable pressure on cancer services to deliver the suspected cancer pathway and there has been a failure to meet those targets. The overarching risk score for cancer is reviewed regularly and remains at 20.

4.4 National peer review programme

The HB has submitted their skin cancer peer review. The panel meeting is scheduled for the 15th July 2024.

5.0 Workforce

5.1 Macmillan partnership

The Macmillan partnership meetings continue and CTMUHB have been successful in securing the following funding from Macmillan over the last year.

- 1 WTE band 4 urology cancer support worker
- Ongoing funding for the welfare benefits advisers

Posts previously funded and now recruited to;

Psychology lead

- The Macmillan Cancer Psychology lead post was filled in addition to the Macmillan Psychologist post. Their role to provide a clinical psychology service to support people with cancer across CTM

Haematology team

- The additional CNS role and support worker roles for haematology have now been filled. Allowing the team to provide more timely care and improved patient support.

Breast

- The band 4 support worker role has been recruited to. This has improved the accessibility of the team and patient support they can provide.

Funding agreements in discussion;

- A partnership between Macmillan and Mesothelioma UK for 0.4 TE band 6 mesothelioma CNS
- Provision of an information pod for Princess of Wales hospital.

The HB has been actively involved in working with Macmillan on a project in conjunction with the Coalfields regeneration trust. This project is now operational and we are supporting three link workers to develop the role.

5.2 Tenovus call back service

CTMUHB have been working collaboratively to initiate a clinical nurse specialist call back service for our patients. This service is being provided by experienced CNSs (employed by Tenovus cancer care) and offers patients six supportive phone calls. We are utilising two offers; one is directly to haematology patients receiving oral Systemic anti-cancer treatment. The follow up is used to provide additional support and monitor for any problems with the treatment. The second provides additional emotional support and reassurance for patients post-surgery, whilst they are waiting for treatment or when there is no further treatment, but they are not suitable for specialist palliative care services. Whilst the uptake has been limited of this offer, it provides an additional level of monitoring and support for patients.

5.3 Prehabilitation Team

The prehabilitation team funded via therapies are now in post supporting people diagnosed with cancer to optimise their physical and psychological health prior to surgery. The team consists of a Physiotherapist, Dietitian, Occupational Therapists, two Therapy assistant practitioners and a clinical co-ordinator.

6.0 Improvement and innovation

Improvement and innovation are crucial in reducing variation across our system and in making strides forward to improve our cancer outcomes. Recently completed and ongoing work streams and projects to support our aims include:

- A business case for a 3rd endoscopy theatre has been approved along with the workforce model. This will facilitate 3 day session working and sustainability. Go live date awaited. The British Airways site near the Royal Glamorgan Hospital has been procured to provide a regional diagnostic site.
- Tele-dermatology, which is currently live in Princess of Wales is now being rolled out across CTMUHB.

- Business Intelligence improvements have been made in line with Cancer Network's specifications. Ongoing Business Intelligence improvements will continue to be made in line with service needs.
- The CANISC replacement Programme is ongoing. The replacement is now being used by Breast, Colorectal and Urology. The aim is for all other tumour sites to be using the new system by August 2024 in preparation for CANISC being decommissioned in October 2024.
- The lung health check pilot work (to improve early detection of lung cancer) has started. All the scans have been undertaken and the learning is being evaluated and reported.
- Investment in Trans Nasal Endoscopy equipment to provide this diagnostic in an outpatient setting, which releases endoscopy suite capacity for additional procedures.
- In addition to post abnormal endoscopy have extended accelerated imaging to include radiology diagnostics within 72 hrs for suspected cancer post cystoscopy.
- Improved STT % HB overall with continued working on increasing further across a number of pathways.
- Merging the Urology MDTs to increase sustainability and enable clinical learning across CTMUHB.
- Procurement of a local anaesthetic transperineal prostate biopsy machine for Royal Glamorgan Hospital. This will provide an equitable service across CTM with sufficient capacity to meet demand. The service is expected to start in May 2024.
- Work underway to merge the Colorectal MDTs to increase sustainability and enable clinical learning across CTMUHB.
- The Breast service for the HB is now run from the Snowdrop centre next to the Royal Glamorgan site.
- Introduction of Gynaecology one/two stop. Disestablishment of the SLA with Swansea Bay UHB to increase efficiency and sustainability and provide equity of service across CTMUHB.
- Prehabilitation service now offered to patients across CTM with a Colorectal and Upper Gastrointestinal malignancy. This is part of a phased roll out taking place over 24/25 to include additional cancer sites.
- Palliative care AHP lead secondment – Review of AHP Specialist Palliative Care services across CTM with the aim to ensure HB equity and efficiency across the service.
- CTM Cancer Patient Reported Experience Measures (PREMs) – in progress.
- Reduction in Urgent Suspected Cancer and BSW endoscopy waiting times via the endoscopy transformation programme. The latter is now achieving the 4 week standard for screening colonoscopy.
- Endobronchial ultrasound (EBUS) offered across the Health Board population.
- Text and remind rolled out.
- Improved % of patients informed they do not have cancer < 28 days.
- Standardisation of pathways across HB in a number of services.
- Roll out of digital referrals to Breast and Head & neck in RGH / PCH.

7.0 Challenges

There are a number of long standing challenges across the HB.

- Achieving the SCP target which is largely attributed to the increased volume of demand and capacity shortfalls in key diagnostic areas.
- Providing a sustainable pathology and radiology service. Collectively this relates to workforce, capacity and demand with both internal and regional solutions required to resolve. The latter forms part of the Welsh cancer improvement plan.

- Achieving performance and backlog clearance in line with target trajectories.

A significant amount of work has been undertaken with our informatics department to reconfigure trajectories for both backlog clearance and achievement of the SCP target over the next 12 months. These have been approved, submitted and agreed by WG.

Agenda Item
9.2.7

Quality & Safety Committee

CTMUHB Nosocomial COVID-19 Incident Management Programme Closure Report

Dyddiad y Cyfarfod / Date of Meeting	16th May 2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Debbie Bennion, Head of Nosocomial COVID-19 Investigation Team
Cyflwynydd yr Adroddiad / Report Presenter	Nigel Downes, Assistant Director of Quality and Safety
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	Endorse for Board Approval

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
National Nosocomial COVID-19 Programme Board	19/09/2023	Noted
National Nosocomial COVID-19 Delivery Group	13/03/2024	Noted
Nosocomial COVID- 19 Incident Management Group	26/03/2024	Noted
Infection, Prevention and Control Committee Meeting	16/04/2024	Approved

Acronyms / Glossary of Terms	
COVID-19	COVID-19 is an illness caused by a strain of coronavirus called SARS-CoV-2. This virus is responsible for the global pandemic since 2020.
CTMUHB	Cwm Taf Morgannwg University Health Board

NHS EXECUTIVE WALES	Previously known as the Delivery Unit
HCAIs	Health Care Associated Infections
IPC	Infection, Prevention and Control
NNCP	National Nosocomial COVID-19 Programme
PTR	Putting Things Right
SRO	Senior Responsible Officer

1. Situation /Background

1.1 The purpose of this report is to provide the Quality and Safety Committee of Cwm Taf Morgannwg University Health Board with assurance regarding delivery of the CTMUHB Nosocomial COVID-19 Incident Management Programme. This is linked to the National Nosocomial COVID-19 Programme (NNCP).

1.2 On 25 January 2021, the Quality & Safety Team at the NHS Wales DU (NHS Executive) were commissioned by Welsh Government to develop a national Framework to support a consistent national approach towards investigations following patient safety incidents of nosocomial COVID-19. In March 2021, the National Framework for the 'Management of patient safety incidents following nosocomial transmission of COVID-19' was published and updated in October 2021.

1.3 The key outcome of the programme will be to provide a high level of assurance that all patient safety incidents of nosocomial COVID-19 are investigated in line with the requirements of the National Health Service (Concerns, Complaint and Redress Arrangements) Regulations 2011 – Putting Things Right.

1.4 The Programme was commissioned to investigate all Nosocomial COVID-19 cases between 1st April 2020 and 31st March 2022.

1.5 At the September 2023 CTMUHB Quality & Safety meeting a report was presented which summarised the March 2023 "Delivery Unit" "National Nosocomial COVID-19 Programme Interim Learning Report".

1.6 This is the final report from the CTMUHB Nosocomial COVID-19 Incident Management Programme as the Programme ended on 31st March 2024.

2. Specific Matters for Consideration

2.1 PROGRAMME OVERSIGHT

2.2 Delivery pace continued to increase significantly once the team was well established and the investigation approach embedded. A monthly completion target of 166 cases per month was agreed in April 2023 in order to ensure that all investigations would be completed within the life span of the programme. The team consistently delivered ahead of this target and completed all cases (3233) within the remit of the Programme by 31st March 2024.

2.3 The Programme Management and its associated budget is part of the portfolio of the Assistant Director for Quality and Safety. This ensured continued effective oversight, clear leadership for the incorporation of the Duty of Candour responsibilities and closer liaison with business-as-usual quality and governance processes for healthcare associated infections.

2.4 The programme spending delivered within its allocated budget and the allotted funding for 2023/24 was fully accounted for in the planned workforce spend.

2.5 The finance team will undertake an end of Programme financial balance reconciliation to ensure all invoices/ payments have been accounted for. A financial return to Welsh Government will be submitted by the financial team.

2.6 WORKSTREAMS – Team investigation methodology and governance arrangements

2.7 Data validation activity against Public Health Wales (PHW) reporting and the internal Nosocomial COVID-19 investigation database enabled robust tracking to be easily monitored. The Programme Team were supported by PHW Epidemiology colleagues and CTMUHB Clinical Audit as part of hospital Mortality Review process.

2.8 The Nosocomial COVID-19 database allowed for swift and accurate data reporting on completion figures for monthly national submissions.

2.9 The CTMUHB Nosocomial COVID-19 Incident Management Programme Group, chaired by the SRO met on a bi-monthly basis to ensure the Health Board's SRO was sighted on progress and risks.

2.10 The CTMUHB Nosocomial COVID-19 Incident Management Programme Group provided a written report which includes an update on the programme risk register bi-monthly to CTMUHB's Infection and Prevention & Control Committee.

2.11 The model of investigation used by the CTMUHB COVID-19 Programme Team is viewed as an exemplar. This model comprised of a small team with a dedicated lead, clinical reviewers, and non- clinical reviewers, an infection prevention and control reviewer, Putting Things Right and governance support.

2.12 This team had all the characteristics of a high performing team e.g. very defined measurable goals with robust plans to deliver, clear roles and accountability, collective values, a shared vision and purpose; with all team members having a strong rapport and demonstrating a desire to grow and develop.

2.13 INVESTIGATIONS AND QUALITY ASSURANCE

2.14 By the 31st March 2024 the CTMUHB Programme Team had completed all 3233 cases.

2.15 By the 31st March 2024 all mortality reviews had been completed.

2.16 A total of 591 of the 3233 cases required a comprehensive clinical review.

2.17 All cases which underwent a clinical review (591) were managed via the Putting Things Right process. Families or patients were contacted by phone call, received a follow up letter and received either a full investigation report or "No care and service delivery problem" report, along with a covering explanation letter if they were in agreement to receive one.

2.18 One response is currently with the Legal and Risk team as the team have requested advice on Breach of Duty.

2.19 Legal and Risk have agreed that there is a breach of our duty of care in one of our referrals. This is the first and only agreed admission of breach of duty however, it currently does not appear to be a qualifying liability as there does not appear to be any harm resulting from the breach.

2.20 To date no cases from the CTMUHB Nosocomial COVID-19 Programme have been referred to the Ombudsman.

2.21 Multi-disciplinary Care review panels were convened for all 591 cases, at all times these panels remained quorate. Scrutiny in these panels has helped to develop the quality of investigations and ensure that the investigation scope remained appropriate.

2.22 Audit work to provide assurance on the quality and consistency of the non-clinical aspects of the investigation process has demonstrated a pleasing level of accuracy and audits continued to be undertaken on a monthly cycle throughout the programme.

2.23 The NHS Executive visited the Nosocomial COVID-19 Investigation team in August 2023 in order to sense checking the learning from the investigations to date, discuss any organisational changes that may have been implemented on the back of the learning and to hold an informal programme evaluation session with the Nosocomial Team. Following the visit, the CTMUHB team received extremely positive feedback which included assurance with regard the governance processes in place and noted the commitment, professionalism and compassion of all the members of the team. It was noted in particular that the multi-disciplinary nature of the team i.e. clinical investigators (which included an Infection Prevention and Control expert), non-clinical investigators and the make of up the PTR team was an exemplary model.

2.24 Stakeholder, patient and family contact

2.25 The CTMUHB Communications Lead continues to liaise with the NHS Executive Communication COVID-19 programme lead.

2.26 Attendance at Care Review Panels by frontline clinicians ensured that important feedback and learning is was heard and allowed for wider cascade and dissemination.

2.27 Proactive contact into the patient-facing helpline remained at a very low level. The investigation team have facilitated 8 face to face family meetings during the course of the Programme.

2.28 The Programme Team received only 2 requests for Freedom of Information data related to the Programme, these were responded to in the required time frame via the usual Health Board governance process.

2.29 The use of the CIVICA Survey on "COVID-19 Investigation Programme Relatives Feedback" has been used from August 2023. This is a standard survey which is used by all Health Boards in Wales. CTMUHB received highest number of responses (63% response rate) out of all the Health Boards in Wales. CTMUHB chose to offer feedback surveys to every family/patient who had received an investigation report or outcome letter from the CTMUHB COVID 19 Investigation Team.

2.30 THEMATIC LEARNING AND IMROVMENT

2.31 The Programme has continued to collate learning and share findings with each individual care group, via "7 Minute Briefings". All wave briefings have now been placed on the CTMUHB's Learning Repository along with the DU (NHS Exec) Interim Learning Report.

2.32 A patient story will be presented at a future Improving Care Board and Quality and Safety Committee meeting.

2.33 The Head of the Nosocomial COVID-19 Investigation team along with all members of the Programme Team provided two update sessions (in February 2024 and March 2024) to the Assistant Director of Patient Quality and Safety and the Heads of Quality in terms of the processes and systems in place and to hand over any legacy cases (likely to be those referred to Legal and Risk). All members of the Nosocomial COVID-19 Investigation team were in attendance and updated those present at the meeting with their key component roles and individual responsibilities within the Programme.

2.34 CTMUHB Nosocomial COVID-19 Investigation team has submitted Health Board learning from the second year of the Programme to the NHS Executive. The NHS Executive plan to publish their Final Learning Report in May/June 2024.

2.35 The SRO of the Programme has submitted the required Board Governance assurance and exit questionnaire to the NHS Executive.

3. Key Risks / Matters for Escalation

3.1 To receive assurance that the CTMUHB Nosocomial COVID-19 Investigation team completed all cases within the scope of the programme by the 31st March 2024.

3.2 To be advised that a full programme risk register was reviewed bi-monthly at the Nosocomial COVID-19 Incident Management Programme Group, with the overarching Programme risk reviewed at the Infection, Prevention and Control Committee. There is currently one risk which remains and meets the threshold (Risk Score 15) for escalation to the Organisational Risk Register.

3.3 To be advised that Risk 5201 – "Risk that investigations required for post 31st March 2022 patient safety incidents related to COVID-19 were not in the portfolio of the COVID-19 programme team thus resource and plan to undertake investigation needs to be managed as a "business as usual" process (Current risk score 15) This risk has been transferred to the Assistant Director of Quality and Safety as the Programme ended on 31st March 2024.

3.4 To be advised that the Nosocomial COVID-19 cases recorded after the 30 April 2022 will also be subject to the requirements of the National Framework and PTR regulations. The NHS Executive has confirmed that the approach to managing and investigating HCAIs as patient safety incidents are included in the refreshed version of their Nationally Reportable Incidents Policy.

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: Dying Well Living Well
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Enablers of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Whole-systems Perspective
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Domains of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Person Centred
	If more than one applies please list below: Safe Effective Efficient Timely Equitable

Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* Quality *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Any new or altered services would have their own QIA undertaken
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: Any new or altered services would have their own EIA undertaken
Cyfreithiol / Legal	Yes (Include further detail below)	
	Any incidents where a breach of duty or qualifying liability is believed to exist will follow appropriate legal process. The Health Board will work closely with NWSSP Legal and Risk services.	
Enw da / Reputational	Yes (Include further detail below)	
Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	Yes (Include further detail below)	

5. Recommendation

5.1 The Quality & Safety Committee is asked to NOTE this report

Agenda Item
9.2.8

Quality & Safety Committee

Human Tissue Act (2004)
Compliance and Progress Report

Dyddiad y Cyfarfod / Date of Meeting	16/05/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Dr Paul D Davies, Designated Individual for the Human Tissue Act
Cyflwynydd yr Adroddiad / Report Presenter	Dr 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
- Chief Operating Officer - Executive Medical Director - Director of Operations	22/04/2024	Approved

Acronyms / Glossary of Terms	
HTA	Human Tissue Act
HTAuth	Human Tissue Authority
POW	Princess of Wales Hospital
RGH	Royal Glamorgan Hospital
PCH	Prince Charles Hospital
YCR	Ysbyty Cwm Rhondda
YCC	Ysbyty Cwm Cynon
HTARI	Human Tissue Act Reportable Incident
PLR	Pregnancy Loss Remains

1. Situation /Background

1.1 The Health Board manages a range of clinical and support services which are involved in the removal, storage, use and disposal of human tissue in the Post Mortem sector across the three main hospital sites and thus is subject to the legal requirements of the Human Tissue Act (2004) (HTA) and regulated by the Human Tissue Authority (HTAuth).

1.2 The purpose of this report is to present the work undertaken to maintain HTA compliance and provide assurance to the Health Board that services within its licenced sites are legally compliant.

1.3 The Health Board is licensed by the HTAuth through compliance inspections which are undertaken every four years or as required.

1.4 This report provides a status update on HTA standards compliance, the Welsh Recommendations (November 2021) with regard to community body stores at YCC and YCR and the recent Fuller Inquiry (Phase 2) Recommendations.

1.5 The Executive Medical Director has requested a more detailed assessment against the Fuller Inquiry (Phase 2) recommendations for presentation in the next Quality and Safety Committee meeting.

2. Specific Matters for Consideration

Quality Control

2.1 The Designated Individual (DI) was appointed by the Health Board and HTAuth in November 2020 and has worked toward strengthening the governance of compliance with the standards set out within the HTA. The DI has predominantly focused upon seven key themes (Figure 1) within a clinical governance framework.

2.2 The Quality Control Department within Pathology also has a specific role in ensuring there is an annual and cyclic programme of audit around the specific standards with the HTAuth Codes, predominantly Code A (Consent) and Code B (Post Mortem).

2.3 Code B (Post Mortem) was updated by the HTAuth in 2023 and the DI has assessed its content and appraised staff accordingly.

2.4 This quality system is augmented through regular inspections of a range of services by the DI including Mortuary Departments, Maternity Services, Emergency Departments, Theatres, Early Pregnancy Units and Gynaecology Wards.

2.5 During 2023 the DI conducted 33 such inspections.

2.6 For those departments outside Pathology, the focus is mainly upon compliance with guidance regarding the sensitive disposal of PLR under 24 weeks and the dignity of the deceased.

Figure 1 HTA clinical governance; the 7 key themes to ensuring compliance

2.7 The outcomes of each local inspection are reported to the Persons Designated for the clinical area and corrective actions put in place.

2.8 Shared learning arising from all inspections is reported widely to clinical teams and the HTA Board.

2.9 The inspection process and the clinical governance framework (Figure 1) ensures the Health Board is HTA compliant.

2.10 During 2023 and in 2024 there has been a focus upon security following the Fuller Inquiry and the following scheduled audits have been in place since 2020;

- Swipe Card Access Audit; a 6 monthly check on those staff who have swipe card access to the Mortuary Departments and Body Stores and their authorisation status. The DI is responsible for authorising all personnel for security access to the Mortuary and Body Stores. Access is strictly limited to Mortuary Staff, Trained Mortuary Porters and a limited number for Facility managers only.
- Swipe Card and CCTV Audit; a 6 monthly random check of out of hours access to ensure the authorised swipe card user matches the observed staff member and their duties.

- CCTV Audit; a 6 monthly audit of CCTV recording ability and the quality of the recording. The minimum standard is maintaining the ability of a CCTV system to record for at least up to 14 days.
- Whilst YCC and YCR are not HTA-Licenced sites the DI has been visiting these areas and conducting inspections with Facility managers to improve standards. The outcomes of these audits are linked into the on-going work to consolidate both the YCC and YCR into Pathology and thus apply the relevant HTA standards for body storage.

Engagement

2.11 Engagement and effective communication is key to compliance. Such engagement includes sharing audit findings, exploring incident outcomes, standard operating procedure reviews, improvements in compliance and seeking ideas on the development of services.

2.12 To assist this objective the DI has introduced a network of 14 Persons Designated across a wide range of services and specialities within the Health Board, focused mainly at the three HTA licenced sites which are Prince Charles Hospital, Royal Glamorgan Hospital and Princess of Wales Hospital.

2.13 The Persons Designated for Facilities and Estates also have oversight of the YCC and YCR body stores.

2.14 Persons Designated appointed by the DI are able to directly influence services in relation to licensable activities.

2.15 The HTA recommends that the role is supplementary within the governance framework, although the DI remains responsible for supervising the activities to be authorised by the Licence.

2.16 The DI meets up with the Persons Designated group every six weeks to share learning and provide support where needed.

2.17 Establishing such a wide ranging network ensures that there is support across departments. To date this has been received well.

2.18 One key area of development for engagement has been the introduction of an *Office 365* Sharepoint page specifically to support Persons Designated and relevant clinicians / managers in relation to the HTA.

2.19 With the support of the Assistant Director of ICT this intranet portal is now operational and has been helpful as a *one stop* site for all matters related to the HTA to support departments throughout the Health Board.

2.20 For example, the following information can be found at this site for shared learning by Persons Designated and for prospective inspection by the HTA;

- Outcomes of local inspections and audit
- HTA newsletters
- Incident Trend Analysis
- Shared Learning log
- Educational Powerpoint presentations
- Estate reports on service records for the ventilation systems within the Mortuary Department

2.21 This new sharepoint page continues to be improved and developed.

2.22 The DI is also a member of the National Pathology Anatomical Pathology Compliance Workforce Group with all other DIs in Wales and also participates in HTAuth Webinars, the most recent held in March on security compliance.

Legal Compliance

2.23 The Health Board was inspected by the HTAuth and the published report is now available on the HTAuth website at;
https://content.hta.gov.uk/sites/default/files/2023-04/2023-02-16%2021%2022%2012338%20Royal%20Glamorgan%20Hospital%20Post%20Mortem%20inspection%20report%20-%20FINAL_0.pdf

2.24 The outcome of the inspection concluded that the Designated Individual and the Licence Holder are suitable in accordance with the requirements of the legislation.

2.25 Following the inspection the HTAuth reported 15 advisory items for the Health Board to consider within the final report.

2.26 Whilst advisory items are not classed as shortfalls against the current standards, they are important suggestions for quality improvements to service delivery. Many of these advisory items have now been addressed including a new door swipe access system for the viewing room at PCH Mortuary and new security caging for the external condensers at POW.

2.27 It was indicated by the HTAuth that in time some of these advisories are likely to inform future changes to statutory standards, thus it is important to consider their value in practice.

2.28 It is likely that future HTA inspections will include also non-licenced body stores in light of the Fuller Inquiry.

2.29 The Medical Examiner (Wales) Regulations will come into force on 9 September 2024. From that date all deaths in England and Wales will be independently reviewed, without exception, either by a medical examiner or a coroner. Medical examiners' obligations, duties and responsibilities will be statutory and recognised by law.

2.30 The laying of the Regulations now means there is approximately 6 months for the final preparatory work to be undertaken across all stakeholders involved in the death certification process so that all frontline services are ready.

2.31 All HTA related incidents are collated by the DI and presented on a quarterly basis to the HTA Board and Persons Designated. Table 1 presents data collated over the last three years.

2.32 The importance of collating such data is primarily to analyse trends and seek improvements in clinical and service areas which may be experiencing issues with training compliance and high staff turnover.

Table 1: HTAct Related Datix incidents reported from April 2021 to March 2024 by Incident Type and Hospital site (n = 143)

		PLR	Deceased	Equipment	Security	PCH	RGH	POW	Other	TOTAL	HTARI	Near-Miss
2021/22	**Q1**	3	9	0	0	0	2	10	0	**12**	1	0
	Q2	7	14	1	0	8	7	6	1	**22**	1	0
	Q3	11	15	2	0	10	10	8	0	**28**	0	1
	Q4	4	5	0	0	4	1	3	0	**9**	0	0
2022/23	**Q1**	4	4	0	3	6	0	4	1	**11**	0	1
	Q2	3	5	0	0	3	3	2	0	**8**	1	0
	Q3	6	6	0	1	5	2	6	0	**13**	0	1
	Q4	7	3	0	0	8	1	1	0	**10**	1	0
2023/24	**Q1**	2	2	0	0	0	0	4	0	**4**	0	0
	Q2	1	8	1	1	5	1	5	0	**11**	0	0
	Q3	4	2	0	0	4	2	0	0	**6**	1	0
	Q4	6	3	0	0	4	3	1	1	**9**	1	1

2.33 For 2021/22 there were 71 HTA related incidents including two HTARIs and one near-miss HTARI.

2.34 In 2022/23 there were 42 HTA related incidents including two HTARIs and two near-miss HTARI.

2.35 For 2023/24 there were 30 HTA related incidents including two HTARIs and one near-miss.

2.36 The overall reduction can be attributed to diligent follow-up and learning post incidents, general awareness raising and regular inspection and audit.

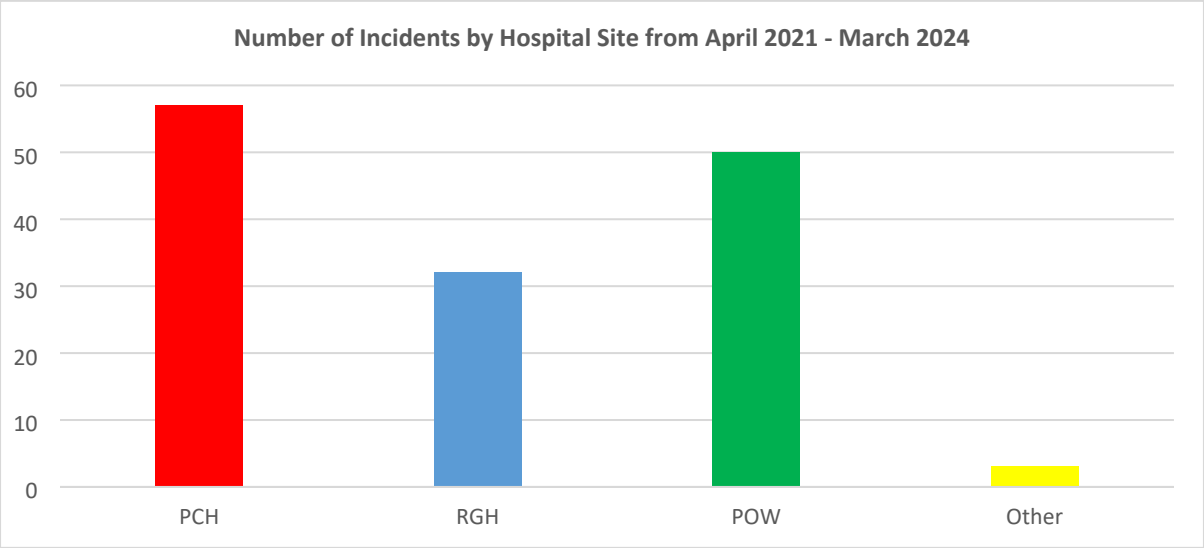
2.37 As with the audit programme, any shared learning from the outcomes of the incidents is communicated and discussed within the Persons Designated group and HTA Board.

2.38 The HTAuth have recently updated their HTARI guidance for Licenced NHS Health Boards and Trusts. There have been no major changes to the main categories for reporting HTARIs however there are additional triggers which may lead to more reporting of near-miss HTARIs.

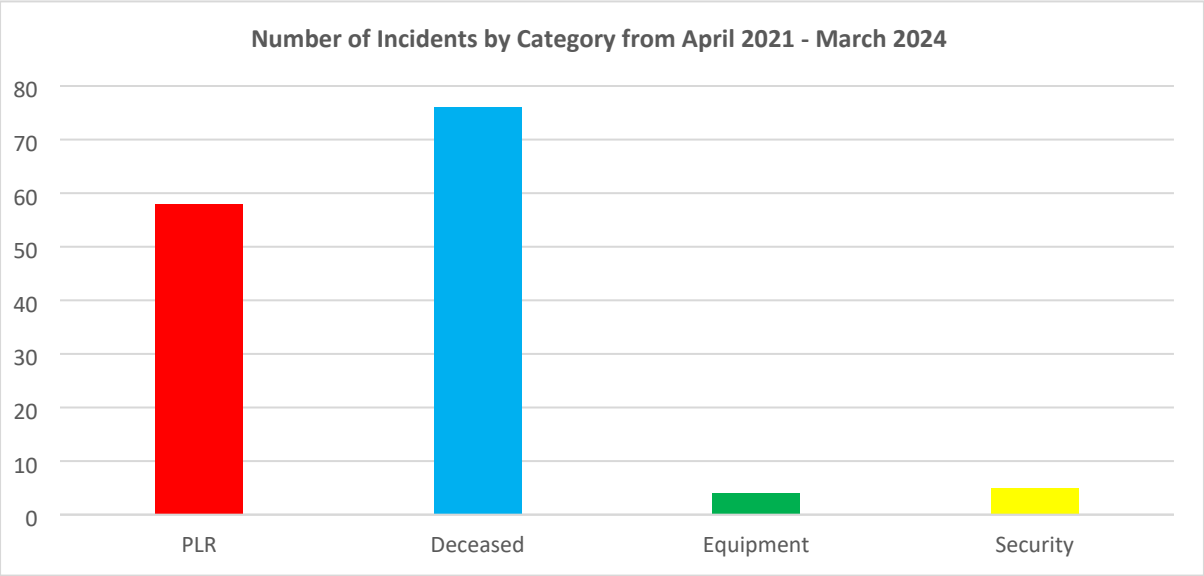
2.39 In terms of differences between hospital sites, the Royal Glamorgan Hospital site has fewer incidents because it has less Maternity and Gynaecology clinical services (Graph 1).

2.40 In terms of type of incidents the leading two categories are reports regarding the adult deceased, followed by PLRs. The majority of PLR incidents relate to incomplete or incorrect paperwork from clinical areas. (Graph 2).

Graph 1 - HTAct Related Datix incidents reported from April 2021 to March 2024 By Hospital site (n = 143)



Graph 2 - HTAct Related Datix incidents reported from April 2021 to March 2024 By Hospital site (n = 143)



Welsh Government Guidelines for Community Body Stores

3.1 Welsh Government has published interim recommendations to Health Boards in Wales following the Fuller Inquiry in 2021. These recommendations are as follows:

- Identify and appoint a single accountable officer for body storage facilities who can oversee implementation of the recommendations and provide updates to your Board / Welsh Government.
- Review and consolidate where possible their body storage arrangements, especially in community hospital settings
- Consolidate the management of body stores and where possible align them to mortuary and post-mortem services
- Apply relevant HTAct post-mortem sector licensing standards and guidance to body storage areas

3.2 At the time of the report both YCC and YCR were determined to be secure however a plan to consolidate the management of the body stores and align these to mortuary services in Pathology was determined to have an annual cost implication.

3.3 These resource challenge has now been mostly resolved and there is a plan to move forward with the necessary changes via a Task and Finish Group between Pathology, Facilities, Nursing and Hospital Management.

3.4 This plan will ensure that the relevant HTAct post-mortem sector licensing standards and guidance (in the main) will be applied to body storage areas and ensure the Welsh Government recommendations are met.

3.5 The Pathology Directorate will have overall responsibility of standards with the support of the DI; a similar set up to HTA licenced sites.

3.6 It is envisaged that this work will be completed within the next three months and that current challenges to full compliance will be resolved, which include;

- The introduction of a 24/7 Refrigeration Alarm system at both YCC and YCR (revenue stream to be identified)
- New CCTV coverage at YCR body store
- Improved Standard Operating Procedures for transfer into the Body Stores from Wards
- Improved Standard Operating Procedures for release from the Body Stores
- Introduction of an audit schedule to cover a number of HTA standards

4 Fuller Enquiry (Phase 1) Recommendations

4.1 The David Fuller inquiry: Phase 1 report was published on 28 December 2023 and a recent letter (4/3/24) from the National Clinical Director NHS Wales sets out the 17 recommendations, mainly related to Mortuary Security. Please see the following document link;

David Fuller inquiry: phase 1 report - GOV.UK (www.gov.uk)

4.2 Professor Chris Jones states *" The Report makes a set of Recommendations that, although specific to Maidstone and Tunbridge Wells NHS Trust, will become a blueprint for health boards in Wales to follow to prevent such horrific events from ever happening again."*

4.3 The three main Mortuary Departments at each HTA Licenced site meet the majority of the recommendations.

4.4 The greater challenge is the implementation of the recommendations at YCC and YCR.

4.5 It is anticipated that the consolidation of both body stores into Pathology, as mentioned earlier, will put in plans to meet all the recommendations.

4.6 The Executive Medical Director has requested the DI to prepare a more detailed analysis and assurance report for the next Quality and Safety Committee meeting.

5 Key Risks / Matters for Escalation

5.2 There is a need to address the recommendations from Welsh Government for the consolidation of community body stores to the overall management of mortuary services within the Pathology Directorate.

5.3 There is a need to ensure the Fuller Inquiry (Phase 1) recommendations are met within the community body stores ay YCC and YCR.

6 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 *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)*)	Leadership
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Domains of Quality (*Duty of Quality Statutory Guidance (gov.wales)*)	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:	If no, please include rationale below: This paper is for noting.
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: This paper is for noting
Cyfreithiol / Legal	Yes (Include further detail below)	
	HTA Compliance at POW/RGH/PCH is a legal requirement and the Designated Individual has primary legal responsibility under Section 18 of the Act.	
Enw da / Reputational	Yes (Include further detail below)	
	Non-compliance with the HTA is a reputational risk for the Health Board.	
Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	Yes (Include further detail below)	
	To achieve the Welsh Government recommendations for Community Body stores there is a need to identify two revenue streams as described in this report.	

7 Recommendation

7.2 This paper is for discussion and NOTING

8 Next Steps

8.2 Continue to implement the governance framework of the 7 key themes within Figure 1 (page 3) to ensure and maintain compliance with the Human Tissue Act.

8.3 Implement a Task and Finish group to improve standards within the body stores and consolidation of the YCC and YCR within mortuary services.

Agenda Item
9.2.9

Quality & Safety Committee

HEALTHCARE INSPECTORATE WALES IMPROVEMENT PLAN TRACKER REPORT SEPTEMBER-OCTOBER 2023

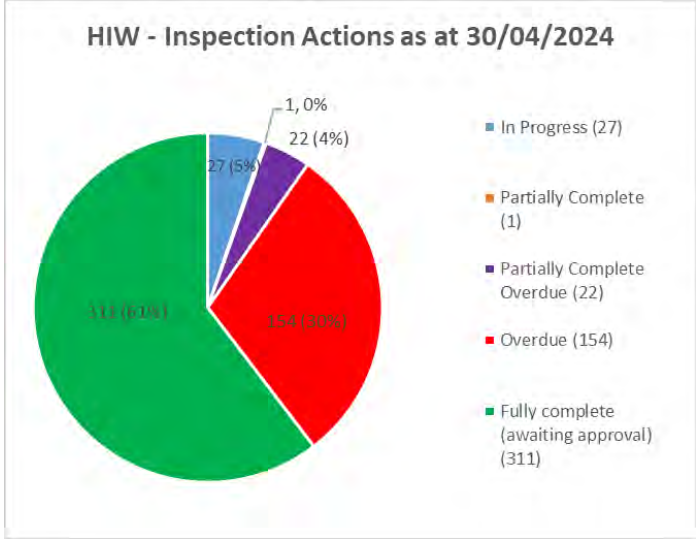
Dyddiad y Cyfarfod / Date of Meeting	16th May 2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Claire Brown Head of Quality Assurance and Compliance
Cyflwynydd yr Adroddiad / Report Presenter	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

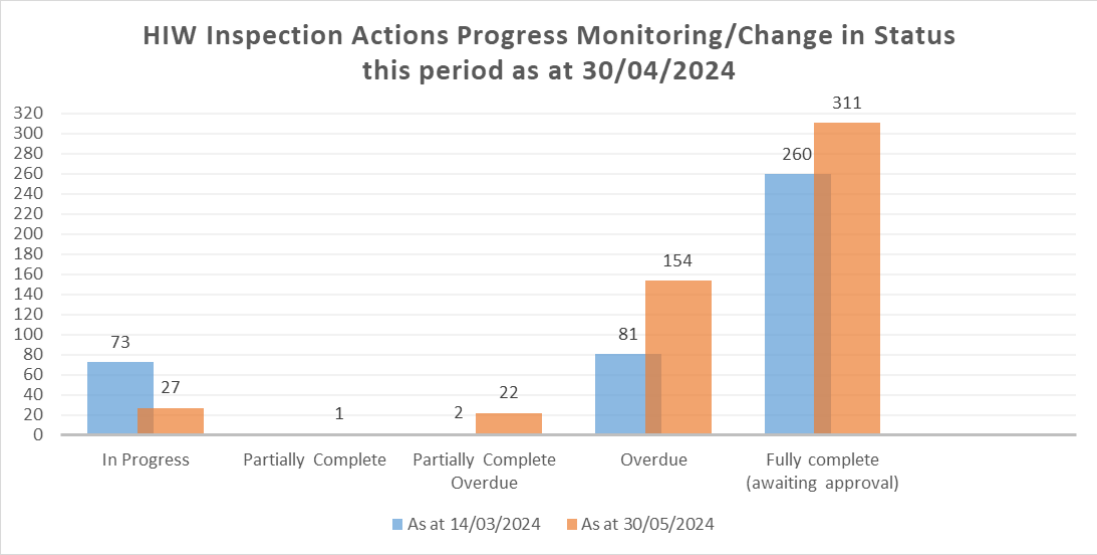
Pwrpas yr Adroddiad / Report Purpose	For Noting

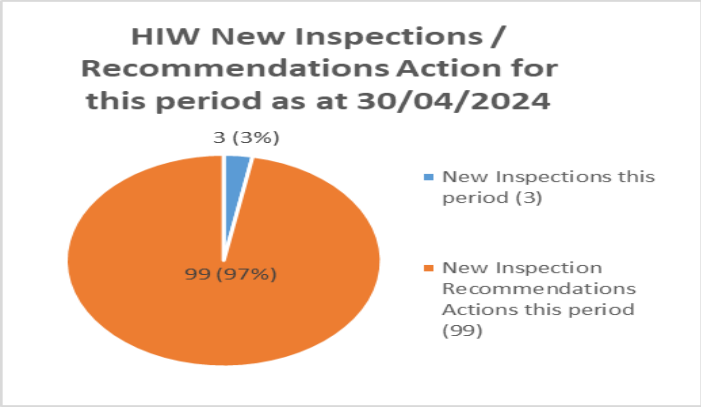
Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
(Insert Details)	Click or tap to enter a date.	

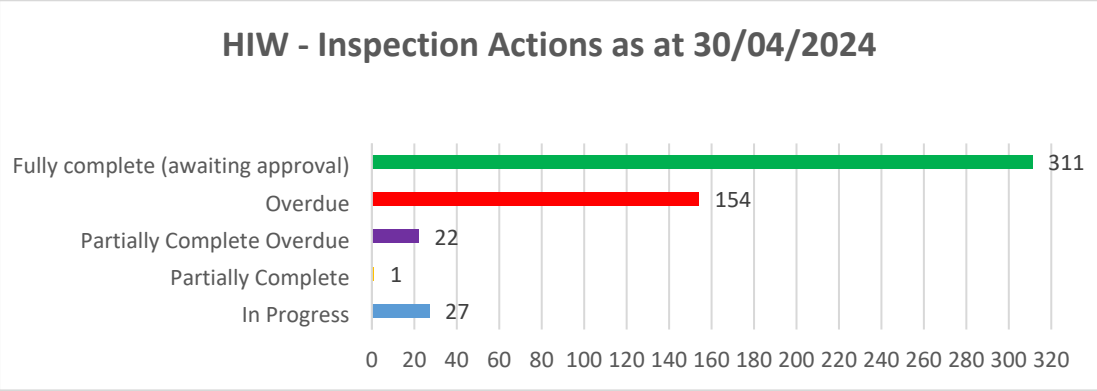
Acronyms / Glossary of Terms	
HIW	Healthcare Inspectorate Wales
AMaT	Audit Management and Tracking

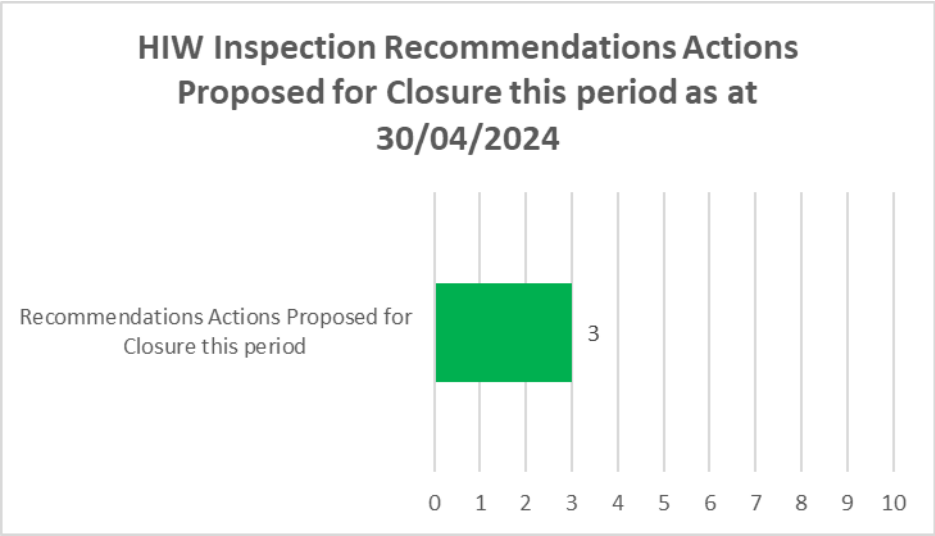
HIW Dashboard as at 30/04/24











Actions by Status- As at End April 2024					
Total Number of Actions	**Actions passed due date**	**Actions ongoing/partial complete**	**Yellow- Actions on Target to meet original or revised completion date**	**Actions Completed**	**Completed actions closed in AMaT**
515	154	22	28 *(27 In Progress and 1 Partially Complete)*	311	

1. Situation /Background

1.1 The purpose of this report is to present an update to the Quality & Safety Committee on progress against the open actions held on the Healthcare Inspectorate Wales (HIW) tracker following acceptance of the submitted improvement plan(s) to HIW following their Inspection(s) across the organisation for the timeframe March to April 2024.

1.2 Oversight and continuous review for assurance is reported to the Care Groups Quality, Patient Safety and Experience Committee(s)

1.3 A dashboard summary of the Health Inspectorate Wales (HIW) Improvement plans and Immediate Assurances from inspections have been included on page 2 of this report, however, the detailed tracker is also included for information.

1.4 Communication has been sent out of all Heads of Quality within Care Groups to seek their support in updating the AMaT system by a prescribed date before each Quality and Safety committee. The Head of Quality Assurance and compliance has now instigated a data cleanse with Heads of Quality from each care group. This will take time to complete due to the nature and complexity of the historic recommendations.

2. Specific Matters for Consideration

2.1 Each iteration of the HIW tracker 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 changes and progress on the actions which remain as open as these turn to closed/completed actions throughout this and future reports.

2.2 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. Work is ongoing to get the appropriate leads trained and able to upload independently to AMaT.

2.3 Where actions are reported as complete/closed the Care Groups are responsible for ensuring the supporting evidence is available to support the closure and completeness of such actions. The introduction of the Audit Management and Tracking system (AMaT), whereby Care Groups are able to update independently directly into the system will support a more effective and efficient process by which the reviews can be updated.

2.31 A breakdown of the status position with regards to all actions up to the end of February 2024 is detailed below.

- A total of 515 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.

This is further broken down as follows:

- 154 actions reported as Red with the actions being those which are incomplete and have passed the agreed due date;
- 22 actions reported as Amber which are those actions partially complete/overdue;
- 28 actions reported as Yellow which are those on target to meet original completion date (In Progress / Partially Completed);
- 311 actions reported as Green are completed actions subject to approval

2.4 Current Position

- There were 3 Improvement Plans added to the tracker during this period.
- 1 Improvement plans was fully completed and is awaiting Executive approval.
- 3 Recommendation Actions are now fully completed and closed in AMaT this period.

2.5 Healthcare Inspectorate Wales request regular three-monthly updates on all improvement plans where ongoing or outstanding actions remain following the initial submission of the improvement plan, these are updated by the responsible Care Group and submitted to HIW following Executive Director review and sign off.

3. Key Risks / Matters for Escalation

3.1 As outlined above, 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.

3.2 Steps have been taken to seek updates from the Care Group leads in relation to outstanding HIW improvement plans to ensure full closure and assurance of actions taken to compete all the improvement plans in an agreed and timely manner. Work is ongoing to complete a data cleanse of all inspections.

3.3 Due to the change in the audit management and tracking process which is still a work in progress (please see table of software development requests (APPENDIX 2), there continues to be a requirement for extra manual inputting and management of the data in order to provide committee members with useable data. This continues to necessitate the requirement to adhere to a strict deadline for receipt of updates.

3.4 All leads should now have received instructions and assistance in getting set up on the AMaT system. The team will continue to guide and support leads through this new automated process to ensure committee members are receiving robust, meaningful and timely updates.

3.5 Identification of themes and risks will continue to develop over the next 6-12 months.

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/	No - Not Applicable

Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	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: This is an overarching position update report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment which will be undertaken by the responsible Care Group.
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: This is an overarching position update report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment which will be undertaken by the responsible Care Group.
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 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 Working in partnership continues to ensure a smooth and robust transition across to the Assurance and Compliance team who will co-manage the compliance of HIW Inspections moving forward.

Code	Title	Date of Inspection	Care Group & DON Lead	Recommendations	Actions
Healthcare Inspectorate Wales (HIW)/2017/141	National review of Ophthalmology Services - report published 2017 - 1st update submitted 2019-follow up update submitted December 2022	30/01/2017	**Planned Care** Sharon O'Brien, Nurse Director	22	22
Healthcare Inspectorate Wales (HIW)/2020/136	Quality Check Summary Clinical Decisions Unit, Prince Charles Hospital [Prince Charles Hospital - Clinical Decisions Unit (Ref: 20067)]	10/12/2020	**Unscheduled Care** Emma James, Nurse Director	3	3
Healthcare Inspectorate Wales (HIW)/2020/139	Quality Check Summary Ysbyty Cwm Rhondda [Ysbyty Cwm Rhondda - Ward A1 (Ref: 20030)]	08/09/2020	**Primary Care and Community** Lucie Williams, Nurse Director	2	2
Healthcare Inspectorate Wales (HIW)/2021/135	Quality Check Summary Seren Ward, Royal Glamorgan Hospital [Improvement plan - Seren Ward - Royal Glamorgan Hospital (Ref: 20090)]	20/04/2021	**Mental Health & Learning Disabilities** Ana Llewelyn, Nurse Director	1	1
Healthcare Inspectorate Wales (HIW)/2021/137	National Review of Mental Health Crisis Prevention in the Community	30/06/2021	**Mental Health & Learning Disabilities** Ana Llewelyn, Nurse Director	17	18
Healthcare Inspectorate Wales (HIW)/2021/138	Quality Check Summary Pinewood House [Pinewood House - Quality Check]	20/07/2021	**Mental Health & Learning Disabilities** Ana Llewelyn, Nurse Director	2	2
Healthcare Inspectorate Wales (HIW)/2022/129	HIW & CIW Joint Community Mental Health Team (CMHT) Inspection Report (Announced) Bridgend North CMHT, Maesteg Community Hospital [HIW Improvement Plan Service: Bridgend North CMHT (Maesteg Hospital) (Ref: 3189)]	01/11/2022	**Mental Health & Learning Disabilities** Ana Llewelyn, Nurse Director	6	10
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	**Children & Families** Suzanne Hardacre, Director of Midwifery	7	7
Healthcare Inspectorate Wales (HIW)/2022/132	Hospital Inspection Report (Unannounced) Prince Charles Hospital – Maternity Services [Appendix C - Improvement Plan - Prince Charles Hospital - Maternity Unit (Ref: 3110)]	26/09/2022	**Children & Families** Suzanne Hardacre, Director of Midwifery	3	3
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	**Unscheduled Care** Emma James, Nurse Director	1	2
Healthcare Inspectorate Wales (HIW)/2022/36	Hospital Inspection Report (Unannounced) Angelton Clinic, Glanrhyd Hospital [Improvement plan Service Angelton Clinic – Glanrhyd Hospital (Ref: 3171)]	14/11/2022	**Mental Health & Learning Disabilities** Ana Llewelyn, Nurse Director	5	5
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	**Mental Health & Learning Disabilities** Ana Llewelyn, Nurse Director	39	180
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	**Unscheduled Care** Emma James, Nurse Director	2	2
Healthcare Inspectorate Wales (HIW)/2023/140	HMP Parc Prison	16/05/2023	**Primary Care and Community** Lucie Williams, Nurse Director	7	7
Healthcare Inspectorate Wales (HIW)/2023/154	Paediatric Ward - Princess of Wales Hospital-Appendix A-Immediate Assurance (Ref: 03421)	25/09/2023	**Children & Families** Suzanne Hardacre, Director of Midwifery	1	2
Healthcare Inspectorate Wales (HIW)/2023/155	National Review of Patient Flow - a journey through the stroke pathway	07/09/2023	**Unscheduled Care** Emma James, Nurse Director	50	50
Healthcare Inspectorate Wales (HIW)/2023/156	Hospital Inspection Report (Unannounced) Paediatric Ward, Princess of Wales Hospital [Appendix C - Princess of Wales Hospital, Paediatric Ward 25 & 26 September 2023 (Ref: 03421)]	25/09/2023	**Children & Families** Suzanne Hardacre, Director of Midwifery	1	1
Healthcare Inspectorate Wales (HIW)/2023/157	Appendix C - Improvement Plan: Angelton Clinic, Glanrhyd Hospital (Ref: 03445)	13/11/2023	**Mental Health & Learning Disabilities** Ana Llewelyn, Nurse Director	25	26
Healthcare Inspectorate Wales (HIW)/2023/158	Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03414)	20/11/2023	**Mental Health & Learning Disabilities** Ana Llewelyn, Nurse Director	19	19
Healthcare Inspectorate Wales (HIW)/2023/159	Appendix C - Improvement Plan: Tirion Birth Centre, Royal Glamorgan Hospital (Ref: 03061)	19/10/2023	**Children & Families** Suzanne Hardacre, Director of Midwifery	5	22
Healthcare Inspectorate Wales (HIW)/2023/160	Appendix C - Improvement Plan: Ty Llidiard (Ref: 03362)	11/09/2023	**Mental Health & Learning Disabilities** Ana Llewelyn, Nurse Director	20	32
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	**Unscheduled Care** Emma James, Nurse Director	31	36
Healthcare Inspectorate Wales (HIW)/2024/165	Appendix A Immediate Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	09/01/2024	**Children & Families** Suzanne Hardacre, Director of Midwifery	2	27
Healthcare Inspectorate Wales (HIW)/2024/166	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	09/01/2024	**Children & Families** Suzanne Hardacre, Director of Midwifery	14	36

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Date Due	Revised Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	**National review of Ophthalmology Services - report published 2017 - 1st update submitted 2019-follow up update submitted December 2022**	Issues relating to patient referral process. All parties (Welsh Government, NWIS, Ophthalmology Planned Care Board and Health Boards) must work together towards the introduction of electronic patient record/referral system from optometrists directly to secondary care.	Roll out of Open Eyes has been delayed nationally. Primary Care have worked with the programme team to provide contact details for all optometrists requiring access/relevant training. Enhanced support has been offered by the HB ICT programme and projects team to implement Openeyes, the national electronic patient record/referral system for eye care which will support closer and integrated working across care settings. A task and finish group has been established, with the clear objective of implementing the system in glaucoma clinics in the UHB's hospitals by the end of March 2023. The programme plan is to then implement e-communications (including e-referrals) between primary and secondary care as stage 2 and to roll out to the other sub specialities in Ophthalmology as stage 3. These are in the local and national plans to be undertaken in the financial year 2023/24. Programme management support has been provided by WG for the 15 months from Jan 2023 to March 2024.	Planned Care	01.03.2023		**Overdue**	April 2024 Update - DCHW-led rollout of OpenEyes still delayed, possibility of reopening tender process. OE contract with CTM in place until at least Jan 2025 (currently only Glaucoma clinics live). CTM OpenEyes Business Project Manager no longer in post (contract not renewed past March 31st), significantly impeding further rollout of OE in hospital sites as no defined support/project management. Live trial of OpenEyes in 4 glaucoma community optometry practices ongoing. National DCHW-led rollout of e-referrals also delayed, but local work ongoing to establish single inbox for email referrals from primary care into Ophthalmology. Inbox monitoring rota being established, timeline for launch dependent on primary care NHS email roll out below but expected to be live by August 2024. CTM keen to promote roll out of M365 with community optometry practices following successful pilot - provided DCHW with priority list (focusing on practices involved in shared care/WGOS4) during their rollout of NHS email (rolling out April-Aug). Previous Updates - Stage 1 – to be completed by March 2023. Stages 2 & 3 – BC dependent – objective is to start implementation in first half of 2023/24.
			The CHC's National Ophthalmology Review highlighted that some patients felt they had not been provided with sufficient information regarding the reason for their referral. (Patient Referrals - Referral Process) All parties (Welsh Government, NWIS, Ophthalmology Planned Care Board and Health Boards) must work together towards the introduction of electronic patient record/referral system from optometrists directly to secondary care.	Primary care has produced and shared patient information on CTM social media platforms to explain changes in patient referrals and enhanced services now being delivered in primary care/closer to home. Recent recruitment of additional Optometry Advisor [jan'23] will support practices to improve communication and referral pathways for patients and will support practices where poor quality referrals are flagged. HES updates on waiting times are shared with practices via SEWROC to support conversations with patients and manage expectation.	Planned Care	01.04.2024		**Fully complete (Awaiting approval)**	April 2024 Update - EPR/E-referral - see MD1/1. Implementation plan for rollover of shared-care services to new WGOS4 pathways submitted to WG, with cross-sector discussion meeting planned 20/5/24. Once ratified, comms sessions & newsletter to update primary care optoms on changes will be delivered, as will updated patient service signposting. Dec 23 Completed - new optometry contract phased implementation began Oct'23 2- implementation of EPR across HB remains an ongoing process
			Quality of referrals being sent to rapid access pathway (Patient Referrals – Quality of Referrals) A) Health Boards should consider methods to refine referrals to ensure patients enter the most appropriate care pathway in a timely and efficient manner, avoiding unnecessary visits.	Primary Care /HES have already established a number of referral refinement schemes within practices in CTM: • Independent Prescribing • Wet AMD • Diabetic Retinopathy • Glaucoma (develop existing service in place	Planned Care	01.04.2024		**Fully complete (Awaiting approval)**	Completed: all schemes are now established within CTM April 2024 Update - Ongoing pathways continue to monitor under existing shared-care agreements during the WGOS transition phase. Improved data sharing between secondary and primary care re: patient outcomes within these pathways being scoped. Insufficient admin resources within HES team a significant challenge for this. Currently 1.5wte Band 3-5 admin support committed to these pathways (1.0wte Band 3 post vacancy imminent, but recruitment to replace agreed) further admin support necessary to scale up pathways. WG to identify regional Planned Care Board leads to signpost secondary care to potential funding to support WGOS delivery. New HB-wide glaucoma referral refinement pathway being designed, to be live by Oct '24.
			Quality of referrals being sent to rapid access pathway (Patient Referrals – Quality of Referrals) B) Health Boards should consider providing educational events/material to raise awareness among optometrists and other relevant staff of local referral pathways.	Practices are notified when new local referral pathways are introduced and updates circulated to practices. Optometry newsletter to be produced in primary care and circulated 4 times a year. Accelerated Cluster Development will allow closer working for practices within clusters. CTM to hold first event jan'23	Planned Care	01.04.2024		**Fully complete (Awaiting approval)**	April 2024 Update - ACD engagement successful across HB, HB protocol for managing failure to engage being ratified. Local discussion sessions with primary care optometry practices to be delivered once pathway changes finalised over next few months, with newsletter updates. Quarterly ECCG in progress following reinstatement in Dec '23 (next meeting May '24), Monthly cross-sector WGOS planning/implementation meetings between primary & secondary care teams for both Glaucoma and Medical Retina also taking place. Dec 23 update newsletters will continue to be sent to practices via primary care team regarding updates and new referral pathways. There will be ongoing engagement with practices due to the implementation of new contract/WGOS services and communication sent to relevant services ie GMS/pharmacy/secondary care on any relevant changes. Most practices are now engaged with ACD under the new contract obligations and work will continue to engage with those practices not yet engaged. HB ECCG will be the platform for primary care to share updates with secondary care on new contract/WGOS.
			Quality of referrals being sent to rapid access pathway (Patient Referrals – Quality of Referrals) C) Health Boards should ensure feedback is provided to optometrists when required relating to quality of referrals sent to ensure learning.	> 90% of referrals come directly from optometrist with good communication between primary and secondary care. Optometry dept. working with OA developed letter templates to communicate insufficient referral detail to primary care for glaucoma referrals which has improved referral detail.	Planned Care	01.04.2024		**Fully complete (Awaiting approval)**	Dec 23 update the review of quality referrals sent by optometry practices will be an ongoing process
			Lack of feedback provided to optometrists following referral and discharge of patients (Patient Referrals – Communication Following referral) (Discharge patient – Quality of information) A) Health Boards should ensure feedback of diagnosis and a treatment plan is provided to referring optometrists following every referral made to the service, including whether a referral to a low vision service has been made.	Optometrists are copied into all clinic correspondence for new patients when the referral has come from the optometrist in POWH - this will be done across all sites within CTM.	Planned Care	01.04.2024		**Fully complete (Awaiting approval)**	April 2024 Update - Complete. Dec 23 update this is done by the admin staff across the HB in order to ensure that optometrists are kept up to date with patients status within HES. This will be an ongoing process by the service manager to ensure that when a patient is referred by the optometrist that a copy of the clinic correspondence is sent to them for information. All new starters to be informed of the process.
			Lack of feedback provided to optometrists following referral and discharge of patients (Patient Referrals – Communication Following referral) (Discharge patient – Quality of information) B) Optometrists must use the appropriate referral form and ensure that their name and practice address are clearly legible.	Primary care to work with HES to identify where this is an issue within practices and provide support via OA to ensure appropriate information is shared in the referral. New recruitment OA to undertake referral audits to support this. Optometrists contact details are not always clear on the referral form, internal arrangements being made to monitor the quality and individually feedback to the Optometrists via Local advisor.	Planned Care	01.04.2024		**Fully complete (Awaiting approval)**	Dec 23 update this will be an ongoing process. Optometry Advisors will continue to work with both practices and HES to ensure the submission of high quality referrals. Implementation of the EOR system will also support /improve referral process.
			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.	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		**Overdue**	April 2024 Update - EPR rollout delays. December 2023 Update (Date of review 12/12/23) See Item 1What next? By when? By Whom?
				RCO leaflets provided about consent process in pre assessment Information leaflets provided for any eye emergency care Laser information Cataract information ECLO services Blepharitis leaflets FFA – Information Surgery information leaflets • CM08: Cosmetic Blepharoplasty • CM09: Cosmetic Ptosis Surgery • OP01: Cataract Surgery (phacoemulsification) with Monofocal Intraocular Lens Implant • OP02: Blepharoplasty • OP03: Glaucoma Surgery (Trabeculectomy) • OP04: Retinal Detachment Surgery • OP05: Corneal Transplant Surgery • OP06: Correcting a Squint (child) • OP07: Entropion and Ectropion Repair • OP08: Ptosis Surgery (adult) • OP09: Correcting a Squint (adult) • OP10: Ptosis Surgery (child) • OP11: Intravitreal (Anti-VEGF) Injection • OP12: YAG Capsulotomy • OP13: Removing a Chalazion • OP14: LASIK Surgery • OP15: Removal of Pterygium • OP16: LASEK Surgery • OP17: Macular Hole Surgery	Planned Care	01.04.2024		**Fully complete (Awaiting approval)**	April 2024 Update - Additional SLT (glaucoma laser procedure) leaflet being designed, along with procedure counselling guidelines from Glaucoma consultant team, to improve patient experience and laser clinic flow/efficiency. To be discussed in clinical audit meeting in June. Plan for reinstatement of local Glaucoma Patient Education Forums included in business case for potential Glaucoma Diagnostic Hubs at YCC/MCH. Dec 23 update Date of review: 03/08/2023 What next? The health board has a comprehensive selection of patient information leaflets available. In order to ensure that these meet the needs of our patients, these leaflets need to be well stocked and updated nationally through the EIDO programme to ensure that they reflect best practice. Objective to be discussed at directorate meeting to raise awareness to both clinicians and nursing staff about supplying patients with information during their clinical consultations. By when? Weekly review of leaflet stock within clinical area. Objective to be discussed at directorate meeting on 8th August 2023 By whom? Service Manager / Senior Nurse to cascade information to team. Information gathered from the clinical teams regarding what literature is available within the clinical departments. Objective to be discussed at directorate meeting to raise awareness of both clinicians and nursing staff supplying the patients with information during their clinical consultations.
			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.	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		**Overdue**	December 2023 Update (Date of review: 01/01/24) - What next? To continue to monitor the FUNB list across all sub specialties within ophthalmology By when on a weekly basis By whom service manager
			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.	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		**Overdue**	December 2023 Update - this will need ongoing review by the service manager to ensure that the most clinically urgent patients are booked with priority. Ongoing review by the service manager, this practice is currently undertaken in Bridgend but will need to be put into practice in all parts of the HB to ensure a pan CTM approach.
			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.	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		**Overdue**	December 2023 Update - this work will be ongoing to ensure lists re kept up to date and 'clean' at all times. Ongoing review by the service manager to validated and ensure correct ratio of new and follow patients in all clinic templates.
			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.	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		**Overdue**	December 2023 Update (Date of review: 12/12/2023) - What next? Band 5 1.0 Vacancy not appointed in to - position being re-advertised on Trac. Position escalated to HON and CSGM to look for support in the short term. CSGM to determine if harm review team funding can be extended past March 2024 as the project is still ongoing. Macular cluster report due by 15/12/2023, good progressing being made towards this but absence of the Band 5 FLO support is stalling the work. By when? Closing date TBC for band 5 position. A/w feedback about alternate staffing to support in the short term. CSGM to feedback if funding can extended and workforce to be reviewed accordingly By whom? Senior Nurse / CSGM September 2023 Update (Date of review: 03/08 /2023) - What next? Vacancies for harm review workforce are currently out to advert. An cluster RCA commissioning meeting is to be arranged within the next 2/52 regarding the macular service and the patients who have experienced moderate and above harm as a result of a follow up not being booked By when? to be reviewed in 2/52 with update. By whom? Senior Nurse.
			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.	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		**Overdue**	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 GIRFT 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 instill 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 GIRFT 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?

			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.	b) CTM has funded a community optometrist to complete his medical retina higher certificate with a placement in the medical retina service starting in March 2023. We continue to provide independent prescribing, glaucoma certificate and pre-registration placements to community optometrists. An AMD new referral refinement pathway (CARRDS) is due to be implemented in the coming weeks with in house training of participating local community optometrists. This will allow all new AMD referrals to be triaged in primary care. A DRSS new patient scheme has been implemented over the last few months with low risk DRSS patients reviewed by primary care with additional training. DRSS waiting list has significantly dropped and allowed the majority of DRSS patients to be kept in primary care	Planned Care	01.04.2024		Overdue	April 2024 Update - HES training/consultant mentoring for higher qualifications for community optometrists (to allow them to deliver enhanced services) in progress, with joint co-hosting with Cardiff University. 5 CTM consultants currently agreed to provide mentoring services over 2024/25. HEIW funding for administrative placement co-ordinator secured, to be advertised asap. December 2023 Update (Date of review: 12/12/23) - Community optom completed funded academic course successfully, placement pending 2024 (delayed due to consultant workload). Community optom post-grad placements widely delayed due to HES workload/lack of funding - Joint collaboration with Cardiff University to co-host placements in 2024, reducing time intensive burden on hospital site. Funding request for admin placement co-ordinator role submitted to HEIW. AMD community scheme live (June 2023), running well with consultant feedback. What next? By when? By whom?
			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.	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		Overdue	April 2024 Update - CD attending national CIN meetings, to develop regional strategies/shared learning. December 2023 Update - No update received.
			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.	WG to answer	Planned Care	01.04.2024		Overdue	December 2023 Update - No update received.
			ECLO – Limited capacity/cover (Service Support Staff – Eye Care Liaison Officer) Health Boards should ensure that there is ECLO for their eye care clinics at all times and consideration should be given as to whether one ECLO is sufficient for the eye care service.	POW – RNIB ECLO coverage 4 days RGH / PCH / YCR – NHS ECLO for RGH, PCH, YCR – coverage 3 days ? Commissioning issue - ask Elizabeth Beadle	Planned Care	01.04.2024		Overdue	December 2023 Update - No update received.
			Concerns raised by staff in relation to a lack of processes in place to submit comments/suggestions to health board management. (Service Support Staff – Eye Care Liaison Officer) Health Boards must ensure that there are methods in place to allow all staff to raise any concerns/suggestions about improvements to service provision they may have. This process should to ensure that feedback is routinely provided to individuals.	Eye care collab and directorate meeting.	Planned Care	01.04.2024		Fully complete (Awaiting approval)	Complete 01/12/2023 Dec 23 update Date of review: 12 / 12 /23 ECCG re-established as of 1/12/23, regular directorate meetings ongoing What next? By when? By whom?
			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.	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		Overdue	April 2024 Update - CTM Optometry co-authored WG white paper on role of Hospital Optometry in NHS Wales, with specific recommendations on expanding the Welsh hospital optometry workforce and establishing a Hospital Optometry Forum in Wales. To be presented at CIN in May to identify potential resources to implement recommendations nationally, to be followed by local presentation by CTM Optometry at each HB's ECCG over next quarter, to highlight need to develop this workforce across Wales. CTM Optometry collaborated with WIRG, HEIW and ABUHB Optometry on development of UK-wide ESR updates for Optometry. New roles allowing for a defined career progression pathway for optometrists, and more accurate Areas of Work, Occupation Codes and Staff Group approved nationally by NHS Digital in March 2023, to be implemented UK-wide in the National Workforce Data Set June 2024. This will allow the optometry workforce to be more accurately captured by ESR across the NHS, aid in recruitment and offset workforce attrition for Hospital Optometry on a national scale. December 2023 Update (Date of review: 12/12/23) - Optometry SBAR detailing need for hospital optometry workforce expansion in size and clinical role completed. Funding secured from HEIW for 3 hospital optometrists to complete Higher Certificate in Medical Retina qualification (commencing March '24). Optometry-led laser service in situ in RGH, successfully brought laser WL down. What next? By when? By whom?
			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.	See points above. CTM already utilising both hospital and primary care based optometrists in a range of sub-specialities. Primary care pathways and schemes include IPOS or unscheduled care, Glaucoma community monitoring scheme, AMD referrals refinement and DRSS.	Planned Care	01.04.2024		Overdue	April 2024 Update - GIRFT MDT working group on pause following management changeover. December 2023 Update (Date of Review: 12/12/23) - As above, await outcomes from GIRFT MDT workforce working group that will be reviewing the workforce. What next? By when? By whom?
			Issues in relation to poor relationships between primary and secondary care staff impacting on progress to service developments Health boards must ensure that relevant staff engage with the local Eye Care Group. The group should meet regularly and be chaired by a member of the executive team. A key objective is to improve the working relationships between primary and secondary care staff to foster joint working initiatives.	Primary/Secondary care have worked collaboratively to implement shared care pathways in Independent Prescribing/Glaucoma/Wet AMD/Diabetic Retinopathy, work continues to improve and develop these services. Health Board to ensure appropriate representation at local ECCG from a primary care management and clinical perspective/HES management and clinical team to enable appropriate scrutiny/oversight on actions taken to support reduction of waiting times/ workforce//new pathways/implementation of open eyes/contract reform developments	Planned Care	01.04.2024		Fully complete (Awaiting approval)	April 2024 Update - Good cross-sector representation at ongoing ECCG and local OLG meetings. Dec 23 update - Date of review: 12 / 12 / 23 4 shared-care schemes established with frequent cross-sector contact/consultant input/feedback sessions etc. Consultant Connect implemented for Glaucoma scheme (Nov '23) to allow community optoms direct access to Glaucoma team for advice & guidance. ECCG re-established 1/12/23 with good cross-sector collaboration and attendance. HB Optometry Liaison Group long established - continues bimonthly, with both primary & secondary care rep. What next? By when? By whom?
Healthcare Inspectorate Wales (HIW)/2020/136	10.12.2020	**Quality Check Summary Clinical Decisions Unit, Prince Charles Hospital [Prince Charles Hospital - Clinical Decisions Unit (Ref: 20067)]**	The health board must provide HIW with assurance that staffing levels are not currently impacting on the effectiveness of care being delivered to patients and that any changes resulting from the review into staffing establishments at the unit will help reduce the pressures faced on existing members of staff.	During the pandemic additional staff above the established levels for the unit have been agreed to support the pressures within the unit. However filling the shifts was problematic despite agency and bank requests being made to staff bank 6 weeks in advance. The fill rates; October 2020; 64% equivalent to 155 shifts filled and 86 shifts remain unfilled. November 2020; 62% equivalent to 131 shifts filled and 79 shifts remained unfilled. Every effort is made to fill the shifts by offering staff overtime at enhanced rates as agreed by the Health Board. The sickness levels for the unit are robustly monitored; December 2020 9.1% January 2021 10.2% February 2021 6.37% The team are hopeful with the reduced pressures from the pandemic that the sickness trajectory will continue to improve. CDU staffing establishments have been agreed for the 24 bed ward with the GP assessment area being managed separately. Posts have been filled with staff members commencing March 2021 the remaining vacancy rate will be 0.34WTE. In response to the pandemic and high acuity levels within the hospital the surge capacity within CDU has been utilised in line with the escalation policy, the use of these additional 4 beds is being monitored. Continuous quality monitoring continues through the use of a number of systems inclusive of ward based assurance audits, Datix incident reporting, Serious Incidents and patient feedback (complaints/complements). The data is triangulated and continues to indicate that there is no increase in harm or compromised care for patients.	Unscheduled Care	01.03.2021		Fully complete (Awaiting approval)	February 2024 Update - Complete - 14 February 2024 post Covid -19 and remodelling of services in PCH. The unit remains a 24 bedded unit with the same establishment, current vacancies 2.37 wte RN and 2.22 HCSW, the Band 7 is 100% supernummary. There has been positive recruitment to the unit over the past 2 years including new graduates and IEN nurses. CDU establishment including bank and agency use is monitored via 6 weekly Health Board Workforce and Business meetings. Safe to Start commenced in November 2022, 08:00 and 14:30 hours, a whole system approach to review patient flow including safety indicators and nurse staffing-this is essential to ensure staffing is reviewed and measures are put in place to support any short term absences with an audit trail of decision making and actions taken. The fill rate for the past 5 months August, September, October, November, December 2023 and January 2024 - 90%, 93%, 90%, 80, 94% and 95% respectively.
			The service must ensure that any issues identified in Point of Care Audits are actioned in a timely manner and HIW would expect to see an improvement in compliance in future audits undertaken at the CDU. The health board must provide assurance of further actions undertaken in response to the Infection Prevention and Control (IPC) audit undertaken in July 2020. Additionally, the health board must provide assurance that the systems currently in place to monitor and improve IPC standards at the unit are appropriate to ensure the required IPC standards are met.	The key issues for the unit are related to the environment, which are addressed in point 1. Following receipt of the audit report, the Head of Nursing requested an urgent IPC audit, the results have increased to 88%. Key actions remain with the estates department and are being progressed. Daily Spot Checks are undertaken by the ward manager and overseen by the senior & lead nurse. Point of Care monthly audits continue and each area has an improvement plan which will be monitored by the Lead Nurse.	Unscheduled Care	01.03.2021		Fully complete (Awaiting approval)	February 2024 Update - Complete 14 February 2024 post Covid-19 and remodelling of services and nursing structure-Point of Care audits have been replaced with monthly AMaT (Audit, Management and Tracker) as well as unannounced formal audits undertaken by the IPCT. To date the Environmental audit is between 94.6% and 100%. The Head of Nursing chairs the monthly acute services IPC meeting, whereby exception reports are completed by the Senior Nurse and KPI's are monitored closely. Where any deterioration in trends may be identified, targeted work is undertaken with the MDT to maintain and sustain the standards expected. IPC training of the MDT is integral to the improvement work and is monitored via the 6 weekly Workforce and Business meetings. Currently IPC Level 2 for RN=84.6%% and 72% HCSW xxx%. ANTT RN= xxx%. Compliance of IPC audits and training is also monitored via the quarterly IPC Committee meetings chaired by the Director of Nursing, again any required actions are scrutinised and monitored closely.
			The service must improve their ongoing compliance with staff Performance Appraisal and Development Reviews (PADRs) and provide evidence to HIW within three months that all overdue PADRs have been completed.	The compliance at the time of the audit was 53.1%, this has now increased to 79.24%. The outstanding PDR's are due to staff absence and errors within the hierarchy of ESR, these are currently being cleansed to reflect the correct staff in post.	Unscheduled Care	01.03.2021		Fully complete (Awaiting approval)	February 2024 Update - Complete - 14 February 2024, PDR compliance is 91% for the nursing team and this is monitored via the 6 weekly Workforce and Business meeting and clearly aligned to the nursing staff training plans.
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 policy for infection, prevention and control is reviewed.	To present the new IPC strategy to the next IPC Committee meeting in October 2020 for approval, then for sign off.	Mental Health, Community & Primary Care	01.12.2020		Overdue	IPC strategy to be presented at the July 2023 IPC Committee meeting for approval.
			The Health Board should ensure that the escalation procedure is reviewed.	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.	Mental Health, Community & Primary Care	01.10.2020		Overdue	Escalation plan developed and out for consultation.
Healthcare Inspectorate Wales (HIW)/2021/135	20.04.2021	**Quality Check Summary Seren Ward, Royal Glamorgan Hospital [Improvement plan - Seren Ward - Royal Glamorgan Hospital (Ref: 20090)]**	The health board must ensure that compliance with mandatory training is completed and kept up to date. Additionally, a process needs to be put in place to ensure future compliance with mandatory training.	85% of applicable staff groups will be fully compliant with mandatory training in PMVA, ILS/BLS and Fire training. Progress towards this target and future training compliance rates will be managed using ESR and monitored through line management arrangements. Deviation from the proposed improvement trajectory and failure to maintain the target levels of compliance will be escalated at Clinical Service Group Performance Review meetings. Mandatory training compliance to be included as a standing agenda item during line management sessions. Compliance to be reported on and monitored in the Clinical Service Group (CSG) Workforce and Organisational Development meeting and ILG Performance Review meeting.	Mental Health, Community & Primary Care	10.07.2021		Fully complete (Awaiting approval)	Partially Complete. • Training plan was instigated with trajectory for 85 % compliance by 10 July 2021. At time of reporting (10/7/21) compliance is April 21 July 21 ILS 6% ↑64% BLS 0% ↑38% PMVA – Mod D 20% ↑73% PMVA Mod A/B – 41% ↑87% PMVA Mod C 8% ↑67% Fire 50% ↑87% Covid risk assessment 46% ↑80% • PMVA mod A/B&C is time intensive training (6 hours per person) and clinical pressures have delayed completion. Additional pay has been used to release capacity to ensure 85 % compliance by 10th August 2021. • BLS attendance has been impacted by availability of training sessions with ward based model now established to address 10th September 2023 Confirmation received from Brahms Robinson that the whole of the 2021 Seren Ward Action Plan has been completed
Healthcare Inspectorate Wales (HIW)/2021/137	30.06.2021	**National Review of Mental Health Crisis Prevention in the Community**	Health boards must support people to develop an individual crisis plan to aid them in seeking further support when required.	The Cwm Taf Morgannwg (CTM) Crisis Review Forum will develop guidelines around crisis plans for those not under Care and Treatment Planning (CTP) who have had contact with Mental Health Services.	Mental Health, Community & Primary Care	01.10.2022		Partially complete (Overdue)	April 2024 Update - Evidence being collated. Due for closure and ratification by MH&LD QRSE June 24.

				Results of audits from crisis contingency planning to be fed back through the Together for Mental Health partnership forum on a 6 monthly basis for assurance and evidence of improvement.	Mental Health, Community & Primary Care	01.06.2022		Partially complete (Overdue)	April 2024 Update - Complete. Evidence awaiting ratification in MH&LD QSRE June 24.
			Health boards must take steps to improve the timeliness of assessment or intervention following referral to mental health statutory service (such as LMPHSS and CMHT) whilst also considering how people are supported in the community whilst awaiting assessment or intervention.	CTM currently operates a Single Point of Access service in Bridgend to ensure that there is clear criteria for prioritisation of referrals into Mental Health Services. This is being piloted in the other 2 localities within CTM to ensure a single pathway to services. Following completion of pilot review findings for potential roll out across remaining areas in CTM. 111 dial 2 has partial roll out. This will be extended to cover evening 7 days per week (currently operating weekends only) and further review undertaken.	Mental Health, Community & Primary Care	01.10.2022		Partially complete (Overdue)	April 2024 Update - Complete. Evidence awaiting ratification in MH&LD QSRE June 24
			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.	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, Community & Primary Care	01.08.2022		Partially complete (Overdue)	April 2024 Update - Partially complete, but with outstanding work. Complete by August 2024.
			Health boards and GP services must consider how communication between different teams in primary care can be improved and strengthened, to ensure prompt mental health advice and efficient and timely referral processes.	Existing programme of roll out of MH nurse practitioners in Primary Care to be developed and extended to ensure appropriate support at the Primary Care as well as ease of access where statutory services needed. Proposal to be developed between Primary Care and Mental Health.	Mental Health, Community & Primary Care	01.10.2022		Partially complete (Overdue)	April 2024 Update - Complete. Evidence awaiting ratification in MH&LD QSRE June 24
			Health boards must consider how arrangements can be strengthened to ensure primary care professionals are able to access timely specialist advice on mental health conditions, appropriate treatments and medication.	Existing programme of roll out of MH nurse practitioners in Primary Care to be developed and extended to ensure appropriate support at the Primary Care as well as ease of access where statutory services needed. Proposal to be developed between Primary Care and Mental Health.	Mental Health, Community & Primary Care	01.10.2022		Partially complete (Overdue)	April 2024 Update - Complete. Evidence awaiting ratification in MH&LD QSRE June 24
			Health boards need to consider how they can strengthen linkages between services to improve access and provision for individuals needing support for their mental health and well-being.	CTM currently operates a Single Point of Access service in Bridgend to ensure that there is clear criteria for prioritisation of referrals into Mental Health Services. This is being piloted in the other 2 localities within CTM to ensure a single pathway to services. Following completion of pilot review findings for potential roll out across remaining areas in CTM. 111 dial 2 has partial roll out. This will be extended to cover evening 7 days per week (currently operating weekends only) and further review undertaken.	Mental Health, Community & Primary Care	01.10.2022		Partially complete (Overdue)	April 2024 Update - Complete. Evidence awaiting ratification in MH&LD QSRE June 24
			Health boards and GP services must ensure that there are clear and robust follow up processes in place to ensure timely and appropriate follow up for people who have received crisis intervention, and are not subsequently admitted in to hospital.	Service Mangers in Mental Health are working with 3rd sector to develop managed posts utilising C-19 response grants to support people who have been in crisis but not requiring secondary care to ensure their follow up has been helpful or to advise alternatives.	Mental Health, Community & Primary Care	01.10.2022		Partially complete (Overdue)	April 2024 Update - Complete. Evidence awaiting ratification in MH&LD QSRE June 24
			Health boards need to consider how they can strengthen the role and involvement of the third sector to improve the range of provision for individuals needing support for their mental health and well-being.	Programme of review of Service Level Agreements to be in place as well as develop future services.	Mental Health, Community & Primary Care	01.10.2022		Partially complete (Overdue)	April 2024 Update - Complete. Evidence awaiting ratification in MH&LD QSRE June 24
			To prevent the requirement for multiple referrals, health boards must ensure that referral processes are clear to all services, and when appropriate, a single point of access to the range of health board mental health services is implemented to support referral and patient options.	CTM currently operates a Single Point of Access service in Bridgend to ensure that there is clear criteria for prioritisation of referrals into Mental Health Services. This is being piloted in the other 2 localities within CTM to ensure a single pathway to services. Following completion of pilot review findings for potential roll out across remaining areas in CTM. 111 dial 2 has partial roll out. This will be extended to cover evening 7 days per week (currently operating weekends only) and further review undertaken.	Mental Health, Community & Primary Care	31.10.2022		Partially complete (Overdue)	April 2024 Update - Complete. Evidence awaiting ratification in MH&LD QSRE June 24
			Health boards should review the community mental health services available in their localities, to ensure that services focus on individualised needs of people to prevent a deterioration in mental health, and to provide timely care and support in all community services when required.	Existing programme of roll out of MH nurse practitioners in Primary Care to be developed and extended to ensure appropriate support at the Primary Care as well as ease of access where statutory services needed. Proposal to be developed between Primary Care and Mental Health.	Mental Health, Community & Primary Care	31.10.2022		Partially complete (Overdue)	April 2024 Update - Complete. Collating evidence and due for ratification in MH&LD QSRE June 24
			Health boards, emergency services and primary care services should consider how mental health staff can be incorporated within emergency call handling teams across Wales, to enable early advice and support to people who need urgent care or support for their mental health.	CTM currently operates a Single Point of Access service in Bridgend to ensure that there is clear criteria for prioritisation of referrals into Mental Health Services. This is being piloted in the other 2 localities within CTM to ensure a single pathway to services. Following completion of pilot review findings for potential roll out across remaining areas in CTM. 111 dial 2 has partial roll out. This will be extended to cover evening 7 days per week (currently operating weekends only) and further review undertaken.	Mental Health, Community & Primary Care	01.10.2022		Partially complete (Overdue)	April 2024 Update - Complete. Evidence awaiting ratification in MH&LD QSRE June 24
			Health boards should ensure clear advice and information is available and promoted to people with mental health needs, to help maximise their knowledge about additional support services available within the community including the third sector.	Ongoing work regarding the development of specific mental health information advice and support through the development of Cwm Taf Morgannwg website.	Mental Health, Community & Primary Care	31.10.2022		Partially complete (Overdue)	April 2024 Update - Complete. Evidence awaiting ratification in MH&LD QSRE June 24
			Health boards should consider how they can strengthen collaboration with third sector organisations to enable appropriate direct referrals in to NHS mental health services when required.	CTM currently operates a Single Point of Access service in Bridgend to ensure that there is clear criteria for prioritisation of referrals into Mental Health Services. This is being piloted in the other 2 localities within CTM to ensure a single pathway to services. Following completion of pilot review findings for potential roll out across remaining areas in CTM. 111 dial 2 has partial roll out. This will be extended to cover evening 7 days per week (currently operating weekends only) and further review undertaken.	Mental Health, Community & Primary Care	01.10.2022		Partially complete (Overdue)	April 2024 Update - Complete. Evidence awaiting ratification in MH&LD QSRE June 24
			Health boards should ensure that single point of access services are implemented across Wales and is accessible to all professionals and public to help facilitate prompt support and care for people with mental health needs.	CTM currently operates a Single Point of Access service in Bridgend to ensure that there is clear criteria for prioritisation of referrals into Mental Health Services. This is being piloted in the other 2 localities within CTM to ensure a single pathway to services. Following completion of pilot review findings for potential roll out across remaining areas in CTM. 111 dial 2 has partial roll out. This will be extended to cover evening 7 days per week (currently operating weekends only) and further review undertaken.	Mental Health, Community & Primary Care	01.10.2022		Partially complete (Overdue)	April 2024 Update - Complete. Evidence awaiting ratification in MH&LD QSRE June 24
			Health boards must consider how to support and embed the mental health practitioner roles further and ensure that they can link directly into a seamless mental health pathway.	Existing programme of roll out of MH nurse practitioners in Primary Care to be developed and extended to ensure appropriate support at the Primary Care as well as ease of access where statutory services needed. Proposal to be developed between Primary Care and Mental Health.	Mental Health, Community & Primary Care	01.10.2022		Partially complete (Overdue)	April 2024 Update - Complete. Evidence awaiting ratification in MH&LD QSRE June 24
			Health boards should consider how adults with urgent mental health needs, and who are experiencing mental distress, can easily access safe places in the community, which can provide a calm and safe space in a less clinical setting as an alternative to hospital admission or contacting emergency services.	Sanctuary services have been developed with third sector in Bridgend locality. This is being rolled out across Merthyr Cynon in the next 12 months with a view to further roll out across CTM.	Mental Health, Community & Primary Care	01.03.2023		Partially complete (Overdue)	April 2024 Update - Complete. Evidence awaiting ratification in MH&LD QSRE June 24
			Health boards, and Public Health Wales, should consider what additional steps can be taken to raise mental health support awareness in men, to support their mental well-being and signposting to support services.	A Grant of 75k is being made available for community groups to bid against to support men who do not typically access primary care or mental health services about their mental wellbeing. Successful bidder's programmes will be evaluated after 12 months for impact.	Mental Health, Community & Primary Care	01.12.2022		Partially complete (Overdue)	April 2024 Update - Complete. Evidence awaiting ratification in MH&LD QSRE June 24
Healthcare Inspectorate Wales (HIW)/2021/138	20.07.2021	**Quality Check Summary Pinewood House [Pinewood House - Quality Check]**	The health board must provide assurance on how it will meet principle nine outlined by the Chief Nursing Officer for Wales for at least two registered nurses to be rostered every shift, or if determined as not necessary, that there must be the ability to deploy a second registered nurse without delay.	Undertake a review of the night time staffing resource across the rehabilitation service in CTM and develop an options appraisal to address the risk of one registrant by night.	Mental Health, Community & Primary Care	30.11.2021		Overdue	October 2023 Update (Date of Review: 20/10/2021) - Further to discussions with the Head of Mental Health Nursing it has been advised that that the CNO principles do not apply to Mental Health Rehabilitation areas. We will however, continue to monitor our staffing levels on a daily basis and redeploy staff as necessary to ensure there are safe staffing levels at all times.
			The heath board must provide assurance of its plans to ensure all staff are fully compliant with their mandatory training as soon as possible.	Review all core competencies across the rehab service with an improvement plan for 85%+ compliance.	Mental Health, Community & Primary Care	30.11.2021		Overdue	October 2023 Update (Date of Review: 14/10/2021) - It has been agreed with the Senior Nurse and Ward Managers that the following actions will be undertaken immediately to start addressing the training compliance with support from the L&D department: 1) Review hierarchy lists; 2) Ensure Group alignment numbers are correct; 3) Look at appropriate required compliance and accurate records and L&D department will take forward to the subject experts on teams' behalf. Regular meetings with new L&D representatives to address and correct the issues associated with core mandatory training compliance.
Healthcare Inspectorate Wales (HIW)/2022/129	01.11.2022	**HIW & CIW Joint Community Mental Health Team (CMHT) Inspection Report (Announced) Bridgend North CMHT, Maesteg Community Hospital [HIW Improvement Plan Service: Bridgend North CMHT (Maesteg Hospital) (Ref: 3189)]**	The health board must implement a signing in and out book to ensure an appropriate audit trail of medication stock.	Spot checks to be completed by the Senor Nurse to monitor compliance	Mental Health, Community & Primary Care	28.04.2023		Fully complete (Awaiting approval)	
				Audit of medication to take place. CTMUHB Homecare visited the team on 20th January 2023 and they have agreed to attend the CMHT monthly for three months and then three monthly to audit and help with stock management checks. The home care team only audit Polar Speed medication (Abilify and Paliperidone). For all other depot medication staff who order these medication will audit at the same time.	Mental Health, Community & Primary Care	28.04.2023		Fully complete (Awaiting approval)	
			The health board must ensure that substantive medical staff are appointed as far as possible to ensure continuity of care.	The health board will continue in its attempts to recruit substantively into the consultant post. This is against a background of higher demand for posts than the supply of senior medical staff to fill them.	Mental Health, Community & Primary Care	31.08.2023		Fully complete (Awaiting approval)	
			The health board and local authority should reflect on comments from staff relating to access to care documents and systems	This is reviewed in monthly performance review meetings with the Senior Team which includes a table on the status on all medical positions in the locality. Progress on recruitment is discussed and there is a focus on having Royal College of Psychiatry Approved Job Descriptions ready for advertisement should a vacancy appear.	Mental Health, Community & Primary Care	31.08.2023		Fully complete (Awaiting approval)	

				A business case for WICCIS implementation has been written and requires Executive sign off for funding. The Mental Health Care Group have allocated a Project Manager.	Mental Health, Community & Primary Care	31.07.2023		Fully complete (Awaiting approval)	
			The health board must ensure that medical staff complete all safeguarding related refresher training in a timely manner	All medical staff to attend 'Safeguarding People' Day	Mental Health, Community & Primary Care	28.04.2023		Overdue	Medical staff booked in to attend 'Safeguarding People
			The health board must ensure that Community Treatment Order (CTO) documentation contains all of the required detail	The MHA team propose to develop an audit tool for CTO MHA statutory documentation and to conduct a CTM wide audit of detention papers for those patients subject to a Community Treatment Order. Compliance will be monitored through our QSRE meetings	Mental Health, Community & Primary Care	31.08.2023		Fully complete (Awaiting approval)	
				We have asked our IMHA provider and South Wales Advocacy to obtain feedback on our service from patients on a community treatment order (CTO). The MHA team and South Wales Advocacy are working collaboratively to develop a questionnaire. The health boards MHA operational group and Mental health act monitoring committee will be kept up to date on progress.	Mental Health, Community & Primary Care	28.04.2023		Fully complete (Awaiting approval)	
			The health board and local authority should reflect on the staff feedback comments provided in this report	A debrief session has been arranged to reflect on the HIW inspection and feedback comments provided in the report.	Mental Health, Community & Primary Care	21.02.2023		Fully complete (Awaiting approval)	
				The inspection findings will also form part of our local QSRE meetings standard agenda to maintain monitoring of the review	Mental Health, Community & Primary Care	28.04.2023		Fully complete (Awaiting approval)	
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.	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	September 2023 Update - new consultant appointments enable 2 sessions of elective work to be staffed by consultant obstetricians. Awaiting 1st consultant to agree job plan 18.09.23 to commence one session a week, moving to 2 session in January 2023.
			The Health Board must ensure that: Patient records are secure and kept out of view at all times to maintain patient confidentiality	All patient records are kept in secure locked trolleys. Monitoring of the security of patient records is completed twice daily by a member of the senior midwifery team	Children & Families	31.01.2024		Overdue	September 2023 Update - recent concern from PCH identifies that learning and improvement is still required in this area.
			The Health Board must ensure that: All staff signatures are identifiable with no gaps in signature sections	The use of the stamps will be audited through the rolling annual record keeping audit. Findings are fed back annually and improvement plans developed quarterly.	Children & Families	01.08.2022		Overdue	September 2023 Update - The stamps are available to all clinicians, the review of the annual record keeping audit will be completed and presented by CSfM team in November 2023 meeting.
			Risk assessments are undertaken and recorded in patient records. Medical discussion and decisions are accurately recorded in patient records.	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		Overdue	September Update (Date of Review: 08/09/23) - email sent to Medical Director of care group for advice on how to progress this recommendation.
			The Health Board must ensure that: Occupational health referrals are dealt with in a timely manner.	Lead for Occupational Health Services asked for target time for referrals to be addressed to support realistic and accurate information giving to staff members	Children & Families	31.01.2024		Fully complete (Awaiting approval)	Sept Update - 8.9.23 email sent to OH lead to advice on progress with this recommendation. Email response from Nicola Bevan - OH Lead giving assurance. The Occupational Health service has successfully recruited into the long-standing vacancies within the service and are due to be fully established by end of September 2023. The previous substantive OH Consultant retired in April 2023 and a new provider has been procured providing two clinics per week plus 5 day clinical support if required. A new OH Physiotherapy template has also been developed to ensure there is sufficient capacity within the service to deliver the full range of Occupational Health Physiotherapy activities. As a result, the waiting times within the department have significantly reduced. In October 2023 CTM Occupational Health Service will be transitioning to a new OH software system as part of an All Wales Occupational Health initiative. One aspect of the new system will introduce an online management referral system which will improve the quality of the referrals and the communication mechanisms between managers and Occupational Health, which will increase transparency and allow the manager to monitor the progress of the referral-Action reviewed by Head of Midwifery (SF) and update to a closed and complete action.
			The Health Board must ensure that: Additional welfare support is available for KIT staff.	Workforce team asked for specific resources for KIT staff going forward.	Children & Families	01.06.2022	01.10.2023	Overdue	September Update (Date of Review: 08/09/23) - email sent to care group's People's Services Lead to advice on progress with this recommendation.
			The Health Board must ensure that: The backlog of incidents are cleared and consideration of further funding should continue.	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	Overdue	September 2023 Update - incident report monitored by executive team. Timely review and closure for moderate harm and above incidents but low and no harm process requires further reviewing and dedicated allocation of time.
Healthcare Inspectorate Wales (HIW)/2022/132	26.09.2022	**Hospital Inspection Report (Unannounced) Prince Charles Hospital – Maternity Services [Appendix C - Improvement Plan - Prince Charles Hospital - Maternity Unit (Ref: 3110)]**	The health board must ensure that they obtain UNICEF reaccreditation.	Social media, weekly feeding post (appendix 1) BFI standards audit (appendix 2) BFI gap analysis (appendix 3) Recruitment of 0.4wte infant feeding midwife to support community midwifery Dashboard breast feeding data and CI projects (appendix 4/6) Senior team BFI training (appendix 5) Executive Director of Nursing appointed as Baby Friendly Guardian(appendix 6)	Children & Families	30.04.2024		In progress	Assessment for accreditation for UNICEF Baby Friendly to be completed by October 2023. Update 28.03.23 Assessment confirmed for December 2023. All staff will have attended 1 day update by September 2023, overseen by Infant feeding Coordinator (Maternity) - Sept 2023-Pre assessment audit completed and advised by UNICEF BFI to postpone for 3 months to drive further improvement in practice. New specialist midwife commences role 18.09.23 (vacant role for 3 months)
			The health board must ensure that oxygen is being recorded on the prescription charts.	Oxygen prescription to be added to 2023 annual record keeping audit. Good practice guidance provided in monthly governance newsletter.	Children & Families	01.02.2023	Autumn 2023	Fully complete (Awaiting approval)	New record keeping audit due to be commenced Autumn 2023 - Sept Update - added to annual record keeping audit sept 23-24. Email advice from service pharmacist 7.8.23 to advise of correct prescribed method for obstetricians as requested
			Review Birth Rate Plus and ensure that staffing requirements are appropriate for the unit.	Current establishment is compliant with 2019 Birth Rate Plus report.	Children & Families	01.02.2023		Fully complete (Awaiting approval)	Draft report received April 2023 Sept Update-CTMUHB Birth-rate plus report 2023 has been agreed by DOM and recommendations around actions will be presented to executive team in October 23
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.	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		Overdue	July 2023 Update - Working across CTM to ensure standardised audits are implemented.
				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		Overdue	
Healthcare Inspectorate Wales (HIW)/2022/36	14.11.2022	**Hospital Inspection Report (Unannounced) Angelton Clinic, Glanrhyd Hospital [Improvement plan Service Angelton Clinic – Glanrhyd Hospital (Ref: 3171)]**	The health board must ensure that the following environmental issues are resolved:- Ceiling tiles in staff office on Ward 2 need replacing.	Ceiling tiles in staff office on Ward 2 need replacing Re-booked with estates on 26/01/2023, job reference 63119. Environmental audits to take place monthly. Environmental issues to form part of monthly Ward Managers meetings and if issues remain unresolved, escalation process to be followed which includes informing IPC leads in weekly meeting and informing Senior Management Team.	Mental Health, Community & Primary Care	28.04.2023		Fully complete (Awaiting approval)	See Appendix 9 for all estates issues and progress
			The health board must ensure that restraints are recorded in patient records and that patient's notes are updated.	Datix to be submitted and written account of restraint to be documented in patient notes. Restraint forms to be completed and uploaded to Datix. Compliance to be monitored through monthly nursing note audits, ward manager meetings and Quality, Safety, Risk and Experience Group meeting.	Mental Health, Community & Primary Care	31.07.2023		Fully complete (Awaiting approval)	
			The health board must ensure that all staff are confident in how to deal with a safeguarding referral.	80% compliance to be achieved for Level 2 and Level 3 Safeguarding Training. Safeguarding to be a standard agenda item in staff meetings to reiterate the process. Safeguarding referral process to be clearly visible in nursing office on both wards.	Mental Health, Community & Primary Care	31.07.2023		Fully complete (Awaiting approval)	
			The health board must ensure that patients' risks are regularly updated and recorded in patient records.	This will be monitored in the Quality, Safety, Risk and Experience Group meeting and closed after 6 months if compliance is maintained and standards upheld.	Mental Health, Community & Primary Care	31.07.2023		Fully complete (Awaiting approval)	
			The health board must ensure that outcome measures are clearly recorded in patient records.	Older Peoples Inpatient Mental Health Service Outcome Measures implementation group to be progressed to identify appropriate outcome measure tool which can then be implemented and embedded into the service, in line with the national work led by Improvement Cymru.	Mental Health, Community & Primary Care	31.07.2023		Fully complete (Awaiting approval)	Sept Update-Action complete July 2023 Update-Outcome Measures working group established. Additional outcome measures training day arranged for 01/08/2023 with PHW. Appropriate OMs identified.
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 1 The health board must ensure that full and comprehensive mental health assessments and physical health assessments are always being completed in a timely manner, in line with the Mental Health (Wales) Measure 2010 under the Mental Health Act 1983.	The oversight of this recommendation will be via the High Quality Records Workstream.	Mental Health, Community & Primary Care	30.06.2023		Overdue	September 2023 Update - Lead Nurses to meet on 18/09/2023 to review workstreams and action progress. Further updates will be provided following this meeting for all actions relating to the Discharge Review.

				Admission pathway for inpatient units will be reviewed to ensure that that comprehensive mental health assessments and physical health assessments will be completed within 6 hours of admission as standard.	Mental Health, Community & Primary Care	30.06.2023		Fully complete (Awaiting approval)	
				On completion agreed pathway will be communicated to all Nursing and Medical staff across all Mental Health services using the care Group "Communication and Learning Framework" as detailed in Recommendation 40	Mental Health, Community & Primary Care	30.06.2023		Fully complete (Awaiting approval)	
				Completion of mental health and physical health checks will be added to the Admission Pathway for all inpatient wards.	Mental Health, Community & Primary Care	30.06.2023		Fully complete (Awaiting approval)	
				Evidence of routine compliance will be shown by adding audit of this standard to the weekly Ward Manager Audit: initial review will be of all admissions for no less than one month or until compliance; and each ward will undertake a weekly spot random audit of 20% (or a minimum of five) of all admissions to the Adult inpatient units using the "ward managers Audit tool.	Mental Health, Community & Primary Care	30.06.2023		Fully complete (Awaiting approval)	Dec 23 update - Completed during this period
				Audit data will be reported/escalated through Care Group Governance Framework	Mental Health, Community & Primary Care	30.06.2023		Fully complete (Awaiting approval)	Dec 23 update - Completed during this period
			Recommendation 2 The health board must ensure that when staff complete patient risk assessments, the method should reflect the requirements set out within national guidance.	The oversight of this recommendation will be via the Skilled and Motivated Workforce Workstream.	Mental Health, Community & Primary Care	31.07.2023		Overdue	
				All staff who are expected to complete clinical risk assessment will receive training in WARRN (nationally recognised) risk assessment and formulation.	Mental Health, Community & Primary Care	31.07.2023		Fully complete (Awaiting approval)	
				This training will be delivered to all new staff within 8 weeks of commencement of an inpatient role or at induction period for junior staff, with a target of 85% for all staff who require the training. The HB standard for all mandatory training is 85% minimum, and is considered to be a prudent and appropriate target, with consideration of predictable staff turnover and anticipated unavoidable challenges to training.	Mental Health, Community & Primary Care	31.07.2023	31.01.2024	Overdue	February 2024 Update - WARNN compliance 69% There is an expectation that 85% training compliance is achieved by next Improvement Board 27/02/2024. December 2023 Update - Compliance for WARRN Risk Assessment training is at 68% as at 24/11/23
				Compliance will be reported monthly by the CTP Lead and monitored through the Risk Steering Group. An initial demand and capacity exercise has been completed, with external training provision through Spring 2023. Present compliance is at 69.5 % (from 35 % in Feb 2023) with a trajectory of 80% by end of June 23. There is a programme of ongoing WARRN training delivered by a cohort of clinical trainers. This programme has been developed to ensure that there is capacity to deliver against 100% of anticipated demand annually.	Mental Health, Community & Primary Care	31.07.2023		Fully complete (Awaiting approval)	
				Inpatient units will review paper and electronic archives and systems and remove all risk documentation other than the HB approved Clinical Risk Formulation and Management Plan.	Mental Health, Community & Primary Care	31.07.2023		Fully complete (Awaiting approval)	
				Evidence of routine compliance will be shown through the weekly Ward Manager Audit, which contains a review of risk assessment documentation of a sample of patient records. Mental Health Ward Assurance audits will be added to the Health Board electronic audit system.	Mental Health, Community & Primary Care	31.07.2023		Fully complete (Awaiting approval)	
			Recommendation 3 The health board must ensure that mental capacity assessments are undertaken by relevant staff, which reflect the criteria set within the relevant legislation and national guidance.	The oversight of this recommendation will be via the Safe Discharge Workstream.	Mental Health, Community & Primary Care	30.06.2023		Overdue	
				The Inpatient multi-disciplinary team have developed a formal template for documentation of patient reviews and multidisciplinary discussions. This formalises the necessity to routinely record the MDT opinion of the person's capacity and any need for full Mental Capacity Assessment using the approved Health Board Framework. This will be implemented across the Care Group.	Mental Health, Community & Primary Care	30.06.2023		Fully complete (Awaiting approval)	
				Evidence of routine compliance will be shown through the weekly Ward Manager Audit, which contains a review of MDT documentation of a sample of patient records.	Mental Health, Community & Primary Care	30.06.2023		Fully complete (Awaiting approval)	
				Ward manager Audit tool has been digitised to enable rapid real time reporting of results through the "Audit management and Tracking (AMaT) process. Non-compliance will be reported weekly by ward managers to Senior Nurses; with immediate remedial action if necessary, and escalation to Clinical Service Group management team if required.	Mental Health, Community & Primary Care	30.06.2023		Fully complete (Awaiting approval)	Dec 23 update Completed during this period
				Compliance/non-compliance will be formally reported at CSG QSRE (with any variation over time noted) and reported/escalated through Care Group Governance Framework	Mental Health, Community & Primary Care	30.06.2023		Fully complete (Awaiting approval)	Dec 23 update Completed during this period
				Staff will learn from audit results when shared with staff teams through the Quality/Audit/learning agenda points in formal team meetings	Mental Health, Community & Primary Care	30.06.2023		Fully complete (Awaiting approval)	
				Audit data will be reported/escalated through Care Group Governance Framework	Mental Health, Community & Primary Care	30.06.2023		Fully complete (Awaiting approval)	
				Each clinical area (inpatient and community) will have designated training board/information space for the sharing of learning / local audit/ educational resource, with specific information (leaflets/posters) relating to the right of the carer under the Social Services and Wellbeing Act.	Mental Health, Community & Primary Care	30.06.2023		Fully complete (Awaiting approval)	
			Recommendation 4 The health board must ensure that carers assessments are routinely offered and where required, undertaken for relevant individuals, in line with The Mental Health Act 1983 Code of Practice.	Admission pathways for inpatient units will be reviewed to ensure that carers assessments are routinely offered where required.	Mental Health, Community & Primary Care	30.06.2023		Fully complete (Awaiting approval)	February 2024 Update - Completed
				Carers assessments are offered at the point of admission and recorded on admission paperwork. The process will be shared with all staff through Communication and Learning Framework (Recommendation 40). Audit of the process will be fed back to teams and any remedial action will reinforce compliance	Mental Health, Community & Primary Care	30.06.2023		Fully complete (Awaiting approval)	February 2024 Update - Completed
				The inpatient multi-disciplinary team have developed a formal template for documentation of patient reviews and multidisciplinary discussions. This formalises the necessity to routinely record consultations with the patient's family and care network.	Mental Health, Community & Primary Care	30.06.2023		Fully complete (Awaiting approval)	February 2024 Update - Completed
				Evidence of discussions with carers will be recorded within the clinical notes, following the template format. Evidence of routine compliance will be shown through the weekly Ward Manager Audit, which contains a review of MDT documentation of a sample of patient records.	Mental Health, Community & Primary Care	30.06.2023		Fully complete (Awaiting approval)	February 2024 Update - Completed
				Ward Manager Audit tool has been digitised to enable rapid real time reporting of results through the "Audit management and Tracking (AMaT) process. Non-compliance will be reported weekly by ward managers to Senior Nurses; with immediate remedial action if necessary, and escalation to Clinical Service Group management team if required.	Mental Health, Community & Primary Care	30.06.2023		Fully complete (Awaiting approval)	February 2024 Update - Complete - Manual Audits to be undertaken until audit can be digitalised.
				Compliance/non compliance will be formally reported at CSG QSRE (with any variation over time noted) and reported/escalated through Care Group Governance Framework.	Mental Health, Community & Primary Care	30.06.2023		Fully complete (Awaiting approval)	February 2024 - Completed
				Staff will learn from audit results when shared with staff teams through the Quality/Audit/learning agenda points in formal team meetings	Mental Health, Community & Primary Care	30.06.2023		Fully complete (Awaiting approval)	February 2024 Update - Completed
				Audit data will be reported/escalated through Care Group Governance Framework.	Mental Health, Community & Primary Care	30.06.2023		Fully complete (Awaiting approval)	February 2024 - Completed
				Audit information will also be will be communicated to all staff through Ward training boards, daily safety briefing etc.	Mental Health, Community & Primary Care	30.06.2023		Fully complete (Awaiting approval)	February 2024 - Completed
			Recommendation 5 The health board must ensure that patient care and treatment plans: a) Reflect the requirements set out within the Mental Health (Wales) Measure 2010; b) Are routinely signed and dated following review or update, to allow for the identification of relevant staff members.	Inpatient units have reviewed paper and electronic archives and systems and removed all care planning documentation other than the HB Inpatient Management Plan and Care and Treatment Plan (CTP)	Mental Health, Community & Primary Care	31.07.2023		Fully complete (Awaiting approval)	
				The standards around signing reviewed and completed Care and Treatment Plans which are outlined in the HB Care and Treatment Plan (CTP) Policy will be communicated to all appropriate staff through ward training boards and daily safety briefings.	Mental Health, Community & Primary Care	31.07.2023		Fully complete (Awaiting approval)	

				The CTP audit tool has been reviewed, digitised and added to "Audit management and Tracking (AMaT) process. A bi monthly audit programme is underway as a pilot with roll out from July 2023.	Mental Health, Community & Primary Care	31.07.2023		Fully complete (Awaiting approval)	
				Evidence of routine compliance will be shown by adding audit of this standard to the weekly Ward Manager Audit: initial review will be of all admissions for no less than one month or until compliance; and weekly sample of admissions going forward.	Mental Health, Community & Primary Care	31.07.2023		Fully complete (Awaiting approval)	
				Effectiveness of implementation will be evident in audit outcomes and compliance with national reportable KPI. These are monitored through the monthly Integrated Performance meeting chaired by the Care group Service Director and informed by the "Performance Scorecard" that is produced monthly by the MH Performance team.	Mental Health, Community & Primary Care	31.07.2023		Fully complete (Awaiting approval)	
			Recommendation 6 The health board should review the ward round structure and arrangements in place, to ensure that sufficient time is permitted to adequately discuss all patients.	A review of ward round arrangements across the Health Board will be undertaken. This will include : Consultation with patients and carers Consultation with the multi-disciplinary team Benchmarking with other mental health services	Mental Health, Community & Primary Care	31.08.2023		Fully complete (Awaiting approval)	
				Standards for ward round arrangements will be developed, communicated and implemented across the Care Group. These arrangements will be shared with all staff through Communication and Learning Framework (Recommendation 40). Audit of the process will be fed back to teams and any remedial action will reinforce compliance	Mental Health, Community & Primary Care	31.08.2023		Fully complete (Awaiting approval)	
				An audit tool for the monitoring of these standards will be developed and included as part of the Health Board Electronic System.	Mental Health, Community & Primary Care	31.08.2023		Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
				Audit of ward round arrangements will be undertaken weekly. Compliance/non compliance will be formally reported at CSG QSRE (with any variation over time noted) and reported/escalated through Care Group Governance Framework.	Mental Health, Community & Primary Care	31.08.2023		Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
				Staff will learn from audit results when shared with staff teams through the Quality/Audit/learning agenda points in formal team meetings	Mental Health, Community & Primary Care	31.08.2023		Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
				Audit data will be reported/escalated through Care Group Governance Framework.	Mental Health, Community & Primary Care	31.08.2023		Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
			Recommendation 7 The health board must ensure that arrangements are in place to enable prompt communication and information sharing between inpatient and community teams during the discharge process.	The Safe Discharge Workstream will develop standardised discharge communication processes across the Care Group.	Mental Health, Community & Primary Care	31.08.2023		Fully complete (Awaiting approval)	
				In acknowledgement of the significant work programme that is required across CTM to return it to a position of delivering consistently high quality Mental Health services; a Quality Improvement Programme has been implemented to ensure whole service engagement and consistency of approach across the Health Board.	Mental Health, Community & Primary Care	31.08.2023		Fully complete (Awaiting approval)	
				The Improvement Programme is led at Care Group level by the Director of Nursing, with six distinct workstreams within the "High Quality Inpatient Care" sub programme. Each is led at a Senior level (Lead Nurse or equivalent), with an overarching aim to ensure that all action, change and improvement will be consistently and universally implemented across CTM.	Mental Health, Community & Primary Care	31.08.2023		Fully complete (Awaiting approval)	
				This consistency of approach will be further reinforced with the imminent reorganisation of the MH Care group to provide Senior leadership and Governance structures that have responsibility for the delivery of all inpatient care across CTM.	Mental Health, Community & Primary Care	31.08.2023		Overdue	February 2024 Update - Reorganisation of MHLD Care Groups has commenced with shadow directorates from 01/02/2024. December 2023 Update - Reorganisation of the MHLD Care Group in progress.
				Compliance/non compliance will be formally reported at CSG QSRE (with any variation over time noted) and reported/escalated through Care Group Governance Framework).	Mental Health, Community & Primary Care	31.08.2023		Fully complete (Awaiting approval)	February 2024 - Complete
				Staff will learn from audit results when shared with staff teams through the Quality/Audit/learning agenda points in formal team meetings.	Mental Health, Community & Primary Care	31.08.2023	21/11/2023	Fully complete (Awaiting approval)	February 2024 Update - Complete
				Audit data will be reported/escalated through Care Group Governance Framework.	Mental Health, Community & Primary Care	31.08.2023	21.11.2023	Fully complete (Awaiting approval)	February 2024 Update - Complete
			Recommendation 8 The health board must ensure that all relevant staff complete appropriate training for timely and effective communication and information sharing relating to the discharge process.	A review of ESR function and recording of mandatory and MH specific training within the MH care group and has developed a universal spreadsheet to enable accurate and consistent reporting of compliance. This was completed in March 2023.	Mental Health, Community & Primary Care	31.07.2023		Fully complete (Awaiting approval)	
				Subsequently the care group has rolled out a local training record that will enable accurate reporting of the range of mandatory and MH specific training.	Mental Health, Community & Primary Care	31.07.2023		Fully complete (Awaiting approval)	
				WARRN risk management training: An initial demand and capacity exercise has been completed, with external training provision through Spring 2023. Present compliance is at 63.3 % (from 49 % in April 2023) with a trajectory of 87% by end of October 23.	Mental Health, Community & Primary Care	31.07.2023	27.02.2024	Overdue	February 2024 Update - Revised completion date 27/02/2024, 69% Currently. December 2023 Update - WARRN Risk Assessment Training compliance as at 24/11/2023 - 68% Revised completion date to 31/01/24
				PMVA; An initial demand and capacity exercise has been completed, with external training provision through Spring 2023. Present compliance is at 69.5 % (from 35 % in Feb 2023) with a trajectory of 80% by end of June 23.	Mental Health, Community & Primary Care	31.07.2023	27.02.2024	Overdue	February 2024 Update - Current compliance 81% Revised completion date 27/02/2024. December 2023 Update - PMVA Training compliance as at 24/11/2023 - 68% Revised completion date to 31/01/24
				Care and Treatment Planning	Mental Health, Community & Primary Care	31.07.2023	27.02.2024	Overdue	February 2024 Update - Current compliance 70% Revised completion date 27/02/2024. December 2023 Update - Information Governance Training compliance as at 24/11/23 is 81% Revised completion date to 31/01/24.
				Information Governance Compliance for WARRN and CTP will be reported monthly and monitored through the Risk Steering Group. This will be monitored via Clinical Service Group performance meetings.	Mental Health, Community & Primary Care	31.07.2023	27/02/2024	Fully complete (Awaiting approval)	February 2024 Update - Current compliance 81% Revised completion date 27.02.2024
				This will also enable reporting of training compliance through monthly Integrated Performance meeting chaired by the Care group Service Director.	Mental Health, Community & Primary Care	31.08.2023		Fully complete (Awaiting approval)	
				The care group is developing a Service Improvement Team (SIT) the service lead of which will gather intelligence from the wider Audit programme, unmet need process, wider learning and staff feedback through PADR to develop a training needs analysis (TNA).	Mental Health, Community & Primary Care	31.08.2023		Fully complete (Awaiting approval)	
				Additional bespoke training will be developed in response to the TNA the completion of the work of the Safe Discharge Workstream.	Mental Health, Community & Primary Care	31.08.2023		Fully complete (Awaiting approval)	February 2024 Update - Complete
			Recommendation 9 The health board must ensure that minutes are completed for inpatient MDT meetings. This is to ensure an accurate record of attendance, key discussion points and agreed actions are available to all staff.	4.4 Ensure that arrangements are in place to maintain comprehensive records following formal MDT meetings, discharge planning meetings or others relating to patient care, and ensure these are shared and reviewed by relevant staff.	Mental Health, Community & Primary Care	31.08.2023		Fully complete (Awaiting approval)	
				As part of the ward round and multi-disciplinary review (recommendation number 6) the Safe Discharge Workstream will develop standardised approaches for recording multi-disciplinary meetings across the Care Group.	Mental Health, Community & Primary Care	31.08.2023		Fully complete (Awaiting approval)	
				In acknowledgement of the significant work programme that is required across CTM to return it to a position of delivering consistently high quality Mental Health services; a Quality Improvement Programme has been implemented to ensure whole service engagement and consistency of approach across the Health Board. The Improvement Programme is led at Care Group level by the Director of Nursing, with six distinct workstreams within the "High Quality Inpatient Care" sub-programme. Each is led at a Senior level (Lead Nurse or equivalent), with an overarching aim to ensure that all action, change and improvement will be consistently and universally implemented across CTM. This consistency of approach will be further reinforced with the imminent reorganisation of the MH Care group to provide Senior leadership and Governance structures that have responsibility for the delivery of all inpatient care across CTM.	Mental Health, Community & Primary Care	31.08.2023		Fully complete (Awaiting approval)	February 2024 Update - Complete December 2023 Update - Reorganisation of the MHLD Care Group in progress.

				The Safe Discharge Workstream have agreed standards for format of content of ward round and MDT meeting to record attendance, key discussion points and agreed actions; an agreed template for recording this in the patient notes; and storage and access arrangements for all involved professional across CTM.	Mental Health, Community & Primary Care	31.08.2023		Fully complete (Awaiting approval)	
				As a mitigation for the multiple record system that are still in place across the CTM Mental Health service the Safe Discharge Workstream has developed a matrix for clinical team /staff access ("who accesses what system for what purpose") for all systems across the mental health service. This informs all clinical staff of how to access patient clinical risk and discharge planning, information both in and out of hours describes mitigants and escalation.	Mental Health, Community & Primary Care	31.08.2023		Fully complete (Awaiting approval)	
				An audit tool for the monitoring of these standards will be developed and included as part of the Health Board electronic audit system.	Mental Health, Community & Primary Care	31.08.2023		Fully complete (Awaiting approval)	December 2023 Update - Audit tool developed but not yet digitised. Manual audit to be undertaken until audit can be digitised. Completed during this period.
				Compliance/non compliance will be formally reported at CSG QSRE (with any variation over time noted) and reported/escalated through Care Group Governance Framework.	Mental Health, Community & Primary Care	31.08.2023	21.11.2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
				Staff will learn from audit results when shared with staff teams through the Quality/Audit/learning agenda points in formal team meetings	Mental Health, Community & Primary Care	31.08.2023	21.11.2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
				Audit data will be reported/escalated through Care Group Governance Framework.	Mental Health, Community & Primary Care	31.08.2023	21.11.2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
			Recommendation 11 The health board must ensure that patients and, where appropriate, their family, carer and/or advocate are able to provide their views to inform inpatient care and discharge planning. These views and any subsequent actions should be recorded within the patients' notes.	As part of the ward round and multi-disciplinary review (recommendation number 6) the Safe Discharge Workstream will develop standardised approaches for ensuring that family, carer and/or advocate views are documented across the Care Group.	Mental Health, Community & Primary Care	31.08.2023		Fully complete (Awaiting approval)	
				In acknowledgement of the significant work programme that is required across CTM to return it to a position of delivering consistently high quality Mental Health services; a Quality Improvement Programme has been implemented to ensure whole service engagement and consistency of approach across the Health Board. The Improvement Programme is led at Care Group level by the Director of Nursing, with six distinct workstreams within the "High Quality Inpatient Care" sub programme. Each is led at a Senior level (Lead Nurse or equivalent), with an overarching aim to ensure that all action, change and improvement will be consistently and universally implemented across CTM. This consistency of approach will be further reinforced with the imminent reorganisation of the MH Care group to provide Senior leadership and Governance structures that have responsibility for the delivery of all inpatient care across CTM.	Mental Health, Community & Primary Care	31.08.2023		Fully complete (Awaiting approval)	
				The HB will undertake a weekly spot random audit of 20% (or a minimum of five) of all admissions to the Adult inpatient units using the "ward managers Audit tool.	Mental Health, Community & Primary Care	31.08.2023	21.11.2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
				Audit tool for the monitoring of these standards will be developed and included as part of the Health Board electronic audit system.	Mental Health, Community & Primary Care	31.08.2023	21.11.2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
				Compliance/non compliance will be formally reported at CSG QSRE (with any variation over time noted) and reported/escalated through Care Group Governance Framework	Mental Health, Community & Primary Care	31.08.2023	21.11.2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
				Staff will learn from audit results when shared with staff teams through the Quality/Audit/learning agenda points in formal team meetings.	Mental Health, Community & Primary Care	31.08.2023	21.11.2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
				Audit data will be reported/escalated through Care Group Governance Framework	Mental Health, Community & Primary Care	31.08.2023	21.11.2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
				The views of people with lived experience are critical to the safe and effective delivery of mental health services. The Lived Experience Group will develop a lived experience framework so that people can contribute meaningfully to both care and service design/delivery.	Mental Health, Community & Primary Care	31.08.2023		Fully complete (Awaiting approval)	February 2024 Update - Complete
			Recommendation 12 The health board must ensure that crisis or contingency plans and relapse indicators are routinely developed and documented as part of the discharge planning process. This information should be discussed, agreed and shared with relevant teams, the patient and where appropriate, their family or carer, prior to or on discharge.	In acknowledgement of the significant work programme that is required across CTM to return it to a position of delivering consistently high quality Mental Health services; a Quality Improvement Programme has been implemented to ensure whole service engagement and consistency of approach across the Health Board. The Improvement Programme is led at Care Group level by the Director of Nursing, with six distinct workstreams within the "High Quality Inpatient Care" sub programme. Each is led at a Senior level (Lead Nurse or equivalent), with an overarching aim to ensure that all action, change and improvement will be consistently and universally implemented across CTM. This consistency of approach will be further reinforced with the imminent reorganisation of the MH Care group to provide Senior leadership and Governance structures that have responsibility for the delivery of all inpatient care across CTM .	Mental Health, Community & Primary Care	31.08.2023		Fully complete (Awaiting approval)	February 2024 Update - Complete
				The HB will undertake a weekly spot random audit of 20% (or a minimum of five) of all admissions to the Adult inpatient units using the "ward managers Audit tool.	Mental Health, Community & Primary Care	31.08.2023	21.11.2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
				The process will be shared with all staff through the Communication and Learning framework (Recommendation 40) . Audit of the process will be fed back to teams and any remedial action will reinforce compliance	Mental Health, Community & Primary Care	31.08.2023	21.11.2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
			Recommendation 13 The health board must ensure that patient records are routinely being updated by staff, to detail what, when and to whom information is being shared with as part of the discharge process.	As part of recommendation 7 the Safe Discharge Workstream will develop standardised discharge recording and communication processes across the Care Group.	Mental Health, Community & Primary Care	31.08.2023		Fully complete (Awaiting approval)	
				In acknowledgement of the significant work programme that is required across CTM to return it to a position of delivering consistently high quality Mental Health services; a Quality Improvement Programme has been implemented to ensure whole service engagement and consistency of approach across the Health Board. The Improvement Programme is led at Care Group level by the Director of Nursing, with six distinct workstreams within the "High Quality Inpatient Care" sub programme. Each is led at a Senior level (Lead Nurse or equivalent), with an overarching aim to ensure that all action, change and improvement will be consistently and universally implemented across CTM. This consistency of approach will be further reinforced with the imminent reorganisation of the MH Care group to provide Senior leadership and Governance structures that have responsibility for the delivery of all inpatient care across CTM .	Mental Health, Community & Primary Care	31.08.2023		Fully complete (Awaiting approval)	February 2024 Update - Complete
				Ward manager Audit tool will be digitised to enable rapid real tile reporting of results through the "Audit management and Tracking (AMaT) process. Non-compliance will be reported weekly by ward managers with Senior Nurses; with immediate remedial action if necessary, and escalation to Clinical Service Group management team if required.	Mental Health, Community & Primary Care	31.08.2023		Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
				The HB will undertake a weekly spot random audit of 20% (or a minimum of five) of all admissions to the Adult inpatient units using the "ward managers Audit tool.	Mental Health, Community & Primary Care	31.08.2023		Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
				Compliance/non-compliance will be formally reported at CSG QSRE (with any variation over time noted) and reported/escalated through Care Group Governance Framework.	Mental Health, Community & Primary Care	31.08.2023		Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
				Staff will learn from audit results when shared with staff teams through the Quality/Audit/learning agenda points in formal team meetings.	Mental Health, Community & Primary Care	31.08.2023	21.11.2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
				Audit data will be reported/escalated through Care Group Governance Framework.	Mental Health, Community & Primary Care	31.08.2023	21.11.2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
			Recommendation 14 The health board must ensure arrangements are in place to mitigate against the risks associated with expedited patient discharges, ensuring that timely information is shared with relevant community teams.	The oversight of this recommendation will be via the Safe Discharge Workstream. The workstream will define an expedited discharge and develop a procedure for management of expedited discharges to ensure: An Offer of Home Treatment following discharge Formal communication with the Community Mental Health Team by ward manager Those identified as expedited will be escalated to the Clinical Service Group Senior Management Team for scrutiny and learning Review of process and decision making for each case	Mental Health, Community & Primary Care	30.06.2023		Fully complete (Awaiting approval)	
				The care group will audit all cases who are considered to have been subject to "expedited discharge" using standards agreed within the procedure.	Mental Health, Community & Primary Care	30.06.2023		Fully complete (Awaiting approval)	
				Compliance/noncompliance will be formally reported at CSG QSRE (with any variation over time noted) and reported/escalated through Care Group Governance Framework.	Mental Health, Community & Primary Care	30.06.2023		Fully complete (Awaiting approval)	
				Audit results will be shared with staff teams through the Quality/Audit/learning agenda points in formal team meetings.	Mental Health, Community & Primary Care	30.06.2023	21.11.2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
				Audit data will be reported/escalated through Care Group Governance Framework.	Mental Health, Community & Primary Care	30.06.2023	21.11.2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during this period

				The expedited discharge procedure will not include measure to support inpatients who have been given leave earlier than planned as this process is defined in Health Board Policy for Management of Section 17 leave (MH 12), and Policy for planning leave for informal patients (MH44).	Mental Health, Community & Primary Care	30.06.2023		Fully complete (Awaiting approval)	February 2024 Update - Complete
			Recommendation 15 The health board must provide an update to HIW on the actions taken or are outstanding, to mitigate the risks associated with the availability of inpatient beds.	The oversight of this recommendation will be via the Access and Alternatives to Admission Workstream. It is uncommon for CTM occupancy to be at 100% even at ward level. However, current arrangements for escalation of bed availability differ across the acute hospital sites in the Health Board. A standardised approach will be developed to include: •Daily care group huddles •Shared process for the management of bed availability •Action card guidelines for the management of acuity •Out of hours contingency arrangements •Daily reporting of bed availability	Mental Health, Community & Primary Care	31.07.2023		Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
				The Mental Health Act operational group will lead on the development of the Section 140 Policy so that there is clarity about the arrangements when CTM occupancy is at 100%.	Mental Health, Community & Primary Care	31.07.2023	15.03.2024	Overdue	February 2024 Update - Revised completion date 15/03/2024. December 2023 Update - Revised completion date. Revised timescale refers to the ratification of the new S140 policy.
			Recommendation 16 The health board should consider the benefits of reinstating the huddle meetings to help manage the issues with patient flow in and out of the inpatient units.	The oversight of this recommendation will be via the Access and Alternatives to Admission Workstream. See response to recommendation 15	Mental Health, Community & Primary Care	31.07.2023		Fully complete (Awaiting approval)	
			Recommendation 17 The health board must consider the causes and subsequent options to minimise the number of delayed discharges occurring within inpatient mental health wards.	The oversight of this recommendation will be via the Safe Discharge Workstream. The Care group will undertake a review of inpatient demand and capacity to: •Define the conditions described by staff in the review •Understand potential causes of delayed discharges. •Identify nursing/MDT •Interventions that will address inpatient blockages to flow The outcome of the demand and capacity review will inform the work of the Access and Alternatives to Admission workstream and the Rehabilitation Programme.	Mental Health, Community & Primary Care	31.08.2023		Fully complete (Awaiting approval)	February 2024 Update - Complete
			Recommendation 18 The health board must ensure that the management and storage of paper patient records used within POWH inpatient mental health unit, and across the health board as a whole, is reviewed: a) to ensure a standardised approach to allow for more efficient access to patient information; b) to maintain the security of patient data and clinical information	The oversight of this recommendation will be via the High Quality Records Workstream. A programme of work is underway to: • Standardise approaches to the management of paper records if these are required • Maximise risk mitigations for existing processes • Undertake a scoping exercise to phase out paper notes ensuring that the Care Group maximises the use of existing digital systems prior to the implementation of the Single Electronic Record. • Learn from the clinical record improvement at Ty Llidiard whilst recognising that the wider care group has additional challenge in terms of scale and complexity.	Mental Health, Community & Primary Care	31.07.2023		Fully complete (Awaiting approval)	Recommendation ratified as completed by the Inpatient Improvement Board on 17/10/2023
				The Safe Discharge Workstream have introduced governance measures to limit access to any patient held on the W and T electronic drives , with senior level authorisation required in order to gain access	Mental Health, Community & Primary Care	31.07.2023		Fully complete (Awaiting approval)	Recommendation ratified as completed by the Inpatient Improvement Board on 17/10/2023
				Medical records teams on PoW and RGH sites are responsible for maintaining confidentiality and access to patient paper based records, tracking notes when in use. Out of hour there is access to paper records through the Crisis resolution services on both sites.	Mental Health, Community & Primary Care	31.07.2023		Fully complete (Awaiting approval)	Recommendation ratified as completed by the Inpatient Improvement Board on 17/10/2023
				The Safe Discharge Workstream are rolling out best practices across Bridgend (in line with RTE learning) , to rationalise the volume of appear records held, undertaking a scoping exercise into the efficacy of a paper record phase out pre WCCIS implementation. (Completion date 15 July 2023)	Mental Health, Community & Primary Care	31.07.2023		Fully complete (Awaiting approval)	Recommendation ratified as completed by the Inpatient Improvement Board on 17/10/2023
				As a mitigation for the multiple record system that are still in place across the CTM Mental Health service the Safe Discharge Workstream has developed a matrix for clinical team /staff access ("who accesses what system for what purpose") for all systems across the mental health service. This informs all clinical staff of how to access patient clinical risk and discharge planning, information both in and out of hours describes mitigants and escalation.	Mental Health, Community & Primary Care	31.07.2023		Fully complete (Awaiting approval)	Recommendation ratified as completed by the Inpatient Improvement Board on 17/10/2023
			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.	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, Community & Primary Care	30.06.2023		Overdue	February 2024 Update - It has been decided that WCCIS would no longer be the system implemented and that the Health Board are exploring two system options whilst awaiting a National Solution. December 2023 Update - Status relates to the Implementation of WCCIS Update to be provided to HIW 31/01/1024 The Health Board is working closely with Digital Health and Care Wales and other Health Boards in relation to implementation. However, in light of implementation challenges faced by another Health Board, discussions at a national level are ongoing in relation to the preferred digital solution to a unified patient clinical record system.
				A business case has been developed and endorsed by the Executive. There are however challenges with the preferred national system. The Health Board is working closely with Digital Health and Care Wales and other Health Boards as part of the review of the national strategic programme for the Welsh Community Care Information System. The outcome of this review will influence timescales for WCCIS implementation for the Health Board. A CTMUHB WCCIS Workshop is scheduled for 15th June 23 led by MHLD Service Director. CTMUHB WCCIS Programme Board to start from 25th July 23 chaired by the Deputy Chief Operations Officer and Executive Director for Digital. A WCCIS Operational Group will start in July/ August 23 chaired by MHLD Service Director and IT/ Digital Senior manager. WCCIS Implementation Plan timescales for MHLD to be refreshed and presented to WCCIS workshop on 15th June 23.	Mental Health, Community & Primary Care	30.06.2023		Fully complete (Awaiting approval)	
				As a mitigation for the multiple record system that are still in place across the CTM Mental Health service the Safe Discharge Workstream has developed a matrix for clinical team /staff access ("who accesses what system for what purpose") for all systems across the mental health service. This informs all clinical staff of how to access patient clinical risk and discharge planning, information both in and out of hours describes mitigants and escalation	Mental Health, Community & Primary Care	30.06.2023		Fully complete (Awaiting approval)	WCCIS implementation aim end 2024
			Recommendation 20 The health board must implement actions to mitigate against risks associated with staff access to clinical records in different teams to patient information in a timely manner.	The oversight of this recommendation will be via the High Quality Records Workstream. As a mitigation for the multiple record system that are still in place across the CTM Mental Health service the Safe Discharge Workstream has developed a matrix for clinical team /staff access ("who accesses what system for what purpose") for all systems across the mental health service. This informs all clinical staff of how to access patient clinical risk and discharge planning, information both in and out of hours describes mitigants and escalation.	Mental Health, Community & Primary Care	31.07.2023		Fully complete (Awaiting approval)	Recommendation pending ratification at Inpatient Improvement Board on 21/11/2023
				In alignment with the Access and Admission workstream and Safe Discharge workstream drivers, process mapping has been undertaken and flow diagrams regarding passing patient information between CMHT and Inpatient for admission and discharge have been completed and shared across the MHLD care Group.	Mental Health, Community & Primary Care	31.07.2023		Fully complete (Awaiting approval)	Recommendation pending ratification at Inpatient Improvement Board on 21/11/2023
			Recommendation 21 The health board must ensure that discharge letters provide sufficient information to patients and where appropriate family or carers, to help manage patient care following discharge. Where applicable, this should include information on the patients' rights to self-refer to the service, in line with the Mental Health (Wales) Measure 2010	"This element of recommendation 21 has been addressed as part of the immediate assurance action plan: 4.1.1 Review discharge letter templates, to ensure they provide sufficient information to patients and other key staff to support a patient following discharge and help maintain their safety and wellbeing"	Mental Health, Community & Primary Care	31.07.2023		Fully complete (Awaiting approval)	
				Aligned with recommendation 6 and recommendation 11 the Safe Discharge Workstream will ensure that there is a standardised approach to communication with patients and where appropriate their family or carers.	Mental Health, Community & Primary Care	31.07.2023		Fully complete (Awaiting approval)	
				In acknowledgement of the significant work programme that is required across CTM to return it to a position of delivering consistently high quality Mental Health services; a Quality Improvement Programme has been implemented to ensure whole service engagement and consistency of approach across the Health Board. The Improvement Programme is led at Care Group level by the Director of Nursing, with six distinct workstreams within the "High Quality Inpatient Care" sub programme. Each is led at a Senior level (Lead Nurse or equivalent), with an overarching aim to ensure that all action, change and improvement will be consistently and universally implemented across CTM. This consistency of approach will be further reinforced with the imminent reorganisation of the MH Care group to provide Senior leadership and Governance structures that have responsibility for the delivery of all inpatient care across CTM	Mental Health, Community & Primary Care	31.08.2023		Overdue	Reorganisation of the MHLD Care Group in progress
				In alignment with the work undertaken by the High quality records workstream , the inpatient units are now using a uniform template for electronic discharge letters and recording, storage and circulation if also uniform This has also been adapted for OA Services to ensure parity across inpatients and CMHTs.	Mental Health, Community & Primary Care	31.08.2023		Fully complete (Awaiting approval)	
				As a mitigation for the multiple record system that are still in place across the CTM Mental Health service the Safe Discharge Workstream has developed a matrix for clinical team /staff access ("who accesses what system for what purpose") for all systems across the mental health service. This informs all clinical staff of how to access patient clinical risk and discharge planning, information both in and out of hours describes mitigants and escalation	Mental Health, Community & Primary Care	31.08.2023		Fully complete (Awaiting approval)	
				The HB will undertake a weekly spot random audit of 20% (or a minimum of five) of all discharges to the Adult inpatient units using the "ward managers Audit tool.	Mental Health, Community & Primary Care	31.08.2023	21.11.2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
				Ward manager Audit tool has been digitised to enable rapid real time reporting of results through the "Audit management and Tracking (AMaT) process. Non-compliance will be reported weekly by ward managers to Senior Nurses; with immediate remedial action if necessary, and escalation to Clinical Service Group management team if required.	Mental Health, Community & Primary Care	31.08.2023	21.11.2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
				Compliance/non-compliance will be formally reported at CSG QSRE (with any variation over time noted) and reported/escalated through Care Group Governance Framework.	Mental Health, Community & Primary Care	31.08.2023	21.11.2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
				Staff will learn from audit results when shared with staff teams through the Quality/Audit/learning agenda points in formal team meetings.	Mental Health, Community & Primary Care	31.08.2023	21.11.2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
				Audit data will be reported/escalated through Care Group Governance Framework	Mental Health, Community & Primary Care	31.08.2023	21.11.2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during this period

			Recommendation 22 The health board must ensure that discharge letters are sent to patients, family, their GP and other applicable services within 24 hours of their discharge date. This should also be documented within the relevant patient records.	The oversight of this recommendation will be via the Care Group Policies Group.	Mental Health, Community & Primary Care	31.08.2023		Overdue	
				The inpatient team will revise the Hospital Discharge Procedure (MH40) in line with Nice Guideline [NG53] Transition between inpatient mental health settings and community or care home settings.	Mental Health, Community & Primary Care	31.08.2023		Fully complete (Awaiting approval)	February 2024 Update - Complete
				This will make explicit a standard that within 24 hours, a letter which includes the details of a person's current prescription, the reasons for any changes in medicines and their immediate medication treatment plan, is emailed to the person's GP, with a copy given to the person and, if appropriate, the community team and other specialist services	Mental Health, Community & Primary Care	31.08.2023		Fully complete (Awaiting approval)	February 2024 Update - Complete
				The procedures will be shared with all staff through Communication and Learning Framework (Recommendation 40)	Mental Health, Community & Primary Care	31.08.2023		Fully complete (Awaiting approval)	February 2024 - Complete
				Audit of the process will be fed back to teams and any remedial action will reinforce compliance	Mental Health, Community & Primary Care	31.08.2023		Fully complete (Awaiting approval)	February 2024 Update - Complete
				Evidence of routine compliance will be shown through a process audit of all discharges within 24 hours (ward manager) and Bi weekly document review (Senior Nurse) , and Bi monthly CTP audit (CTP Lead).	Mental Health, Community & Primary Care	31.08.2023		Fully complete (Awaiting approval)	February 2024 Update - Complete
			Recommendation 23 The health board must ensure that discharge summaries are completed and sent out to the patients' GP and other relevant services involved in the post discharge care and treatment, within a week of the discharge.	The oversight of this recommendation will be via the Ward Assurance Group. This standard is explicit within the Health Board Procedure (MH40) standard and is monitored through a process audit of all discharges within 24 hours (ward manager) and Bi weekly document review (Senior Nurse). This audit will be included in the Health Board electronic audit tool	Mental Health, Community & Primary Care	30.06.2023		Fully complete (Awaiting approval)	
			Recommendation 24 The health board must ensure that patients are followed up within three days post discharge from mental health units, in line with national guidance.	The oversight of this recommendation will be via the Ward Assurance Group.	Mental Health, Community & Primary Care	30.06.2023		Fully complete (Awaiting approval)	February 2024 Update - Complete
				This standard is explicit within the Health Board Discharge Procedure (MH40) standards.	Mental Health, Community & Primary Care	30.06.2023		Fully complete (Awaiting approval)	
				This standard is monitored through a process audit of all discharges within 24 hours (ward manager) and Bi weekly document review (Senior Nurse) , and bi monthly CTP audit (Community Senior Nurse). This audit will be included in the Health Board electronic audit tool	Mental Health, Community & Primary Care	30.06.2023		Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
				The High Quality Clinical Records Workstream will provide solutions for the monitoring of discharge follow up by community teams using different record systems.	Mental Health, Community & Primary Care	30.06.2023		Fully complete (Awaiting approval)	
			Recommendation 25 The health board must take action to manage the risks of insufficient staff numbers and temporary staffing needs on inpatient mental health wards.	The oversight of this recommendation will be via the Skilled and Motivated Workstream.	Mental Health, Community & Primary Care	30.06.2023		Overdue	
				The inpatient units have developed staffing escalation processes to ensure effective support to those staff who have responsibility for safe staff decision making on a shift by shift basis. These will be reviewed to ensure a consistency of approach across all inpatient units.	Mental Health, Community & Primary Care	30.06.2023		Fully complete (Awaiting approval)	Recommendation pending ratification at Inpatient Improvement Board on 21/11/2023
				A review of nursing establishments across the inpatient units is underway. This will be informed by present best practice guidance and the principles that have been developed by the ongoing All Wales Mental Health Nurse staffing programme.	Mental Health, Community & Primary Care	30.06.2023		Fully complete (Awaiting approval)	Recommendation pending ratification at Inpatient Improvement Board on 21/11/2023
				Alternative approaches to recruitment and retention will be explored including: •Recruitment events •Skill mix review •Exploration of Band 4 roles •Overseas recruitment •HCSW to registered nurse training pathways	Mental Health, Community & Primary Care	30.06.2023		Fully complete (Awaiting approval)	Recommendation pending ratification at Inpatient Improvement Board on 21/11/2023
				The care group will monitor staffing, recruitment and retention issue s and the effectiveness of the approaches detailed through a monthly Nursing Staffing and Workforce meeting.	Mental Health, Community & Primary Care	30.06.2023		Fully complete (Awaiting approval)	Recommendation pending ratification at Inpatient Improvement Board on 21/11/2023
				Workforce issues such as vacancies and sickness are reported , by clinical service group at monthly Integrated performance meeting	Mental Health, Community & Primary Care	30.06.2023		Fully complete (Awaiting approval)	Recommendation pending ratification at Inpatient Improvement Board on 21/11/2023
			Recommendation 26 The health board should undertake a community workforce capacity and demand review, to ensure relevant community teams are sufficiently resourced to manage their patient caseloads.	"The oversight of this recommendation will be via the Care Group Strategic Transformation Board. The Health Board will undertake a demand and capacity review of the community teams and will consider • Referral pathways • Utilisation of local resources • Thresholds for access to community teams • Caseload numbers and acuity • Skill mix • Workforce wellbeing	Mental Health, Community & Primary Care	31.08.2023		Fully complete (Awaiting approval)	Recommendation ratified as completed by the Inpatient Improvement Board on 17/10/2023
				The demand and capacity review will include engagement with staff working within community teams within the health board, as staff experience, engagement and feedback is an essential part of a compassionate leadership approach to service review.	Mental Health, Community & Primary Care	31.08.2023		Fully complete (Awaiting approval)	Recommendation ratified as completed by the Inpatient Improvement Board on 17/10/2023
			Recommendation 27 The health board must provide an update on the status of the Merthyr Cynon CRHT assessment facilities within PCH.	The oversight for this recommendation will be via the Access and Alternatives to Admission Workstream. The PCH Crisis Assessment Space is now operational within PCH Emergency Department.	Mental Health, Community & Primary Care	30.09.2023		Overdue	February 2024 Update - Discussed in Improvement Board Meeting 23/01/2024. Lead Nurse tasked to provide an update at next meeting 27/02/2024. December 2023 Update - Capital works in PCH are ongoing. The Care Group is working closely with colleagues at Prince Charles Hospital as part of the estates planning processes and to implement a substantive arrangement for crisis assessment. Capital works in PCH are due to be completed end of January 2024 which will give the care group opportunity to access to dedicated space in PCH ED. May 2023 Update - Please note this timescale is for the medium term solution. An update on substantive arrangements will be provided 30 Sept 2023.
				Crisis and Liaison Staff risk assess the patient and depending on need will remain with them in the room at all times.	Mental Health, Community & Primary Care	30.09.2023		Overdue	
				The current room has been stripped of ligature points as far as is reasonably practicable but is not an anti-ligature environment so is reliant on risk assessment and observation of the patient.	Mental Health, Community & Primary Care	30.09.2023		Fully complete (Awaiting approval)	
				Hand held panic alarms have been ordered and will be delivered to Crisis Team w/c 12th June 23	Mental Health, Community & Primary Care	30.09.2023		Fully complete (Awaiting approval)	
				The Care Group is working closely with colleagues at Prince Charles Hospital as part of the estates planning processes and an update on substantive arrangements for unscheduled/crisis assessment will be provide to HIW assessment 30 Sept 2023.	Mental Health, Community & Primary Care	30.09.2023		Overdue	Status relates to the substantive arrangements for unscheduled/crisis assessment in PCH
			Recommendation 28 The health board must ensure communication arrangements are embedded, to allow for essential sharing of information between teams regarding patient care and treatment planning during the hospital stay and after discharge.	As a mitigation for the multiple record system that are still in place across the CTM Mental Health service the Safe Discharge Workstream has developed a matrix for clinical team /staff access ("who accesses what system for what purpose") for all systems across the mental health service. This informs all clinical staff of how to access patient clinical risk and discharge planning, information both in and out of hours describes mitigants and escalation.	Mental Health, Community & Primary Care	31.07.2023		Fully complete (Awaiting approval)	
				In alignment with the Access and Admission workstream and Safe Discharge workstream drivers, process mapping has been undertaken and flow diagrams regarding passing patient information between CMHT and Inpatient for admission and discharge have been completed and shared across the MHLD care Group.	Mental Health, Community & Primary Care	31.07.2023		Fully complete (Awaiting approval)	
				In acknowledgement of the significant work programme that is required across CTM to return it to a position of delivering consistently high quality Mental Health services; a Quality Improvement Programme has been implemented to ensure whole service engagement and consistency of approach across the Health Board.	Mental Health, Community & Primary Care	31.07.2023		Fully complete (Awaiting approval)	
				The Improvement Programme is led at Care Group level by the Director of Nursing, with six distinct workstreams within the "High Quality Inpatient Care" sub programme. Each is led at a Senior level (Lead Nurse or equivalent), with an overarching aim to ensure that all action, change and improvement will be consistently and universally implemented across CTM.	Mental Health, Community & Primary Care	31.07.2023		Fully complete (Awaiting approval)	

				This consistency of approach will be further reinforced with the imminent reorganisation of the MH Care group to provide Senior leadership and Governance structures that have responsibility for the delivery of all inpatient care across CTM .	Mental Health, Community & Primary Care	31.07.2023		Overdue	February 2024 - Reorganisation of MHLD Care Groups has commenced with shadow directorates from 01/02/2024. December 2023 Update - Reorganisation of the MHLD Care Group in progress.
			Recommendation 29 The health board must take action to ensure there is sufficient medical capacity across all mental health teams.	The oversight for this recommendation will be via the Medical Productivity Group.	Mental Health, Community & Primary Care	31.07.2023		Overdue	
				The care Group Medical Director is leading on the development and progress of a Medical Workforce Productivity Committee with the purpose of developing a pan care Group medical workforce plan to ensure the delivery of safe High quality care. This programme of work is focusing on: • Medical recruitment • Medical retention • Design of new roles • Monitoring of job planning • Management of temporary roles	Mental Health, Community & Primary Care	31.07.2023		Fully complete (Awaiting approval)	
				Medical Workforce Productivity Group is now established with CTM wide membership and terms of reference agreed and following first meeting in May 2023. Workstreams agreed for • Recruitment and retention • Unplanned care • Diverse workforce and Vacancy rates agreed as the Initial Outcome measure	Mental Health, Community & Primary Care	31.07.2023		Fully complete (Awaiting approval)	
				Following the June 2023 Medical Workforce Productivity Group, staffing levels were identified as Baseline WTEWTE Apr-23WTE May-23 Consultants45.4(100%)15(32%)15 (32%) Specialty Doctor26(100%)11 (42%)13 (50%) While there are at present significant rates of vacancy across the MH medical workforce, the Care group is successfully maintaining a cohort of Locum Doctors as a mitigating measure while the recruitment and retention programme scales up. At present (June 2023) the Care Group Medical Director is assured that there are locum doctors covering all vacant substantive posts " In addition the Medical Workforce Productivity Group has agreed timescales for delivery of actions within the Recruitment and retention; Unplanned care & Diverse workforce Workstreams.	Mental Health, Community & Primary Care	31.07.2023		Overdue	
				The care group will monitor staffing, recruitment and retention issues and the effectiveness of the approaches detailed through a monthly Medical Staffing and Workforce meeting.	Mental Health, Community & Primary Care	31.07.2023		Fully complete (Awaiting approval)	
				Workforce issues such as vacancies and sickness are reported , by clinical service group at monthly Integrated performance meeting	Mental Health, Community & Primary Care	31.07.2023		Fully complete (Awaiting approval)	
			Recommendation 30 The health board must consider how it can work with therapies staff: a) to act on the concerns raised; b) to enable them to undertake their role to adequately manage the needs of patients during their recovery phase prior to discharge.	The oversight for this recommendation will be via the Safe and Therapeutic Environment Workstream.	Mental Health, Community & Primary Care	30.09.2023		Overdue	
				As part of the pan CTM Quality Improvement Programme, an event was held on 26th April to consider in partnership the options to provide occupational therapy facilities including but not limited to the provision of: • Development of MDT with access to AHPs and Therapists • Access to Sufficient ADL Equipment • Activities schedules • Facilitated Ad-hoc access to recreational facilities The workstream will review current facilities and scope out potential new areas and facilities. Whilst the workstream is further developing the OT team have been provided with temporary arrangements for therapy space, which has enabled them to continue to deliver the service, with reduced numbers for group sessions.	Mental Health, Community & Primary Care	30.09.2023	21.11.2023	Fully complete (Awaiting approval)	December 2023 Update - Completed this period
			Recommendation 31 The health board must consider the need to undertake a review of the capacity and demand of the mental health therapy services, and whether the establishment is correct to meet the demand.	The oversight for this recommendation will be via the Skilled and Motivated Workforce Group.	Mental Health, Community & Primary Care	31.03.2024		Overdue	
				At Therapies Governance meeting on 18/05/2023 the Health Board reviewed HIW recommendation 31, and is in agreement that a multi-professional review of demand and capacity of the MH therapy workforce is required and will be undertaken. This review will entail a (not exclusive) range of Allied health Professionals including Psychology, Art Therapy, Physiotherapy, Dietetics and SALT. This review of the therapies workforce is underway and is considering: •Strategic workforce drivers •National guidance •Quality standards •Demand and capacity The Occupational Therapy review and subsequent job planning exercise has been completed and the Deputy Head of OT reports that the Occupational Therapy workforce is at full capacity and as such is able to meet demands for assessment, treatment and review that are presented on the Adult inpatient units.	Mental Health, Community & Primary Care	31.03.2024		Overdue	
				The remaining demand and capacity review will include engagement with staff working within each of the Therapies disciplines, as staff experience, engagement and feedback is an essential part of a compassionate leadership approach to service review. This review will conclude in the development of a MH Therapy workforce proposal for consideration.	Mental Health, Community & Primary Care	31.03.2024		Overdue	February 2024 Update - Consultant Clinical Psychologist is leading on this action from a psychological therapies perspective and the recommendation is on track to be completed by 31/03/2024.
				This review has many interdependencies with the Improvement programme work streams and as such will have a completion timescale of 31 March 2024	Mental Health, Community & Primary Care	31.03.2024		Overdue	
				In the interim the Health Board has appointed an 8c psychologist to work as Clinical lead for the Adult inpatient service with a remit of developing the available skills within the inpatient workforce, building their psychological safety and resilience; and providing robust clinical challenge when required within the MDT	Mental Health, Community & Primary Care	31.03.2024		Fully complete (Awaiting approval)	December 2023 Update - Completed during this period - 8c Clinical Psychologist Adult Inpatient Lead commenced in post from October 2023
				In addition the recently instituted morning inpatient "board rounds" provide an opportunity for Multidisciplinary discussion and care planning and a conduit for making clinical enquiry of the psychology resource when then are not actually on site	Mental Health, Community & Primary Care	31.03.2024		Overdue	
				The Clinical Teams are further able to discuss risk formulations and complex clinical need at the monthly Complex Case Peer Review meeting, chaired by the Head of Mental Health Psychology & Psychological Therapies	Mental Health, Community & Primary Care	31.03.2024		Overdue	
				AHP and psychological therapies in acute services have a long tradition of offering training placements to clinical psychology trainees, counselling psychology trainees, art psychotherapy trainees and psychology undergraduate yearlong placements students. This has created additional capacity to ensure a tiered approach to working with people in acute care. This additional capacity has enabled more patients to be offered protocol based psychological interventions.	Mental Health, Community & Primary Care	31.03.2024		Fully complete (Awaiting approval)	
				For the wider nursing team training on Compassionate Care, and Psychologically Informed Practice has been arranged and delivered to the RMN and HCA workforce in acute services, while further training is being planned and commissioned with a third sector provider to deliver ASSIST suicide prevention training to the workforce by October 31 2023	Mental Health, Community & Primary Care	31.03.2024		Overdue	
			Recommendation 32 The health board must consider the staff feedback highlighted in this report and consider undertaking a training needs analysis for inpatient and community staff, to identify any training gaps and help ensure all staff have the appropriate knowledge and skills to effectively undertake their role.	The oversight for this recommendation will be via the Skilled and Motivated Workforce Workstream. Please refer to the response to recommendation 8.	Mental Health, Community & Primary Care	31.08.2023		Fully complete (Awaiting approval)	February 2024 Update - Complete
				In addition to the core learning skills for mental health staff and informed by the outcome of the wider In-patient Improvement workstreams a full training needs analysis will be completed to identify further opportunities for skills development.	Mental Health, Community & Primary Care	31.08.2023		Fully complete (Awaiting approval)	
				The HB standard for all mandatory training is 85% minimum, and is considered to be a prudent and appropriate target, with consideration of predictable staff turnover and anticipated unavoidable challenges to training.	Mental Health, Community & Primary Care	31.08.2023		Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
				In light the scale of improvement required, in addition to the organisational mandatory and statutory training requirement, the Mental Health care group are focusing only on a core set of Mental Health specific skills including WARRN, CTP and PMVA training, and any Mental Health Act /statutory training that is immediately identified through on going learning.	Mental Health, Community & Primary Care	31.08.2023		Fully complete (Awaiting approval)	
				The care group is developing a Service Improvement Team (SIT) the service lead of which will gather intelligence from the wider Audit programme, unmet need process, wider learning and staff feedback through PADR to develop a training needs analysis.	Mental Health, Community & Primary Care	31.08.2023		Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
				The Care Group will focus on increased compliance within the time scale 31 August 2023 review, but outside this will revisit the fuller training needs analysis this in 12 months' time (31 May 2024) with a fuller understanding of the lessons from the Inpatient improvement work streams.	Mental Health, Community & Primary Care	31.05.2024		Fully complete (Awaiting approval)	
			Recommendation 33 The health board must ensure that all staff across the mental health services are aware of how to access support, and that timely access to occupational health and well-being support is available to staff when required.	The oversight for this recommendation will be via the Skilled and Motivated Workforce Workstream. Good staff experience is critical to the development of the care group and to high quality patient outcomes.	Mental Health, Community & Primary Care	31.08.2023		Fully complete (Awaiting approval)	February 2024 Update - Complete
				"The Care Group will: •Establish a programme of Wellbeing Activists in each team to work as champions for this agenda. •Implement the learning from the Ty Llidiard and Maternity Services improvement work on staff engagement •Work with people services and occupational Health to determine blockages to assess service and possible mitigants •Develop mechanisms to demonstrate appreciation and celebrate success •Seek to understand the root causes of staff distress and explore solutions"	Mental Health, Community & Primary Care	31.08.2023		Fully complete (Awaiting approval)	

				The care group uses a range of methods to seek feedback and input form the staff group. A programme of feedback and analysis of a regular Staff wellbeing survey is coordinated by the Health Board Peoples Services, a senior Business partner of which works alongside the care group leadership team. Triangulation of these methods will enable the care group to more fully evaluate impact of the measures implemented.	Mental Health, Community & Primary Care	31.08.2023		Fully complete (Awaiting approval)	
			Recommendation 34 The health board should ensure there is adequate and consistent engagement with all staff around the audit arrangements in place across its mental health services, and that staff are made aware of all audit result and any actions required for improvement.	The oversight for this recommendation will be via the Ward Assurance Group. A programme of digitised audits across the community and inpatient teams is underway.	Mental Health, Community & Primary Care	30.06.2023		Overdue	
				The Clinical Service Groups will use Sharing Information/learning arrangements within the services e.g. QSRE, team meetings, 7 minute briefings to maintain a staff awareness of quality assurance work. In addition the Health Board electronic audit system will provide the opportunity for audit outcomes to be visible for staff, patients and visitors at ward level.	Mental Health, Community & Primary Care	31.07.2023		Fully complete (Awaiting approval)	December 2023 Update - Completed during this period. Manual audits are being undertaken until audits can be digitised.
			Recommendation 35 The health board must ensure that the audit process is reviewed within its mental health services, and that a robust and sustainable audit action management plan is implemented (as applicable), to ensure actions are monitored and to assure itself that implemented improvements are being sustained.	The oversight for this recommendation will be via the Research and Audit Group. A new Research and Audit group has been developed with the ward assurance group reporting to it. Please see response to recommendation 34 for comment on ward assurance. In addition to ward assurance audits, the Research and Audit Group will develop a broader Care Group audit plan. The Care Group is developing a dedicated service improvement team to support the delivery of the present clinical audit/ Quality Improvement. Activity that is taking place. Job descriptions are currently being developed with the expectation that recruitment will be completed by the end of July 2023.	Mental Health, Community & Primary Care	31.07.2023	21.11.2023	Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
				This resource will be work in partnership with the clinical teams to embed both a culture of improvement and shared learning. Engagement with staff at all levels will be a key objective of this team.	Mental Health, Community & Primary Care	31.07.2023		Fully complete (Awaiting approval)	
			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.	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, Community & Primary Care	01.06.2024		In progress	February 2024 Update - Remains in progress December 2023 Update - The HB has revised its process for the ratification of policies which will lead to more timely ratification and will enable all policies and procedures to be ratified by 01/06/24. There are 39 expired MH policies/ procedures. These have been prioritised for updates. The Mental Health Policy Review Group will monitor this review schedule at each meeting. In the interim the Mental Health Policy group has directed the clinical teams to work with the most current version each Clinical policy.
			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.	Mental health policies will follow the agreed organisational process for ratification. All NH specific policies were reviewed by 1 June 2023 and of the 49 MH specific policies - Review underway 4 In date and approved 13 Expired 32. With an agreement that those that require updating will be completed by 1st June 2024. The 32 expired policies have been prioritised with consideration of patient safety, present best practice and clinical impact and a review schedule has been developed with this in mind. The Mental Health Policy group will monitor this review schedule at each meeting through an agenda item. In the interim the Mental Health Policy group has directed the clinical teams to work with the most current version each Clinical policy. On completion agreed policies will be communicated to all Nursing and Medical staff across all Mental Health services using the care Group "Communication and Learning Framework" (recommendation All current and ratified policies will be live on the Mental Health Policies page on the staff internet site SharePoint.	Mental Health, Community & Primary Care	01.06.2024		In progress	
			Recommendation 37 The health board must ensure that risk registers are reviewed, and that consideration is given to risk identification and risk management processes. This must include assuring itself that key staff are adequately trained in identifying risks and their management.	The oversight of risk registers will be dually via the Care Group Quality Safety Risk and Experience Group and the Performance, Planning and Finance Group. Accountability for the management of risk registers at Clinical Service Group will be via operational leaders	Mental Health, Community & Primary Care	30.06.2023		Fully complete (Awaiting approval)	
				The organisational risk register includes risk with a score of over 15. The organisational risk register has been reviewed across the Health Board. Aggregate workforce shortage and training risks are included for CTM. Specific Mental Health risks including clinical records and environmental risks are recorded on the organisational risk register. Risk registers with scores over 12 are monitored at Care Group level via Quality Safety Risk and Experience Group – (see Appendix 1 for governance arrangements), and all other risks are monitored via the Clinical Service Group performance arrangements. The Head of Quality and Safety will lead an operational care group governance meeting to monitor compliance with Putting Things Right, action plans and risk review timescales. Agenda item in performance meeting at senior nurse level in order to encourage escalation and culture of owning risks and mitigation as local level.	Mental Health, Community & Primary Care	30.11.2024		Fully complete (Awaiting approval)	
				Risk identification and Risk management (through organisational risk registers) is a core competency of all managers and training in this area is being delivered to all staff who monitor risk registers within the governance framework	Mental Health, Community & Primary Care	31.08.2023		Fully complete (Awaiting approval)	December 2023 Update - Completed during this period
			Recommendation 38 The health board must consider how it can audit the process in place for social worker identified incidents, which are documented within Datix, and that feedback, learning and actions are shared with them as applicable.	The oversight for this recommendation will be via the Quality, Safety, Risk and Experience Group. The Mental health Governance lead will establish a working group with the Lead Nurses and Local Authority heads of service to develop a mechanism for multi-agency incident reporting.	Mental Health, Community & Primary Care	30.06.2023	31.10.2024	Overdue	February 2024 Update - Update from Business Intelligence Team that they have explored ways for a social worker to be able to access the incident module of Datix, however a solution has not been found. Action agreed: SOP to be developed to describe the process for feedback, learning and actions to be shared with social workers as applicable. Previous Update - The Mental Health Care Group is exploring a way for social workers to be able to report incidents directly through Datix with the Health Board Governance Team and ICT team. This has been delayed by issues with allowing non HB personnel access to HB and NHS systems and organisational changes to the CTM governance and Datix teams. In the meantime, a process for reporting and feeding back on social worker identified incidents in multi-agency meetings and so that learning can be shared will be implemented.
			Recommendation 39 The health board must ensure that any staff who report incidents via Datix are provided with feedback, including any actions taken and learning identified.	"The oversight for this recommendation will be via the Quality, Safety, Risk and Experience Group. Following rollout of new 'Datixweb' functionality, datix reviews cannot be closed without providing the reporter with feedback. Monitoring of incident closures will be via the Quality, Safety, Risk and Experience Group."	Mental Health, Community & Primary Care	30.06.2023		Fully complete (Awaiting approval)	
			Recommendation 40 The health board must ensure that there is a process in place to share learning or actions identified following incidents are cascaded across all teams within its mental health services.	"The oversight for this recommendation will be via the Quality, Safety, Risk and Experience Group. The Mental Health Care Group will develop a Communication and Learning framework that entails: •A Standard operational Policy for cascade/escalation of information Ward/Board/Ward (attached Appendix 6) •Bimonthly Quality, Safety, Risk and Experience (QSRE)meetings where learning is shared between all Clinical Service group (CSG) senior teams •Monthly CSG QSRE for escalation and dissemination of wider learning by Senior Nurses amd MDT. Monthly "Clinical Lead" meetings for escalation and dissemination of wider learning to ward managers and Team leaders •Monthly team/ward meetings for escalation and dissemination of wider learning, and sharing of local Quality improvement and audit information. This will be an universally agendad meeting with action points noted. •7 minute briefings /LASER used as a mechanism to share learning in team/ward meetings; safety briefings on wards; and to individual staff email accounts. •Each clinical area (inpatient and community) will have designated training board/information space for the sharing of learning / local audit/ educational resource •quarterly Post Grad learning Sessions to enable Multi-disciplinary Shared learning The Head of Quality and Safety, in partnership with service leads, will coordinate the sharing of learning, uniformity of approach and resources and content."	Mental Health, Community & Primary Care	30.06.2023		Fully complete (Awaiting approval)	
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 demonstrate suitable daily checks of emergency equipment have been conducted in accordance the health board's policy/requirements.	There is a plan to include the resuscitation trolley on the Health Board AMaT (Audit Management and Tracking) system, whereby it will be a requirement that the Lead Nurses in Unscheduled Care and planned Care undertake a 3 times weekly assurance audit that the checks have been completed.	Unscheduled Care	01.11.2023		Partially complete (Overdue)	Review Date - March 2024 February 2024 Update - The audit tool has been developed and awaiting final approval.- Senior Nursing Leadership audit tool to provide the assurances of audits undertaken by the Ward/Department Managers. Partially Completed - review date March 2024 (AMaT tool awaiting final approval).
			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	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		Partially complete (Overdue)	Review Date - June 2024 February 2024 Update - CDU compliance ILS 40% (RN), BLS 68% and ED compliance ILS 43.75% , BLS 76%. It is important to note the RN's undertake ILS training and therefore BLS is not required - ESR Mandatory Training requires updating. Please note there has been 10 wte New Starters in the last 6 weeks, hence reducing the compliance rate - there is a plan to improve. Partially Completed – review date June 2024 (new recruitment has reduced trajectory of compliance-as described). Previous Update - 65% compliance aim November 2023 with 100% compliance February 2024.
Healthcare Inspectorate Wales (HIW)/2023/140	16.05.2023	**HMP Parc Prison**	HMP Parc Prison to ensure Covid 19 swabs are performed in a timely manner.	All staff to be reminded of working within CTM COVID -19 guidelines alongside Public Health Wales advice. All staff to be reminded of the importance of providing / undertaking COVID 19 swabs when required in a timely manner	Mental Health, Community & Primary Care	31.05.2023		Overdue	September 2023 Update - No update received
			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.	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.	Mental Health, Community & Primary Care	31.08.2023		Overdue	September 2023 Update - No update received
			HMP Parc Prison should ensure that when a decision has been made to transfer a patient to hospital there are no delays due to staffing issues.	Ensure there is a robust process in place to provide monitoring and support for the patient whilst awaiting transfer to hospital.	Mental Health, Community & Primary Care	31.08.2023		Overdue	September 2023 Update - No update received
			HMP Parc Prison must make it clear on the medical record if a review has been made remotely, face to face or via telephone.	Staff to be reminded of the importance of robust comprehensive documentation which evidences accurately the care provided to each patient and how the care was provided. An audit of the documentation for all patients will be undertaken. The results will be shared with the team and an action plan to address identified areas of improvement. NMC Code in relation to record keeping / documentation. A work stream to develop a rolling programme of audit will be undertaken . This will include - spot check audits to ensure continued compliance. A dataset of all audit results to enable prison level audit, feedback and performance and quality reporting information for evidence of driven improvement interventions. Review of current training access and materials.	Mental Health, Community & Primary Care	30.09.2023		Overdue	September 2023 Update - No update received
			When Healthcare requests GP advice via a task there is a corresponding entry in the clinical record for continuity of care.	Staff to be reminded of the importance of this being sent to all clinicians. Compliance will be monitored via monthly record audits. An audit of the documentation for all patients will be undertaken . The results will be shared with the team and an action plan developed to address identified areas for improvement. NMC Code of Conduct in relation to record keeping/ standards/ documentation. A work stream to develop a rolling programme of audit will be taken forward - this will include spot check audits to ensure continued assurance; a dataset of all audit results to enable the prison level audit, feedback and performance and quality reporting information for evidence driven improvement interventions. Review of current training access and materials . Deliver a reflective and learning session to highlight the importance of ensuring documentation is completed accurately and thoroughly evidence and reflect patient centered care.	Mental Health, Community & Primary Care	31.10.2023		Overdue	September 2023 Update - No update received
			HMP Parc Prison should review NEWS 2 escalation policy on requesting an ambulance when someone is severely unwell with sepsis.	All staff to be reminded of the escalation policy. A workstream to understand the current training needs in relation to skills required within the role. This will include- clinically deteriorating patients. Measuring vital signs and use of NEWS training. Acute life threatening events recognition and treatment training. Nursing in adult prison settings training. News Training. Ensure there is a process in place for monitoring of staff training compliance.	Mental Health, Community & Primary Care	30.11.2023		Overdue	September 2023 Update - No update received

			HMP Parc Healthcare must ensure that all medication recommended is supplied.	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.	Mental Health, Community & Primary Care	31.08.2023		Overdue	September 2023 Update - No update received
Healthcare Inspectorate Wales (HIW)/2023/154	25.09.2023	**Paediatric Ward - Princess of Wales Hospital-Appendix A-Immediate Assurance (Ref: 03421)**	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.	Maternity and Neonatal colleagues are piloting QR code system for checking resuscitation trolley. Childrens ward plan to implement same. See further information below. Digitalisation of equipment checks presentation	Children & Families	30.11.2023	03.03.2024	Fully complete (Awaiting approval)	April 2024 Update - The QR code daily resus checking is fully implemented on the children's ward in POW. Using the QR code has digitalised the record keeping making it easier to track, store and retrieve compliance data. December 2023 Update -By end Nov 2023.QR code still piloted in maternity. 6/12/23 Daily checks undertaken 100% November 23. Revised implementation date due to the ongoing pilot in of the QR code across a number of audits in PCH - A status review against the required action will be completed by the end of March 2024.
				All patient safety audits to be captured via AMaT system monthly and compliance monitored at the CYP monthly safety and effectiveness service level meetings.	Children & Families	31.10.2023	01.06.2024	Fully complete (Awaiting approval)	April 2024 Update - The QR code daily resus checking is fully implemented on the childrens ward in POW. Using the QR code has digitalised the record keeping making it easier to track, store and retrieve compliance data. Patient safety audits continue on Amat and compliance is reported monthly to CYP Patient safety and effectiveness group. In addition to this the daily resus trolley check is reported every morning and afternoon on the daily activity and acuity. December 2023 Update (Date of Review: 12/12/23) - As maternity colleagues continue with their pilot - Children's ward have established their own QR code .The CPD lead is responsible for ensuring staff are aware of how to record. This will be piloted in Paediatrics for 6 months commencing 1/1/24. Patient safety checks undertaken on AMaT audit monthly. Reported to patient safety and effectiveness group Implementation date revised until June 24.
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.	CTM UHB will continue to work in partnership with Cardiff and Vale UHB to develop the Regional Network for stroke services and in doing so 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. Work is already underway in our GP Practices to target patients at increased risk of stroke and we will continue to build on this. Learning will be fed back through the CTM UHB Stroke Strategy Group for implementation across the Health Board area.	Unscheduled Care	01.04.2024		Overdue	Ongoing across 2023/24
			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.	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		Overdue	Ongoing across 2023/24
			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.	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		Overdue	Ongoing across 2023/24
			Welsh Government, health boards and WAST must work collaboratively, to consider whether the Immediate Release Directions are effective or need improvements, given the high number of declined Immediate Release Directions occurring across Wales.	Significant improvement work has been undertaken within the Unscheduled Care Group (USC) in relation to immediate release of emergency vehicles, with the introduction of the Cwm Taf Morgannwg Emergency Pressures Escalation Cards. These clearly outline triggers, escalations and actions. Since April 2023, there have been no refusals of immediate release request and the USC group continue to work in collaboration with WAST colleagues as part of the joint review process to review community delays that may have led to an adverse outcome in order to quantify harm and share learning.	Unscheduled Care	01.04.2024		Fully complete (Awaiting approval)	Achieved and ongoing
			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.	Significant work is already underway to ensure the robust management of patient flow. Each site has an established daily Safe2Start meeting which gives assurance around site based escalation, staffing, patient safety and clinical priorities. This meeting allows the identification of clinical priorities, including stroke patients and time frames for movement to inpatient beds. Any 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 is 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. This will be introduced in October 2023 as a test of change before launching in November as a new template. We have introduced Electronic Whiteboards on every ward that tracks each of stage discharge and highlights any blockages in the process. This information is an integrated tool across health and social care partners. We will 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		Overdue	Ongoing
			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).	CTM UHB is aware that consideration needs to be given to dedicated specialist pharmacist support as part of our review of the Stroke Pathway. Additional investment would be required and service and resource prioritisation discussions are ongoing within CTM UHB. The Pharmacy Team are involved in conversations to improve communication regarding estimated dates of discharge and full MDT involvement/use of eWhiteboards	Unscheduled Care	01.04.2024		Overdue	
			Health boards should consider the benefits of dedicated 'discharge phlebotomy slots' for managing the necessary blood tests, to assist with effective and timelier discharge.	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 and timely blood requests to the phlebotomy team would be required. We will look to develop this going forward, in conjunction with improved EDD and use of whiteboard communication.	Unscheduled Care	01.04.2024		Overdue	
			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.	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 is being explored by the USC Group as an option which may have a positive impact on patient flow. We are currently benchmarking different models nationally to understand resources required and outcome measures which if positive and achievable we would be seeking to replicate.	Unscheduled Care	01.02.2024		Overdue	
			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.	CTM UHB appreciates and has significant experience of using predictive methods to enhance patient and system outcomes. Development of models and tools is on the work plan for this year.	Unscheduled Care	01.04.2024		Overdue	Timescale In 2023/24-exact timescale dependent on resource availability
			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.	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.	Unscheduled Care	01.04.2024		Overdue	November launch. Full implementation 24-25.
			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.	Listening to our communities and understanding their experiences is a key part of the CTM UHB Organisational Strategy Action Plan	Unscheduled Care	01.04.2024		Overdue	Ongoing
			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.	A review of current training will take place in relation to Act FAST training. 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		In progress	Review March 2024 Implementation October 2024
			WAST and all health boards must work collaboratively to identify a consistent approach to ensure handover of stroke patients is made within the Welsh Government 15-minute target. This is to ensure that time critical investigations and treatment are undertaken promptly.	Collaborative working with WAST is underway 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.	Unscheduled Care	01.10.2024		In progress	
			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.	Stroke and flow performance indicators 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	Unscheduled Care	01.10.2024		In progress	
			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.	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. 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.	Unscheduled Care	01.10.2024		In progress	
			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.	Significant work is ongoing within CTM UHB to review the clinical workforce required to review stroke patients within the ED. Work is underway 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	Unscheduled Care	01.01.2025		In progress	
			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.	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. 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		In progress	
			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.	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		In progress	
			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.	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		In progress	
			Health boards must ensure that ED staff fully and clearly complete the clinical diagnostic assessment tool for stroke	As part of ongoing work within the USC Group, there is a plan to streamline processes and ensure the domains of quality are 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 on other sites. This work is being done in collaboration with stroke teams and other relevant stakeholders to support the standardisation where possible. This will ensure compliance with completing the clinical diagnostic tool for stroke.	Unscheduled Care	01.10.2024		In progress	
			All health boards should consider the prompt implementation of Artificial Intelligence for stroke imaging following the completion of the all-Wales procurement which was completed in December 2021.	Work is already underway to implement the use of Brainomix within CTM UHB.	Unscheduled Care	01.01.2024		Overdue	
			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.	The CTM UHB Stroke Operational Group will analyse the stroke pathway through from receivership at hospital front door to discharge. 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		Overdue	
			Health boards and WAST must ensure that all staff associated with potential stroke patients are aware of the updated guidance for thrombolysis treatment window of between 4.5 and nine hours, as highlighted within the National Clinical Guideline for Stroke updated in April 2023.	The National Clinical Guideline will be added to our CTM SharePoint site as a direct link for clinical staff. This updated guidance will also be re-circulated to all front line clinical teams and included in staff safety briefings and local governance meetings over the coming months.	Unscheduled Care	01.01.2024		Overdue	
			Health boards must ensure that sufficient staff in EDs across Wales are awarded time to train and are assessed as competent to administer thrombolysis treatment.	Significant work has been completed to ensure ED staff across CTM UHB have time to train and are assessed as competent to administer thrombolysis treatment. The ED team has a designated stroke lead to support this. This is delivered through induction, ED training and simulation exercises	Unscheduled Care	01.10.2024		In progress	
			Health boards must ensure that all possible stroke patients who are clinically appropriate for thrombolysis, receive treatment in a timely manner.	With CTM UHB, all patients presenting in the thrombolysis window (Code 1 stroke) are 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 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		In progress	
			Welsh Government must work with the Thrombectomy Wales Oversight Group, the National Clinical Lead for Stroke, and health boards, to consider how timely and equitable access to thrombectomy treatment for stroke can be made, for all relevant people across Wales.	CTM UHB clinicians are engaged with the Thrombectomy Wales Oversight Group and will continue to contribute to these discussions.	Unscheduled Care	01.04.2024		Overdue	Ongoing
			Health boards must ensure clinicians consider the option of thrombectomy treatment where appropriate, and the decision either way (with rationale), should be clearly recorded within the patient's clinical records.	Within CTM UHB, thrombectomy decisions are recorded in the written notes and discussions with Southmead Bristol are recorded electronically via referapatient.org.	Unscheduled Care	01.04.2024		Overdue	Ongoing
			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.	As part of the Stroke Programme Board/Stroke Operational Group, there is ongoing transformation work around patient flow prioritisation of stroke patients to meet the 4 hour target. This is a key improvement metric within CTM UHB and work will continue around ring fenced 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.	Unscheduled Care	01.04.2024		Overdue	Ongoing

			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.	As above, this continues to be a priority within 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.	Unscheduled Care	01.04.2024		Overdue	Ongoing
			Health boards should consider both the benefits and potential implementation of Early Supported Discharge to patients' physical and mental wellbeing, and to the hospitals, with earlier discharge therefore improving flow through the stroke pathway.	Current ESD service is well established working out of Prince Charles Hospital. Expansion of ESD whole CTM UHB is currently underway following HB investment. Additional ESD workforce are being recruited to and referral criteria/pathway being established so that the service will become CTM-wide.	Unscheduled Care	01.12.2023		Overdue	
			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.	Current therapies workforce data is being captured. A review of therapy workforce provision will be completed to explore the best models for therapy provision.	Unscheduled Care	01.01.2024		Overdue	
			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.	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		Overdue	Ongoing
			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.	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.	Unscheduled Care	01.04.2024		Overdue	Ongoing
			Health boards must ensure that stroke rehabilitation environments are appropriate and are adequate to meet the needs of patients.	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 will include detailed consideration of the environment.	Unscheduled Care	01.04.2024		Overdue	Ongoing
			Health boards must review their board rounds within stroke wards to consider their efficiency and effectiveness so that any actions identified and resolved in a timely manner to facilitate a timely patient discharge.	As part of the 6 Goals national programme for improvement, significant improvement work is focused on board rounds and the early identification of internal and external delays. These will be captured on the electronic white board to allow us to perform thematic analysis in order to positively impact frequent delay issues. An escalation process for delays has been proposed as part of the newly established integrated discharge delivery board, linking directly to oversight and improvement actions associated with pathway of care delays. The Red2Green and SAFER principles will be embedded into all board rounds pan CTM to support timely patient review, planning and discharge when clinically optimised.	Unscheduled Care	01.11.2024		In progress	
			Health boards should ensure that staff are utilising the SAFER Patient Flow principles, to promote safe and timely discharge and help improve patient flow.	As above, work is underway as part of the 6 Goals national programme for improvement, to ensure the early identification of internal and external delays. Reflecting these on the electronic white board will allow us to perform thematic analysis in order to positively impact frequent delay issues. The Red2Green and SAFER principles will be embedded into all board rounds pan CTM to support timely patient review, planning and discharge when clinically optimised.	Unscheduled Care	01.11.2024		In progress	
			Health boards should work collaboratively with local authorities and social care providers to improve the discharge processes in place. This includes the need for improved communication processes, improving the information provided for a robust referral into social care, and the sharing of and compliance with health board discharge policies.	A significant improvement project has been established in CTM UHB as part of the 6 Goals of Urgent an Emergency Care Programme, with an improved integrated approach to discharge and implementation of Discharged to Recover then Assess pathways (D2RA), which is overseen by the integrated discharge delivery board. A new referral and trusted assessment process has been introduced as well as an integrated discharge hub, which co-ordinates and streams all referrals. Data regarding discharge is inputted on Electronic Whiteboards, which is an integrated system accessible to social care partners. This data is used to escalate delays as well as inform our pathway of care delays on associated improvement actions.	Unscheduled Care	01.03.2024		Overdue	
			Health Boards must work collaboratively with social worker teams to consider and understand the processes in place for social worker assessments and allocation to patients. The reasons for delayed assessment and allocation must also be considered to make improvements in this area.	As part of implementation of D2RA, a new supported discharge notification (SDN) has been created to identify patients who require support form a social worker. This is triaged in the discharge hub. Proportionate assessment in an acute setting is promoted through the use of trusted assessment. The SDN is used to highlight when a proportionate assessment is not appropriate and social work intervention is necessary. Delays for assessment and allocation are monitored regularly and escalated through the Discharge Board. A targeted improvement plan has been created to address delays in assessment overall.	Unscheduled Care	01.12.2023		Overdue	
			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.	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.	Unscheduled Care	01.04.2024		Overdue	Ongoing
			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.	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 are monitoring the volume of Pathway 1 discharges as part of monthly D2RA compliance and have seen an increase in Home First (Pathway 1) from initial baseline data January 2023 51% ↳ 66% July 2023.	Unscheduled Care	01.04.2024		Overdue	Ongoing
			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.	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.	Unscheduled Care	01.04.2024		Overdue	
			Health boards must consider their discharge lounge services and whether they are utilised efficiently and effectively to support timely discharge to improve patient flow.	The USC group are reviewing inpatient bed base and patient flow to better understand the requirement for discharge lounges. Planned/predicated discharges are identified through the cross site be meetings, in addition they form part of the out of hours and weekend planning cycle.	Unscheduled Care	01.01.2024		Overdue	
			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.	As above, the USC group are reviewing inpatient bed base and patient flow to better understand the requirement for discharge lounges across our sites. Planned/predicated discharges are identified through the cross site be meetings and form part of the out of hours and weekend planning cycle.	Unscheduled Care	01.01.2024		Overdue	
			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.	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		In progress	
			Welsh Government should consider strengthening its promotion of the Help Us to Help You campaign, to ensure people are appropriately educated and understand how to access healthcare in the right place, first time, by guiding them towards the most appropriate care service.	This is a Welsh Government action but the Health Board will support cascade of messaging.	Unscheduled Care	01.04.2024		Overdue	Action to be removed and replaced with a subsequent agreed action.
			WAST must ensure that all relevant staff are fully aware of the WAST stroke pathway to minimise risks to patient safety.	This is a WAST action but the Health Board will support as required	Unscheduled Care	01.04.2024		Overdue	Action to be removed and replaced with a subsequent agreed action.
			Welsh Government should consider how it can support WAST to develop and implement improvements with its service delivery model, such as increasing the number of advanced paramedic practitioners across Wales, to help reduce the pressure on EDs and improve flow through healthcare systems.	This is a Welsh Government/WAST action but the Health Board will support as required	Unscheduled Care	01.04.2024		Overdue	Action to be removed and replaced with a subsequent agreed action.
			WAST should consider the benefits of training its paramedic staff in the use of the ROSIER stroke assessment tool, to enable staff to differentiate patients with stroke and stroke mimics, such as TIA.	This is a WAST action but the Health Board will support as required	Unscheduled Care	01.04.2024		Overdue	Action to be removed and replaced with a subsequent agreed action.
			WAST must consider its current response times for patients awaiting interhospital transfers for urgent thrombectomy treatment which are classified as 'Red'. This is to ensure a thrombectomy can be completed within the six-hour timescale from the onset of symptoms.	This is a WAST action but the Health Board will support as required	Unscheduled Care	01.04.2024		Overdue	Action to be removed and replaced with a subsequent agreed action.
			Welsh Government must consider the process in place for social work teams and their role in assessment and allocation to patients in hospital, and whether the services across Wales are appropriately funded and managed to support the discharge process from hospital to improve patient flow.	This is a Welsh Government action but the Health Board will support as required	Unscheduled Care	01.04.2024		Overdue	Action to be removed and replaced with a subsequent agreed action.
Healthcare Inspectorate Wales (HIW)/2023/156	25.09.2023	**Hospital Inspection Report (Unannounced) Paediatric Ward, Princess of Wales Hospital [Appendix C - Princess of Wales Hospital, Paediatric Ward 25 & 26 September 2023 (Ref: 03421)]**	We recommend the health board review all relevant policies to ensure they are in line with current guidance	All Paediatric policies are available on Cwm Taf Morgannwg (CTM) SharePoint site. The Children and Young People Care Group (CYP) will re-establish a monthly policy-working group where policies will be reviewed to ensure they are in line with current guidance.	Children & Families	31.12.2023		Overdue	January 2024 Update (Date of Review: 04/01/2024) - Progress continues on SharePoint December 2023 Update (Date of Review: 06/12/23) - Reviews in progress April 2024. Review of all paediatric policies and procedures underway across CTMUHB. This is being cleansed on SharePoint.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	**Appendix C - Improvement Plan: Angelton Clinic, Glanrhyd Hospital (Ref: 03445)**	The hospital communal gardens areas must be tidied and maintained to provide a more pleasant and appealing environment for patients.	The Facilities department have a schedule for garden maintenance works within Angelton Clinic. This will be carried out in the Spring where plants and bulbs will be planted. The Angelton team have also been working closely with the third sector organisation Mental Health Matters who have and will continue to support the maintenance and gardening. This will also provide an opportunity for the patients to be involved as a therapeutic activity.	Mental Health, Community & Primary Care	01.04.2024		Overdue	In Progress Estimated Completion Date April 2024 See Appendix 1
			The health board should ensure the provision of gym and exercise equipment to support patient health promotion and improvement.	Angelton Clinic has a dedicated Physiotherapist. We have identified an area within Angleton Clinic to be used to support physical exercise, patient health and promotion. Appropriate equipment has been identified and is in place.	Mental Health, Community & Primary Care	28.12.2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 2
			The health board should consider reinstating the hospital's dedicated wheelchair accessible vehicle to promote timely patient care.	Angleton Clinic has always had access to a Wheelchair accessible vehicle however unfortunately it was involved in an accident and wasn't repairable, a replacement is on order.	Mental Health, Community & Primary Care	28.12.2023		Fully complete (Awaiting approval)	Completed 28/1[2]/2023 See Appendix 3
			The health board must undertake measures to improve mandatory Welsh language training compliance.	Welsh Language Awareness training levels to reach a minimum of 85% whilst working toward 100% Ward 1 is currently 100% Ward 2 is currently 78.5%	Mental Health, Community & Primary Care	01.01.2024		Fully complete (Awaiting approval)	April 2024 Update - Ward 1= 92% Ward 2=91.18% Previous Update - In Progress Estimated date for completion January 2024 See Appendix 4
			The health board must implement measures to ensure the active offer of Welsh is appropriately delivered in the hospital.	Admission paperwork has been updated to ensure that the patient or relative is asked what their preferred language is on admission and this is clearly documented. A section has been added to the Inpatient Management Plan to identify patients' preferred language. Welsh speaking staff now have the appropriate uniform and/or lanyard displaying that the staff member is a Welsh speaker.	Mental Health, Community & Primary Care	28.12.2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 5a, 5b + 5c
			The health board should ensure the provision of suitable areas where patients can be visited on the wards in addition to the Angelton atrium area.	There is a private visiting area/room along the corridor in Angleton Clinic for visitors that wish to have privacy when visiting their loved ones. If visitors wish to visit their family member on the designated Ward they are welcome to do so within their loved one's personal bedroom. This has been raised and discussed within the carers/families recent meeting.	Mental Health, Community & Primary Care	28.12.2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 6a + 6b

The health board must implement a robust programme of governance oversight which ensures that the hospital's established audit processes and checklists are fully completed within set timescales to ensure the safety of patients, staff and visitors.	All Checks have since been revised. On the advice of the reviewing team the magnetic door checks are now once a day as opposed to three times a day which was leading to gaps. The kitchen fridge temperature check form was showing an expectation of 3x daily checks however the expectation is 2x daily checks which led to gaps. This has now been corrected and the results uploaded to AMAT. Legionella Flushes are being carried out on a weekly basis by the Ward Domestic Team. All checks form part of the Ward Manager weekly check list and Senior Nurse monthly checklist. The Senior Nurse will escalate any concerns immediately and address these at the monthly Ward Managers meetings. Ward Managers will then share the information discussed and address these issues within the wider nursing team staff meetings. Ward managers have put Audits/compliance as a fixed agenda item on ward staff meetings.	Mental Health, Community & Primary Care	28.12.2023		Fully complete (Awaiting approval)	Completed 28/12/2023 Appendix 7, 7a, 7b, 7c,7d, 7e, 7f,7g, 7h, 7i + 14
The health board must implement a programme of governance oversight which ensures that the hospital's maintenance issues are promptly and effectively recorded, addressed and signed off.	A new process has been put in place which is managed by the Directorate Support Manager. We now have one central estates log for all areas within Angelton Clinic which can be accessed via the discharge drive. The Directorate Support Manager inputs the issue reported into the estates log and will escalate any issues to estates. Directorate Support Manager will monitor outstanding jobs and ask estates for updates regularly to ensure all jobs are signed off appropriately. Any outstanding estates issues will be put on the Health and Safety Highlight report and update at the Health and Safety Meeting.	Mental Health, Community & Primary Care	28.12.2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 8a + 8b
•The hospital's outstanding maintenance and environmental issues must be reviewed and rectified to ensure the comfort and safety of patients, staff and visitors. •The health board must undertake a full environmental audit of the Angelton clinic to identify and address any additional maintenance issues.	A new estates monitoring process is currently in place to ensure any outstanding issues are reviewed and rectified to ensure the comfort and safety of patient's staff and visitors.	Mental Health, Community & Primary Care	28.12.2023		Fully complete (Awaiting approval)	April 2024 Update - CTM gardeners have completed work to the ward courtyards and will be routinely maintaining the areas. Previous Update - Completed 28/12/2023 See Appendix 8
•The hospital's outstanding maintenance and environmental issues must be reviewed and rectified to ensure the comfort and safety of patients, staff and visitors. •The health board must undertake a full environmental audit of the Angelton clinic to identify and address any additional maintenance issues.	A full environmental audit within Angelton Clinic will be completed to address and identify any further additional maintenance issues.	Mental Health, Community & Primary Care	01.01.2024		Overdue	April 2024 Update - Environmental audit was undertaken of both wards and all environmental issues identified reported to estates and placed on the estates log. This is reviewed regularly and any outstanding issues escalated. Previous Update - In Progress. Estimated date for completion Jan 2024
The health board must implement robust measures to improve IPC environmental audit compliance on Ward 2.	Environmental audit completed within Ward 2 Angelton Clinic. Audit completed on AMAT, current compliance 85.3%	Mental Health, Community & Primary Care	28.12.2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 10
•The health must implement robust measures to ensure patient foods are regularly checked, suitably stored and appropriately labelled so that the opening and expiry date can be viewed. •Medications must not be stored in the ward kitchen areas.	Following inspection an email has been sent to ALL staff on both wards highlighting the need to ensure that there is no: •Unsealed, unlabelled, expired communal patient foods •Unlabelled non-prescription medications on the top of the kitchen cupboard. Ward Manager weekly check put in place to ensure ward kitchens are kept to a high standard. Senior Nurse monthly spot checks now incorporate kitchen/fridge checks. Any issues identified to be brought to Ward Managers attention for dissemination to ward staff.	Mental Health, Community & Primary Care	28.12.2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 11a, 11b, 7e and 7f
The health board must undertake measures to improve Ward 1 staff compliance with mandatory safeguarding training.	Ward 1 and Ward 2 Safeguarding Adults Level 2 Training has been addressed to increase compliance. Currently Ward 1 at 95% Ward 2 85.71% The HB compliance standard is 85% but both wards will aim for 100% compliance.	Mental Health, Community & Primary Care	28.12.2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 12a + 12b
The health board must review the outdated Medicines Management policy and provide guidance for staff on the storage of medications to support staff in their roles and ensure patient safety.	The health board has updated the policy which was published 15/11/2023.	Mental Health, Community & Primary Care	28.12.2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 13
The health board must: •Strengthen quality governance and leadership and provide clear guidance to staff to ensure the hospitals clinical audit processes are consistently completed. •Ensure that instances when temperatures fall outside recommended guidelines are appropriately recorded and promptly escalated to support patient safety.	Ward audit is completed on a weekly basis by Ward Manager any issues identified are then addressed within the Ward Managers Staff Meeting. All staff have been informed of the escalation process if the room temperature spikes above 25 degrees, new Daily Clinical Room and Fridge Temperature list in place.	Mental Health, Community & Primary Care	28.12.2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 7h + 14
The health board must: •Ensure patient venous thrombosis and adverse reactions assessments are consistently completed to support patient safety. •Implement additional training, governance oversight and action planning for staff to ensure this process is consistently completed.	All prescribing staff have been reminded of the importance of completing the assessments. Angleton Clinic is supported by a designated pharmacist. The MH lead pharmacist has reminded all pharmacy staff who attend the ward to highlight any missed sections e.g. Allergy, VTE and report these to the medical team for review. Completing the assessments will now be included in the induction of new medical staff. The charts and compliance with the recommendations will now be checked during every ward round.	Mental Health, Community & Primary Care	28.12.2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 15a +15b
The health board must review patient observation records documentation to ensure it provides enough space for staff to record sufficient detail.	Therapeutic observation forms have been amended to ensure sufficient space is available for staff to provide sufficient information.	Mental Health, Community & Primary Care	28.12.2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 16
The health board should conduct further discussions with staff to review the hospital's current staffing templates and ensure staffing levels support safe and effective patient care.	The Head of Nursing has recently completed a review of all CTM MHLD inpatient wards. This review has considered changes to shift patterns and recommends that 12-hour shifts are trialled and evaluated. A pilot proposal is being developed.	Mental Health, Community & Primary Care	28.12.2023		Fully complete (Awaiting approval)	Completed 28/12/2023
The health board must undertake a review of the quality and variety of patient food provided at the hospital to ensure that it meets patient satisfaction and dietary requirements.	The current menu for Angelton Clinic has been put in place by the catering Lead to meet the nutritional standards and offer a variety of food for Angelton Patients.	Mental Health, Community & Primary Care	28.12.2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 18a,18b + 18c
The health board must review any outdated or undated policies to provide clear guidance to staff and support them in their roles.	As part of another HIW improvement plan the MHLD Care group has a 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 Terms of Reference have been agreed for the policies group with the process for ratifying policies and procedures reflecting the recently revised organisational process for ratification. The HB has revised its process for the ratification of policies, policies now need a 6-week consultation pan CTM, endorsement via Operational Management Board and then final ratification at QSC. This process will lead to more timely and efficient ratification of the MHLD policies.	Mental Health, Community & Primary Care	28.12.2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 22a + 22b
The health board must implement measures to ensure all outstanding mandatory staff training is completed, regularly monitored and that staff are supported to attend the training.	Mandatory Training has been part of our improvement plan in 2023. Mandatory Training is a fixed agenda item on the monthly Ward Managers meeting. The Senior Nurse checks all mandatory training levels monthly and reports back to Ward Managers this is fed back to the ESR Ward Champion who will then support and encourage staff members to access the mandatory course required and complete. All staff are given time to complete ESR Mandatory Training. ESR is updated automatically and Ward Managers ensure the mandatory training database is also updated.	Mental Health, Community & Primary Care	28.12.2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 18
The health board must ensure that family/carer meetings take place within set timescales to ensure their feedback is regularly captured and addressed as appropriate.	Family/Carer meetings were 3 monthly, this has now been increased to every 2 months to ensure discussions are taking place and feedback is captured.	Mental Health, Community & Primary Care	28.12.2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 21
The health board should consider ways to formally and routinely capture patient feedback in order to drive quality improvement.	Angleton Clinic have recommenced the Patient feedback form in conjunction with Therapy colleagues to encourage completion wherever appropriate. This will be carried out weekly during protected patient time. Feedback will be passed on to the Senior Nurse through the Ward Managers and will be included in the Senior Nurses QSRE report.	Mental Health, Community & Primary Care	28.12.2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 22
The health board must ensure staff meetings are conducted on a regular basis to engage staff, discuss issues and encourage staff feedback.	Ward meetings are held monthly, unfortunately there was an increase in sickness within Angleton Clinic including the Ward Manager and Clinical Lead therefore this led to cancellation of staff meetings. If this situation occurred again the Senior Nurse would now hold the meetings. Ward managers to set dates for monthly staff meetings, dates to be shared with staff well in advance. Timetable to be put in place.	Mental Health, Community & Primary Care	28.12.2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 7h + 23
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.	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, Community & Primary Care	31.01.2024		Overdue	April 2024 Update - In progress. Work is ongoing between the head of nursing and the Datix team. Previous Update - In Progress Due for completion end of Jan 2024

			The health board must ensure ongoing senior management scrutiny of the hospital's systems and audit processes to ensure key and current issues are being effectively escalated, and appropriately action planned to prevent reoccurrence.	On the Senior Nurse spot check list a column has been added to clearly show actions/escalations carried out. This information is shared within the Ward Managers meetings and discussed, the action going forward this is then shared with the wider nursing team through Staff meetings and handovers. The Senior Nurse will share any persistent issues through their QSRE report to the locality QSRE which will then be further escalated if necessary through the Lead Nurses QSRE to the directorate. The Cascade and Escalate Standard Operating Procedure document describes the process.	Mental Health, Community & Primary Care	28.12.2023		Fully complete (Awaiting approval)	Completed 28/12/2023 See Appendix 7f + 25
Healthcare Inspectorate Wales (HIW)/2023/158	20.11.2023	**Appendix C - Improvement Plan: Royal Glamorgan Hospital, Admissions Ward, Ward 21, Ward 22, and Psychiatric Intensive Care Unit (Ref: 03414)**	The health board should review the shared bedrooms and consider updating the rooms to allow patients the privacy of their own room.	The Health Board has reviewed the current ward environment. With consideration of the ward footprint, clinical need and bed capacity within the Adult Mental Health Directorate it is not possible at present to provide a fully single bedroom inpatient provision. To mitigate potential impact of the present arrangements the nursing teams ensure that all shared rooms are single sex, with identified curtained private space for each person. The specific need for single rooms is identified at point of admission/assessment, with consideration of individual need i.e., gender, sexual orientation, or physical need/risk, and care plan developed as required. The nursing team identify patients who wish to have shared rooms e.g. for company. If requested, an individual room will be provided when available and if there is no other pressing clinical need.	Mental Health, Community & Primary Care	09.01.2024		Fully complete (Awaiting approval)	Completed
			The health board should consider the gender balance of staff and ensure that there are enough male staff present on each shift.	The Health Board undertakes a fair and equitable recruitment process, in order to ensure that all staff are employed based on the qualities, values, skills and the experience they demonstrate during recruitment. It is, of course, not lawful to discriminate or make such decisions based on gender. The Royal Glamorgan Hospital (RGH) Senior Nursing team work across adult and older persons wards and will support each ward to ensure that there is an optimal skill, and when possible, gender mix. All shift requirements are monitored at the daily staffing "huddle" to identify particular issues and ensure that safety needs are adequately met i.e. that there are adequate Prevention and Management of Violence and Aggression (PMVA) trained staff on shift. Daily Huddle Documentation; Evidence 1 There is opportunity to alter staff skill and when necessary, gender mix to address needs of an individual e.g. If patient is sexually disinhibited or targeting staff due to gender. In extremis the Senior Nursing team can call on staff from across the care group i.e. Princess of Wales and CAMHS Mental Health wards, and there have been examples of recent good practice.	Mental Health, Community & Primary Care	09.01.2024		Fully complete (Awaiting approval)	Completed
			The health board must ensure a more robust application of the health boards no smoking policy and the framework supporting it.	It is a priority of the Health Board to support the communities we work with to make positive decisions about their health, and we maintain a commitment to support all patients and staff to give up smoking. Since the "Smoke-free Premises and Vehicles (Wales) Regulations 2020" came into force in the Mental Health Unit (MHU) in September 2022, smoking on there has been prohibited. Following implementation, the significant challenges this presented to individuals who found smoking cessation measures to be ineffective or unwelcome were noted, and after discussion with staff and patients the Mental Health Smoking Cessation group agreed that in the RGH MH unit we would create small designated outside smoking areas for restricted use. This seemed to be well received by the patient group, but following an anonymous concern being raised with the Health Inspectorate Wales in summer 2023, this arrangement was halted while the measures were reviewed. Following presentation of a mitigating paper to the Health Board Executive Leadership Group, a "Derogation in compliance" was agreed for a period of six months while the Mental Health Care Group develop options for a permanent solution across all Mental Health sites. It is recognised by the Health Board that this temporarily contravenes the Smoke-free Premises and Vehicles (Wales) Regulations 2020. Mental Health Directorate Smoking Mitigation Paper; Evidence 1.1 Practically, on the RGH MHU, this means that there is an availability of managed smoking sessions at designated times in a space within the footprint of the MHU on the patios/terraces directly off the ward corridor. This is an arrangement that is clearly documented within the care plan of all patients who identify this as being their wish following smoking cessation assessment. The conditions and restrictions of the designated smoking area are made clear to all patients and signposted across the wards. Ash trays are being purchased for designated smoking area, there is a bin currently in place as an alternative. Patio Photo; Evidence 2 Patio Photo; Evidence 3 There is routine discussion within the patient community groups around smoking arrangements and support by the patient groups of self-regulation of cleanliness of such areas by smokers. This is checked by ward staff regularly and extraordinary cleaning requested of facilities if required.	Mental Health, Community & Primary Care	09.01.2024		Fully complete (Awaiting approval)	Completed
			The health board must ensure that Welsh speaking staff wear the appropriate lanyards and badges to help identify them as Welsh speakers.	The Health Board is committed to making the "Active Offer" around services in the Welsh language, as defined in the Welsh Language Measure 2011. A review is underway to identify all Welsh speakers across the MHU. Competence at all levels will be noted and improvement encouraged through Personal Development (PADR). As the routine use of lanyards by Nursing staff in clinical areas is prohibited due to Infection Prevention and Control measures, the Health Board supplies all staff who have a competence in Welsh language with insignia uniforms that identify them to those who wish to communicate in Welsh . For ease of recognition, this identifying uniform will be displayed to patients and visitors on Information Boards in each of the clinical areas. Welsh Language Notice; Evidence 4 Welsh Language Notice; Evidence 5	Mental Health, Community & Primary Care	28.02.2024		Overdue	
			The health board must ensure that a full review is undertaken on the appropriateness and reliability of the current personal alarm systems used.	At time of the HIW inspection (November 2023) there was an Standard Operating Procedure (SOP) in place that directed that a dual personal alarm system was in place on the RGH MHU for all clinical staff. This was due to a recent increase in the frequency of incidents whereby the panic alarm failed to activate when tested. MHU Dual Alarm SoP; Evidence 6 A full diagnostic review of the "all call" system was undertaken in November 2023, with the system noted to be returned to a serviceable and operational state. This issue however remains on the Directorate Risk Register for the immediate future and incidents of alarm failure will be reviewed and reported via the Datix system. The SOP also remains in place on the MHU. A review of any activation failures will be undertaken by the MHU Inpatient Senior Nurse and Assistant Directorate Manager for inpatient services for discussion at Directorate Quality Safety Risk and Experience meeting (QSRE) in June 2024. Subsequently a decision will be made by the Adult Mental Health Senior Leadership Team as to whether the Safe System of working for a dual alarm system can be stepped down or will remain in place with the risk remaining on Directorate Risk Register.	Mental Health, Community & Primary Care	30.06.2024		In progress	
			The health board must address the environmental issues and resolve them in a prompt and timely manner.	The ward 22 damaged chair, with exposed foam filling which is not compliant with the relevant legislation has been condemned and removed with a temporary replacement now in place. A specialist furniture manufacturer has provided a quotation for new seating within the Interview room and a Statement of Need submitted. Ward 22 Interview Room Photo; Evidence 7 Psychiatric Intensive Care Unit (PICU) missing ceiling tiles have now been replaced. PICU Ceiling Photo; Evidence 8 Water damaged ceiling tiles in the Ward 22 office have all been replaced. There remain 6 water damaged tiles between the lounge & dining room awaiting replacement which have been logged with Estates Department. These have been prioritised by Estates as non-urgent, as they are considered decorative rather than safety sensitive, and the progress on replacement is monitored weekly by the Inpatient Deputy Directorate manager Ward 22 Ceiling Photo; Evidence 9 Ward 22 Ceiling Photo; Evidence 10 After consultation with a specialist furniture manufacturer the Inpatient Senior Nurse confirmed the suitability of the dining chairs currently in place in Ward 22.The dining room chairs are multipurpose and need to be moved between dining room and lounge for group discussions/activities and therefore need to be of a manageable weight. The Adult Mental Health Senior Leadership Team acknowledged that the weight of the current chair would allow them to be picked up and potentially brandished as a weapon, however this risk would not be completely eradicated unless the chairs were of a weight that would disadvantage patients with mobility restrictions and potentially increase risk of injury to staff when moving for cleaning purposes. The [nursing team mitigate risk of furniture being used in this way through individual risk assessment and maintaining observation of these areas when in use. Ward 21 bedroom rails and privacy curtains have been replaced. Ward 21 Curtain Photo; Evidence 11 There are long standing difficulties with inadequacy of wastewater/ sewage capacity within the RGH MHU site. As a result, the PICU Extra Care Area (ECA) utilises a Sani-flo macerator system to move waste from ECA to the main sewage system. This can result in issues when foreign objects are placed in toilet in ECA. Groundwork investigations report that a permanent solution to connect ECA to main sewage system would require extensive excavation works with significant capital spend and long-term closure of the PICU. The Adult Mental Health Senior Leadership are of the opinion that this is not viable at present due to disruption of service. The development of a new Mental Health Inpatient facility remains on the Health Board Risk	Mental Health, Community & Primary Care	09.01.2024		Fully complete (Awaiting approval)	Completed
			The health board must ensure that COSHH equipment is stored correctly.	All wards on the MHU have flammable lockers where all laundry detergents are stored. It is the responsibility of all Health Board staff to be aware of and undertake their responsibilities when using COSHH materials. The Inpatient Senior Nurse has emailed a reminder to all staff including HCSW about COSSH and requirement re storage. Standards for storage of COSHH materials; Evidence 13 Checks on the environment are undertaken by ward managers as part of weekly environmental checks (Ward Managers Assurance Audit) and matters of concern addressed with staff at the time or escalated in line with MHU Maintenance SOP; Evidence 12	Mental Health, Community & Primary Care	09.01.2024		Fully complete (Awaiting approval)	Completed
			The health board must ensure that out of date medication is disposed of appropriately.	Following the HIW Review in November 2023, all medication cabinets across the MHU were inspected and no further out of date medications were found. Review of all medication dates and returns to pharmacy is monitored through the "Ward Managers Assurance Audit" which is undertaken weekly and monitored by the Inpatient Senior Nurse. Ward Managers Assurance Audit; Evidence 14 The Mental Health Ward Assurance Group are undertaking a process of digitising this audit. The Inpatient Senior Nurse reports Audit outcomes to Directorate Quality Safety Risk and Experience meeting (QSRE) through monthly exceptions report and action taken as required.	Mental Health, Community & Primary Care	09.01.2024		Fully complete (Awaiting approval)	Completed
			The health board must ensure that MAR charts are fully completed.	Inpatient Senior Nurse and Mental Health pharmacist will revisit the role of pharmacist technician to ensure that review of MARS charts will be included in their routine checks. An email has been sent by the Clinical Director to all medical team to reaffirm the documentation standards required on clerking and reviewing medication. A sample of MARS charts are reviewed through the "Ward Managers Assurance Audit" which is undertaken weekly and monitored by the Inpatient Senior Nurse. Ward Managers Assurance Audit; Evidence 15 The Mental Health Ward Assurance Group are undertaking a process of digitising this audit. The Inpatient Senior Nurse reports Audit outcomes to Directorate Quality Safety Risk and Experience meeting (QSRE) through monthly exceptions report and action taken as required.	Mental Health, Community & Primary Care	09.01.2024		Fully complete (Awaiting approval)	Completed

			The health board must ensure that staff comply with the health board policies and guidance on safe and secure storage of medication trolleys and how they are stored on the wards and in clinical rooms.	Reminder email from Senior Nurse reminding staff of agreed standard Safe Storage of medication; Evidence 16 Security arrangements of medication trolley are reviewed through the "Ward Managers Assurance Audit" which is undertaken monthly and monitored by the Inpatient Senior Nurse. The Mental Health Ward Assurance Group are undertaking a process of digitising this audit. The Inpatient Senior Nurse reports Audit outcomes to Directorate Quality Safety Risk and Experience meeting (QSRE) through monthly exceptions report and action taken as required.	Mental Health, Community & Primary Care	09.01.2024		Fully complete (Awaiting approval)	Completed
			The health board must ensure that observation records include details on patients behaviours.	The present Health Board Observation Policy was scheduled for review in March 2022 and while awaiting approval as part of the ongoing review of Clinical Policies, is still in place as a live clinical document. Within the Policy there is clear direction on the nature of case recording to be undertaken. Safe and Supportive Observation & Engagement Policy; Evidence 17 The Inpatient Senior Nurse has emailed all nursing staff to remind them of the agreed standards within the policy . Observation and Engagement standards; Evidence 18 Following reiterating of the standards a "spot" audit of no less than 10 Observation records across a 2 week period will be undertaken by the Inpatient Senior Nurse and reported to Adult Mental Health Directorate QSRE in March 2024.	Mental Health, Community & Primary Care	30.04.2024		In progress	
			The health board must ensure that there are more variety of choices for patients with specific dietary requirements.	All Health Boards in Wales follow a menu which is based on The All-Wales Catering & Nutrition Standards. The Health Board Catering Service works with clinical teams to adapt the patient menus to patient specific requirements. The present patient menu changed in September 2023 to a two-week rolling menu which replaced an `a la carte' style menu. The new menu was reviewed by the All-Wales dieticians and assessed for compliance with the Catering and Nutrition Standards. The Inpatient Nursing teams seek feedback from patients via the Inpatient Community Group and "Have Your Say" suggestion boxes (which are regularly monitored). This feedback informs discussions with the wider service i.e. Catering and outstanding issues can be escalated to the Adult Mental Health Senior Leadership Team. The Catering Team recognise the need to increase the frequency of the menu review and change and are currently working on the new version for 2024.	Mental Health, Community & Primary Care	09.01.2024		Fully complete (Awaiting approval)	Completed
			The health board must ensure that use of Section 17 leave is recorded.	The Section 17 Leave policy is awaiting revision as part of the ongoing review of Clinical Policies. The inpatient expert group will undertake this review with a documentation standard devised and included. This will be communicated to all staff by Senior Nurse informing staff of agreed standard. In the interim the Senior Leadership team have agreed that as a minimum there will be a clear record in the patient notes of each departure from and return to the ward for all patients including those under Section s17 leave. A "spot" audit of the interim standards no less than 10 patient records across a 2 week period will be undertaken by the Inpatient Senior Nurse and reported to Adult Mental Health Directorate QSRE in March 2024. Following development and dissemination of the Policy standards a " Spot" audit undertaken will be undertaken and reported Adult Mental Health Directorate QSRE in June 2024.	Mental Health, Community & Primary Care	01.06.2024		In progress	
			The health board must ensure that policies are reviewed and kept up to date.	The Health Board Equality and Diversity policy has been reviewed and will be being superseded by a Strategic Equality Plan (SEP). The SEP is in final draft and will be approved by Executive Board in March 2024.	Mental Health, Community & Primary Care	31.03.2024		Overdue	
			The health board must review staffing levels to ensure they meet the demands of the patient group.	The Mental Health Head of Nursing has recently concluded a thorough nursing establishment review that has considered levels of acuity and demand across the Mental Health Inpatient units. This review acknowledged the changing picture of inpatient work and environments since the last Mental Health inpatient staffing review in 2017 and recognised the challenges of maintaining a motivated and engaged workforce when pressures within these clinical settings are increasing. Using principles drawn from All Wales Mental Health Workstream on the implementation of the Nurse Staffing Levels Act, the report makes recommendations about amendments to skill mix and enhancement of Nursing leadership roles the better to improve opportunities for recruitment and particularly staff retention. The Staffing review report will be presented to the Mental Health Nursing Workforce meeting on 25 January 2024, for consideration by Director of Nursing on subsequent actions. Considerations of staffing levels day to day are a core role of the Ward Managers and Senior Nurse, with all shift requirements monitored initially at the daily staffing "huddle" to identify particular issues and ensure that safety needs are adequately met i.e. that there are adequate staff on shift. Review of clinical need is a dynamic process that involves all members of the Nursing team, and staffing levels are increased in response to increased levels of acuity e.g. 1:1 patient observations to maintain safety or a need for intensive personal care. At this time, there is an organisational acknowledgement of the particular challenges to recruitment of unregistered nurses into Mental Health posts and as a result the Health Board embargo on the use of agency Health Care Support Workers, has been temporarily relaxed for the Mental Health Directorate. While there is a high degree of scrutiny around the use of staff in addition to substantive staff, with appropriate evidence and rationale in place, a request for additional bank or agency staff will always be supported by the Senior Nursing Leadership.	Mental Health, Community & Primary Care	09.01.2024		Fully complete (Awaiting approval)	Completed
			The health board must ensure that staff vacancies are filled, and future initiatives are explored to encourage recruitment into the hospital.	Recruitment of band 5 registered nurses remains a challenge and the HB is taking steps to ensure that all vacancies are being filled. The recently completed nursing establishment review has been considered by the Care Group Senior Leadership Team who are currently exploring the financial implications and opportunities of the recommendations. The Head of Nursing is leading on the development of a recruitment and retention plan, which includes actions such as working closely with the local universities to maximise SSP opportunities for recruitment.	Mental Health, Community & Primary Care	09.01.2024		Fully complete (Awaiting approval)	Completed
			The health board must ensure that staff are reminder of the requirements of Duty of Candour and that all staff receive appropriate training.	Service user information about Duty of Candour is available across the units. Duty of Candour Information; Evidence 19 A Duty of Candour E-training module is provided for all staff on the Health Board Electronic Staff Record (ESR). All nursing staff across the MHU will undertake this training, with a target of 85 % compliance for Adult Mental Health units by March 2024. The Inpatient Senior Nurse will report on compliance at Adult Mental Health Integrated performance meeting in April 2024.	Mental Health, Community & Primary Care	31.03.2024		Overdue	
			The health board must ensure that the ECA suite is not used as a bedroom area and should only be used for its intended purpose.	The operational guidance around the use of the ECA is clear that it is to be used as a planned or urgent intervention within the low stimulus environment. This is a resource for individuals who are presently inpatients and as such have a bed within the unit. It will not be used to provide additional bed capacity. This has been agreed by the RGH senior leadership team and circulated to all staff. Any instances of breach of this standard will be reported through the Datix system and escalated by the Inpatient Senior Nurse to the Adult Mental Health Directorate QSRE. Present guidance on the use of ECA will be revised and formalised by the Senior Nurse by 31 January 2024.	Mental Health, Community & Primary Care	31.01.2024		Overdue	
			The health board must make sure that staff feel consulted, involved, and understand decision making processes by senior staff that affect them, and that staff feel confident in sharing ideas and contributing to change.	All patient transfers that take place in working hours are informed by consultation between the ward managers/ Nurse in Charge of both the transferring and receiving ward. This core information is shared with clinical staff through the twice daily handover. In order to ensure that there is clarity of communication, the Nursing team will develop a Ward Transfer proforma for communication of essential clinical information on transfer. The Adult Mental Health Directorate recognises that staff experience, engagement and feedback is an essential part of a compassionate leadership approach to service improvement and as part of the Mental Health Care Group is implementing the learning from the Ty Llidiard and Maternity Services improvement work on staff engagement. The Directorate will use Sharing Information/learning arrangements within the services e.g. QSRE, team meetings, 7 minute briefings to maintain staff awareness of decision making around clinical and operational matters. The Inpatient Senior Nurse will lead on development of the Ward Transfer proforma in collaboration with a working group of qualified and Health Care Support Workers in in order to ensure that all key communications are considered, and the process addresses the concerns about miscommunication of decision.	Mental Health, Community & Primary Care	28.02.2024		Overdue	
Healthcare Inspectorate Wales (HIW)/2023/159	19.10.2023	**Appendix C - Improvement Plan: Tirion Birth Centre, Royal Glamorgan Hospital (Ref: 03061)**	The health board should ensure that a rolling programme of maintenance is in place to ensure centre fit for purpose and effective cleaning can take place.	Paintwork has been re-painted.	Children & Families	28.12.2023		Fully complete (Awaiting approval)	April 2024 Update - Paintwork has been completed. Action can be closed. Previous update - Complete
				Finance secured and replacement blinds ordered.	Children & Families	01.02.2024		Fully complete (Awaiting approval)	April 2024 Update - New blinds now in place. Action can now be closed. February 2024 Update - Complete-new blinds in place.
				AMAT environmental audit undertaken monthly.	Children & Families	28.12.2023		Fully complete (Awaiting approval)	April 2024 Update - Environmental audit in place on the AMAT system. Action can be closed. Previous update - Complete
				Tirion to be added to the RGH site rolling maintenance programme for paintwork.	Children & Families	28.12.2023		Fully complete (Awaiting approval)	April 2024 Update - Added to ongoing maintenance programme. Action can be closed. Previous Update - Complete
				Environment included within rolling programme of Purposeful Visiting annually.	Children & Families	28.12.2023		Fully complete (Awaiting approval)	April 2024 Update - Tirion purposeful visit complete. No further environmental issues identified. Action can be closed. Previous Update - Complete
			The health board should consider expanding the active offer of Welsh in the Birth Centre to ensure that Welsh language care is actively offered to women and families and Welsh speaking staff are clearly identifiable. The health board should consider ways of improving the awareness of the Birth Centre in diverse communities to increase the diversity of women and families that use the centre.	Poster to be displayed depicting iaith gwaith logo up in birth centre areas for service users to identify Welsh speakers.	Children & Families	01.12.2023		Fully complete (Awaiting approval)	February 2024 Update - Complete, posters in place.
				Identify all welsh speaking members of Tirion staff to ensure appropriate uniform with iaith gwaith logo.	Children & Families	01.02.2024		Fully complete (Awaiting approval)	April 2024 Update - As previous update, no Tirion core staff are Welsh speakers. The specialist midwife in attendance during the HIW visit/inspection has now been given appropriate lanyard to identify her as a Welsh speaker. This action can be closed. February 2024 Update - Complete, no Tirion core staff are Welsh speakers. Specialist midwife Welsh speaker now has appropriate identity.
				Maternity services digital booking system includes and collects data relating to language/ communications needs and ethnicity to enable the service to understand the diversity within local communities.	Children & Families	28.12.2023		Fully complete (Awaiting approval)	April 2024 Update - The Welsh Language team have undertaken a visit to the Tirion footprint, and all signs, resources and information are available in Welsh. This action can be closed. Previous Update - Complete
				Implement use of an iPad to support translation and interpreting services for non-English speakers.	Children & Families	28.12.2023		Fully complete (Awaiting approval)	April 2024 Update - There is an i-Pad available at Tirion to support translation and interpreting services for those who are non-English speaking. This action can be closed. Previous Update - Complete

				Specifically looking at setting up an event in partnership with the University of South Wales to engage with students from overseas.	Children & Families	01.03.2024		Overdue	April 2024 Update - This action is ongoing and requires financial investment to support this event. The Women's Experience Midwife is currently scoping this and looking for grants/funding to support the event. February 2024 Update - Ongoing.
				Programme of community-based engagement through Baby Shower events for all prospective service users to attend, which is supported by Tirion birth centre team.	Children & Families	28.12.2023		Fully complete (Awaiting approval)	April 2024 Update - Baby Shower events have been drafted into the CTMUHB Maternity & Neonatal Engagement Plan, however this action is ongoing and requires financial investment to support future events. The Women's Experience Midwife is currently scoping this and looking for grants/funding to support the event. Previous Update - Complete
			The health board must conduct a baby abduction drill at Tirion Birth Centre as soon as possible. Any associated learning from the drill should be shared with staff members.	Updating of the 'Security of the Newborn' guideline in progress, to include auditable standards of an annual baby abduction drill.	Children & Families	01.02.2024		Overdue	April 2024 Update - The draft 'Security of the Newborn- guideline is currently out for consultation and due to be discussed with the intention to ratify in the next Postnatal Forum (awaiting date tbc). The draft guidelines includes an auditable standard of an annual baby abduction drill in each acute maternity setting. February 2024 Update - Final draft to be sent out for consultation on 19/02/2024 for ratification. This will include KPI for annual baby abduction drill on each site.
				Baby Abduction drill planned: Table-top baby abduction drill & local baby abduction drill.	Children & Families	01.12.2024		Fully complete (Awaiting approval)	April 2024 Update - Tirion and RGH have completed both a table-top baby abduction drill/discussions with Tirion staff (14.12.23), and the RGH site have supported a full multi-disciplinary baby abduction drill (22.01.24). This action can now be closed. February 2024 Update - Complete - 14.12.23.
				Baby Abduction drill planned: Full baby abduction drill	Children & Families	01.01.2024		Fully complete (Awaiting approval)	April 2024 Update - Tirion and RGH have completed both a table-top baby abduction drill/discussions with Tirion staff (14.12.23), and the RGH site have supported a full multi-disciplinary baby abduction drill (22.01.24). This action can now be closed. February 2024 Update - Complete - 23.01.24.
			The health board should raise awareness of facilities, outcomes and satisfaction levels of women that have used Tirion Birth Centre with wider colleagues from across the health board.	Annual report of outcomes and experience from Tirion birth centre shared at service-wide audit/governance meeting.	Children & Families	28.12.2023		Fully complete (Awaiting approval)	April 2024 Update - The annual Tirion report for 22/23 has been shared at a service-wide governance meeting. The next annual Tirion report is currently being compiled, and will be shared at a service-wide audit/governance day upon completion. Previous Update - Complete
				Where negativity regarding the model of care is identified, learning via patient story and feedback/reflection by staff is undertaken.	Children & Families	28.12.2023		Fully complete (Awaiting approval)	April 2024 Update - The service share families' stories at all key departmental meetings, and these have included stories from families who have used services at Tirion FMU. There are no current examples of negative feedback from staff. Previous Update - Complete
				Family stories shared at departmental meetings/forums.	Children & Families	28.12.2023		Fully complete (Awaiting approval)	April 2024 Update - The service share families' stories at all key departmental meetings, and these have included stories from families who have used services at Tirion FMU. This action is complete. Previous Update - Complete
				Tirion 'marketing' video developed and shares family's experiences of using Tirion.	Children & Families	28.12.2023		Fully complete (Awaiting approval)	Complete
			The health board should audit, update and share guidelines and policies related maternity care.	Current policies/guideline which expired in 2023 have been extended for a further 12 months via the maternity and neonatal improvement Board governance process.	Children & Families	28.12.2023		Fully complete (Awaiting approval)	April 2024 Update - Ongoing review and updating of guidelines continuing. Previous Update - Complete
				Guideline Service Group produces an annual plan of work to ensure timely review of guidelines.	Children & Families	01.01.2024		Overdue	April 2024 Update - ongoing January 2023[4]
				Staff updated via email and staff social media Comms to ensure awareness of extension of these guidelines.	Children & Families	01.01.2024		Overdue	April 2024 Update - Comms to staff via email, monthly newsletters and governance meetings. January 2023[4]
				There is a maternity/ gynaecology/ISH guideline group which monitors guidelines which are coming out of date.	Children & Families	28.12.2023		Fully complete (Awaiting approval)	April 2024 Update - guideline group in progress monthly. Action can be closed. Previous Update - Complete
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	**Appendix C - Improvement Plan: Ty Llidiard (Ref: 03362)**	The health board must ensure that the young people receive treatment specific to their individual diagnosis and that this is documented clearly within their patient records.	Each young person has an individualised care plan in line with their recovery care outcomes and inclusive of their holistic care needs. Care-plans are audited on a monthly basis. Outcome measurements support tracking quality-of-care against individual patient care needs. The audit asks he following questions; •Is the new care plan being used? •Is it in the YP's voice/words? •Is it outcome focused? •Has it been reviewed? •Is there evidence of an MDT approach? Learning areas are discussed in team meetings and disseminated electronically to the multi-disciplinary team.	Mental Health, Community & Primary Care	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 1
			The health board must improve the appearance of the garden areas for the therapeutic benefit of the young people and ensure ongoing maintenance is undertaken going forward.	The Facilities dept have a schedule for garden maintenance works, additionally the local management team carry out monthly environmental checks and request additional garden maintenance as required. The Ty Llidiard team have been working with the HB Head of People's Experience and have arranged for a voluntary organisation support with the general maintenance of the garden areas.	Mental Health, Community & Primary Care	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 2
			The health board must ensure that the language preference of each young person is identified and recorded in a place that is easily accessible for staff to be aware.	The part A referral form provides a prompt to document the young person's language preference. This is filed at the front of each patient record for ease of reference. See attached, language preference highlighted in yellow. Medical secretaries to monitor full completion of the referral document prior to saving on the patient file. The Part A contains all patient demographics and is filed at the front of the medical record by the ward clerk.	Mental Health, Community & Primary Care	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 3
			The health board must ensure the equality and diversity policy is updated and shared with staff once the policy has been ratified.	The health board will update the Equality and Diversity policy.	Mental Health, Community & Primary Care	01.05.2024		In progress	In Progress Estimated to be completed by May 2024
			The health board must ensure any required repairs and maintenance are undertaken in a timely manner.	The nursing team undertake daily environmental checks to support in early escalation of any maintenance concerns.	Mental Health, Community & Primary Care	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 4 + 4A
				Operational procedure in place to guide staff members on the reporting system for environmental maintenance.	Mental Health, Community & Primary Care	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 4 + 4A
				Facilities log maintained to reflect reports and required actions.	Mental Health, Community & Primary Care	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 4 + 4A
				Senior Nurse to escalate environmental maintenance concerns via Quality Safety Risk and Experience report	Mental Health, Community & Primary Care	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 4 + 4A
				Locality manager can escalate any issues via Health and Safety meeting	Mental Health, Community & Primary Care	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 4 + 4A
			The health board must provide clarity and guidance on staff responsibilities to ensure effective cleaning of the outside areas and staff toilets.	Maintenance of the outdoor garden furniture has been added to the daily environmental checklist that is undertaken by nursing staff. Completion of the daily environmental checklist is audited monthly and learning disseminated via nurse meeting.	Mental Health, Community & Primary Care	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023
				Cleaning schedule of the staff toilets was increased to twice daily on 06/11/2023	Mental Health, Community & Primary Care	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023
				IPC added to the nurse meeting agenda.	Mental Health, Community & Primary Care	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023
			The health board must ensure a system is in place to inform staff that the re-usable medical equipment has been cleaned and is therefore safe to use.	SOP created to support guidance on cleaning re-usable medical equipment between use. All reusable medical equipment will be cleaned between each patient contact and marked with the green "I am clean" verification tape.	Mental Health, Community & Primary Care	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 5 + 6
			The health board must ensure that all staff are aware of the IPC lead and their role and responsibilities so that staff can appropriately escalate any concerns they may have.	All staff have mandatory level 1 and 2 IPC training. Guidance now displayed outlining the name and contact details for the IPC lead. IPC added to the nurse meeting agenda.	Mental Health, Community & Primary Care	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 7
			The health board must review the use of the laundry room to improve its condition and lower the temperature to make the room more bearable for staff to use.	The issues identified have been resolved, the fan has been cleaned and the door adjusted. Portable air conditioning units have been purchased and can be used in this room to lower the temperature.	Mental Health, Community & Primary Care	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 8 + 9
			The health board must ensure the medicines management policy is updated and shared with staff once the policy has been ratified.	The health board will update the medicines management policy.	Mental Health, Community & Primary Care	01.05.2024		In progress	In Progress Estimated to be completed by May 2024
			The health board must remind staff of the importance of undertaking and documenting such checks.	The fridge temperature checks are subject to monthly audit. Audit findings are part of the weekly nurse meeting agenda. Minutes are disseminated to the wider nursing team.	Mental Health, Community & Primary Care	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 10
			The health board must provide an update to HIW on actions taken since the inspection to ensure medication is being stored at the correct temperature.	Clinic room temperature checks operational form the 13.09.23. Compliance is audited on a monthly basis and learning areas disseminated via nurse meeting. Portable aircon units have been purchased and to be used if the clinic exceeds 25 degrees. SOP created to guide staff on the management of retaining the clinic temperature below 25 degrees.	Mental Health, Community & Primary Care	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 11 + 12

			The health board must ensure all potentially harmful materials are locked away and stored appropriately at all times.	The unit now benefits from a new clinic whereby all cupboards are lockable. All cleaning materials usable by nursing staff have now been stored correctly.	Mental Health, Community & Primary Care	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 13
			The health board must provide training to staff to clarify the expectations on staff in terms of reporting adverse drug reactions, for example, to the Medicines and Healthcare products Regulatory Agency (MHRA) through the Yellow Card Scheme.	Prescribed medications are discussed and reviewed by the multidisciplinary team (MDT). Such discussions include potential adverse and therapeutic effects that require monitoring and clear documentation within the MDT records. Those identified at risk of adverse reactions are medically managed accordingly and the individual patient care-plan reflects such management. Ty Llidiard receives support from a dedicated mental health pharmacist who attends the unit and is available to assist staff adverse drug reactions. The registered nurses are trained in paediatric immediate life support that covers management of adverse drug reactions.	Mental Health, Community & Primary Care	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023
			The health board must reflect on this feedback and review with staff and the young people whether any changes to the menu choices and their frequency are required.	The Ty Llidiard dietician met with the young people to collaboratively review the menu. The menu has since been revised in line with the young people's preferences and nutritional requirements. This will continue to be reviewed via the weekly community meeting.	Mental Health, Community & Primary Care	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 14
			The health board must ensure that staff regularly inform the young people about their rights in line with the Mental Health Act Code of Practice for Wales, particularly following a change in the young person's circumstances.	A prompt to support timely and fluid reviews of each young persons understanding of their rights as an informal or detained patient is now included in the patient care-plan. The care-plan will be collaboratively reviewed on a weekly basis by the young person and named nurse.	Mental Health, Community & Primary Care	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 15
				Care-plans are subject to monthly quality checks by the ward manager, findings are captured on AMaT and disseminated via nurse meetings. The minutes of nurse meetings are disseminated to the wider nursing team.	Mental Health, Community & Primary Care	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 1
			The health board must ensure mental capacity assessments undertaken on the young people are completed using the capacity assessment forms available and stored appropriately within the patient records.	The MHLD care group will develop a standardised Mental Capacity Assessment form.	Mental Health, Community & Primary Care	01.05.2024		In progress	In Progress Estimated to be completed by May 2024
			While it may be the case that 12-hour shifts may not be appropriate for Tŷ Llidiard, the health board must reflect on this feedback and continue to discuss this issue with staff to identify alternative solutions to help allay staff concerns and improve their work life balance.	The Head of Nursing has recently completed a review of all CTM MHLD inpatient wards. This review has considered changes to shift patterns and recommendations have been made to trial and evaluate the use of 12-hour shifts	Mental Health, Community & Primary Care	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023
			The health board must discuss the issues raised in relation to staffing levels with staff to fully understand their concerns.	Registered nurses are included in the shift-by-shift assessment of acuity. This supports the planning of additional resources to meet patient need.	Mental Health, Community & Primary Care	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023
				The funded nurse establishment is in line with the Quality Network Inpatient CAMHS standards. Overtime, bank and agency backfill is supported where numbers fall below funded establishment.	Mental Health, Community & Primary Care	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023
				Weekly acuity is assessed using Levels of Care. This supports the reporting of patient acuity within the unit.	Mental Health, Community & Primary Care	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023
				Nurse staffing levels added to nurse agenda to ensure that this provides a forum for staff to discuss any concerns they may have in relation to safe staffing levels.	Mental Health, Community & Primary Care	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023
				Any concerns about staffing levels can be escalated through the senior nurse Quality Safety Risk and Experience report.	Mental Health, Community & Primary Care	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023
				The Head of Nursing holds weekly drop in sessions where staff can raise issues or concerns, including those related to staffing.	Mental Health, Community & Primary Care	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023
			The health board must ensure that all staff receive training in the duty of candour to help them understand their responsibilities in helping meet the new legal requirements.	Advice sheet shared with full multidisciplinary team, this has been captured via online voting buttons to support in tracking staff members understanding of the standards and where any additional support maybe required. Roles and responsibilities under duty of candour added to the multidisciplinary team staff induction. To support assurance of learning and development, the new staff induction is subject to 3 monthly audits.	Mental Health, Community & Primary Care	13.11.2023		Fully complete (Awaiting approval)	Completed 13/11/2023 See Appendix 16, 17 + 18
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.	Cwm Taf University Health Board acknowledges the findings and we recognise improved and robust assurances are required to improve the quality of patient experience and deliver Safe and Effective Care; Plans are in progress to implement Same Day Emergency Care (SDEC) services with part of this being a front door Frailty Model (Acute Care of the Elderly-ACE) as part of the EU reconfiguration work. This will facilitate early identification of our frailty patients and avoid unnecessary long waits in the EU. The implementation of the above units will reduce the potential overcrowding in the Ambulatory Area where patients are waiting for inpatient beds. There has already been significant progress in the last 9 months with the implementation of the gynaecology, surgical and trauma assessment units aligned to inpatient areas that has diverted patient flow from the EU. Further work is going to develop processes and pathways whereby all GP expected patients will transfer directly to the assessment units and avoid the EU footprint. There is an options appraisal being considered to relocate the GPAU, whereby the GP expected patients will not attend the EU. As part of the work described there are Standard Operating Procedures (SOP) in place where patients requiring immediate resuscitation will transfer immediately to ED in order that patient care and safety is maintained.	Unscheduled Care	01.01.2024	01.04.2024	Overdue	Extended to April 2024 due to construction delays and development of SDEC Pathway, where all GP referred patients will be directed and streamed. Frailty Model implemented December 2023, with the successful appointment of 1 Consultant, 2 Advanced Nurse Practitioners, further medical recruitment is ongoing. Following this there is early identification of Frailty Patients within the ED Department with streaming to the inpatient Frailty Ward as required.
				An Ambulatory Care SOP was approved (August 2023) and specifically outlines the number and acuity of patients that can be safely nursed within the designated area and clearly documents the level of escalation required by staff to maintain patient safety, dignity and privacy and staff well-being.	Unscheduled Care	01.09.2023		Overdue	SOP for Ambulatory care remains in place and Huddles continue across the department with a clear focus on patient safety.
				ED Patient Huddles were implemented (April 2021) and this process is a MDT approach to review the priorities within the areas of the EU and escalate concerns to support patient flow and ensure a positive patient experience. The safety huddles are mobile across the vast footprint, to demonstrate clinical presence, leadership and offer a snap shot of patient safety. Across each acute site we have implemented a Safe to Start meeting (since November 2021), this is a formal process with a clear audit trail of site patient flow activity, escalation levels, patient priorities and concerns. This process is a MDT approach including clinical service colleagues undertaken twice a day and is a whole system approach to the patient flow, governance and the professional agenda.	Unscheduled Care	01.09.2023		Overdue	Safe to start meetings continue on site twice daily with regular review of any patient safety concerns and safe staffing is maintained.
				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	01.12.2024	In progress	Delayed due to major capital works on site to December 2024.
				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		Overdue	Awaiting date from Welsh Government following a successful bid for Funding. This will supply an extra toilet and showering facilities.
				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		Overdue	
			Until the planned reconfiguration is completed, the health board is required to provide HIW with details of the action taken to promote the privacy and dignity of patients accommodated in the Ambulatory Care area and 'surge' areas.	The Ambulatory Care area has four single assessment rooms that are available for assessment of new patients and available for patients waiting who require further medical review, nursing intervention and treatment. Alongside this there is a max fax room, and three ambulatory room that support 3 patients in each. The Senior Nurse, ED Clinical Lead and Senior Nursing Team are working closely with the MDT within the EU to ensure there is understanding of their roles and responsibilities and to utilise the designated private rooms to support clinical care for patients affording privacy. To escalate to Senior Staff when there are barriers to achieve this to identify alternative solutions to ensure privacy and dignity. Temporary dignity screens are available to use within the designated waiting rooms to support the improvement. The nursing team have been reminded to close doors of assessment rooms and waiting areas including the use of screens as appropriate reiterating that this is integral to the fundamentals of nursing care.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved 29.09.2023
			The health board is required to provide HIW with details of the action taken to promote the comfort of patients accommodated in the Ambulatory Care area for extended periods of time.	Following the previous review by Health Inspectorate Wales there has been significant investment in recliner chairs that have been placed in the Ambulatory Care area, with further plans to purchase the same type of chairs that extend into a bed, thus will support comfort for patients delayed in the EU. There has also been investment in new seating within the main waiting area of the EU that offer both comfort because of the extra padding but also comply with IPC guidance. Any patient waiting for an inpatient bed who is high risk is identified and escalated as part of the ED Patient Huddle/Safe to Start to ensure an appropriate chair/bed/mattress is provided. The Senior Nurse has ensured that the detail described is included in the daily staff brief and the department monthly meeting to ensure staff are aware of their responsibility and escalation when there are barriers or concerns.	Unscheduled Care	01.12.2023		Fully complete (Awaiting approval)	4 new recliner chairs have been received in March 2024 in Ambulatory Area.
			The health board is required to provide HIW with details of the action taken to review the provision of washing and toilet facilities within the EU, so these are appropriate and sufficient to meet the assessed needs of patients.	It is recognised that the current environment is not a purpose built Ambulatory Care Area and the concern identified is already on the Risk Register. - Staff improvise well with the available resources to ensure patients have their hygiene and toileting needs met. This includes accessing the single assessment rooms to ensure the required care is delivered. The new pathways described in Action 1 will support this improvement long term. - As described in the above action, any patient who is unable to independently transfer to the designated toilet or supported by the nurse is escalated via the EU Patient Safety Huddle and Safe to Start in order that the patient is prioritised for an inpatient bed. The Senior Nurses across the PCH site work closely and dynamically with the EU team to identify bespoke ways of influencing/supporting patient flow in order that the identified patients are prioritised. This includes evoking the Patient pre Emptive transfer, "sitting" patients out on inpatient wards to facilitate an earlier/prompt transfer from the EU. The Head of Nursing and Senior Nursing Team are continually present operationally working proactively with the nursing teams to facilitate identification and prioritisation of these patients.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved 29.09.2023 April 2024 – as above delayed as awaiting date from Welsh Government. Funding approved for extra toilet and showering facilities-specifically Ambulatory Area of ED
			The health board is required to provide HIW with details of the action taken to meet the assessed mobility needs of patients accommodated in the EU.	As described in Action 1 the SDEC and Frailty pathways will support this action proactively and positively to support the deconditioning of patients waiting in the EU. The Nurse Director for Unscheduled Care with support from the Head of Flow has been leading work across the wards and ED/CDU teams have attended the training days for "RED2GREEN" in June 2023, with further training planned-whereby preventing deconditioning. -PJ Paralysis is integral to the quality improvement work. This targets the review and prevention of iatrogenic harm through wasted opportunity to add value to the patient's hospital journey. This not only supports earlier discharges but improves patient outcomes. This also furthers MDT support for frailty at the front door with significant investment in physiotherapy staff to assess mobility needs in the EU. A Quality Improvement Project is being commenced whereby frailty is identified immediately on attendance to ED and appropriate assessment and signposting will be applied. This supports the new Frailty Pathway described in Action 1. A Frailty Consultant has been appointed for the PCH site and is key to the new models being introduced to support improved flow out of ED. 2.0 wte Frailty Advanced Nurse Practitioners have been appointed and awaiting start dates and will support the new pathway work as well as work closely with the ED team to improve knowledge and skill set The Stay Well at Home Team are present 7 days in the EU to support early mobility assessments, are trusted assessors and facilitate early discharge. The acuity in the different areas of the EU is reviewed in Safe to Start, where acuity is identified as high, staff are redeployed to the areas to support. This information is documented in order that an audit trail is present. During the HIW visit the internal escalation of the site was a level 4 with a risk of 16 and 20-there is evidence of staff being redeployed to the Ambulatory Area of EU. This forms part of dynamic staffing within the EU where staff are move flexibly by the senior nurse and head of nursing based on patient needs and acuity.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved 29.09.2023 2 Frailty ANPs appointed-October 2023 Review patients at the front door and streamline access to frailty ward Optimise rolling out formally across the HB-this is the CTMUHB project that encompasses Red2Green and Discharge to Recovery Then Assess Pathways. Daily sitreps available electronically-for audit purposes and action.

			The health board is required to provide HIW with details of the action taken to improve the signage within the EU to help patients and their carers find the X-ray department and other areas independently.	Cwm Taf University Health Board acknowledges the findings and we recognise improvements are required to provide assurances that there is good communication for patients to reduce any anxieties they may have in an unfamiliar environment. Due to the huge construction being undertaken very close to the EU and radiology footprint, signage can be challenging but is an absolute priority in order that patients do not become confused and understand the communication/signage that is in place. The senior leadership team are reviewing all current signage following the completion of significant works between radiology and EU (completed 03.10.2023). In the meantime, temporary signage has been created to support patients as they move throughout the EU footprint, as there is work ongoing across Cwm Taf University Health Board to have consistent signage for the public served by the whole HB.	Unscheduled Care	01.09.2023		Partially complete (Overdue)	Temporary signage has been created to support patients as they move throughout the EU footprint, as there is work ongoing across Cwm Taf University Health Board to have consistent signage for the public served by the whole HB.
			The health board is required to provide HIW with an update on the systems in place to improve patient flow through the EU.	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		Overdue	This work continues to progress via the Optimise Project which formally reports into 6 goals programme board and onto NHS Executive colleagues.
			The health board is required to provide HIW with details of the action taken to reduce the likelihood of patient information recorded on the board used in the Ambulatory Care area being seen by patients and visitors.	This has been reviewed with immediate effect and only patient initials to be used for patients in the waiting room. Patients physically situated in EU ambulatory, initial and surname used to identify location and interventions required. The Senior Nurse for EU has reiterated the above actions and included in her daily briefs with the EU team.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved 29.09.2023
			The health board is required to provide HIW with details of the action taken to provide patients with regular updates on their care and treatment.	The importance of timely and clear communication is fundamental to patient experience and this has been highlighted to the MDT as part of focus groups and staff training. Patients waiting in excess of 24 hours for a bed to be highlighted to NIC and Unit manager, clear communication with patient and relative (where necessary) to explain care plan and expected outcomes. Twice daily EU Senior Nurse walkarounds are undertaken to identify long wait patients, with appropriate clinical escalation as well as site escalation to maximise resource prudence and optimise length of stay as per the quadruple aim. For those patients waiting in the general waiting room-it is a key responsibility of the triage nurse and the assigned HCSW to provide regular updates-30 minute-1 hourly rounding's are undertaken to monitor the area, replenish fluids, identify any issues/concerns and provide updates.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved 29.09.2023 Further to this we have extended our Patient Advocate Liaison Service (PALS) team offering to support patient with regular updates at front door as also ED volunteers support this. We have also implemented Civica to capture Patient Reported Experience Measures (PREM's) within the ED and we are developing this into themes and trends to inform action plans for improvement.
			The health board is required to provide HIW with details of the action taken to deliver the 'Active Offer'.	Cwm Taf University Health Board acknowledges the findings and we recognise action has to be taken to deliver the "Active Offer" as good communication has to be equitable for all our patients. Ensuring bilingual provision greatly impacts the experience of care Welsh-speaking patients have and in many cases Welsh language provision can also lead to better clinical outcomes. Following the previous HIW review signage within each major's space was updated to ensure information relating to patients EU journey and next steps were bilingual. The EU & CDU Senior Nurse is meeting with the HB's Welsh translator to ensure Welsh service users are identified and their needs met. Providing the Welsh language to service users without our Welsh speakers needing to ask. Bi-lingual development of an EU & CDU leaflet to ensure patient care trajectories are understood by those accessing EU services. The Senior Nurse has reiterated to the teams the importance of staff receiving the correct uniforms who are Welsh Speaking as the icon is easily visible to our patients to support equitable and positive experience. The "Active Offer" checklist has been re circulated to the team in EU and the site as a whole.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Completed EU Senior Nurse has met with the HB's Welsh translator to ensure Welsh service users are identified and their needs met. Providing the Welsh language to service users without our Welsh speakers needing to ask. The EU are awaiting the bi-lingual version of an EU leaflet to ensure patient care trajectories are understood by those accessing EU services. The team have also published bi-lingual uniform posters, to highlight staff members to service users.
			The health board is required to provide HIW with details of the action taken to involve patients as much as they want to be in decisions about their care.	Within the department we ensure Multi-disciplinary decision making, inclusive of patient choice it at the forefront at all times for patients whilst in our care. Ongoing nurse-patient advocate and champion nurses identified across site to assist in this delivery, the improvement work being undertaken across the site is shaped around "nothing about me, without me." Which reinforces patients being involved in decisions about their care.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved 29.09.2023
			The health board is required to provide HIW with details of the action taken to ensure patients do feel discriminated against when accessing services.	The Head of Nursing chairs a monthly focus group (a meeting that operationalises the governance agenda for the whole site) to discuss and reinforce the use of the equality and diversity agenda. Including the nine protected characteristics as recognised by the Equality Act. There has already been the development of gender neutral facilities within the PCH site, but as work continues, this will be progressed further. For example: toilet facilities and hygiene maintenance areas are label free. Recent appointment of a Learning Disability specialist nurse, who attends Safe to Start, ensuring patients are identified and their care outcomes have a truly holistic approach. Access to a variety of mechanisms to ensure communication is maximised for individualistic needs, already in place. Sharing of CTMUHB values and behaviours through communication across the MDT is regular and form part of each staff communication. This is also key to the staff appraisal process. Service users have the access to PALs service and putting things right to escalate any concerns. As well as access to clinical team members. In recognition of patient needs champion nurses are in place for pregnancy loss, learning disabilities, dementia, Welsh language and further emerging roles. The opportunity for staff to attend training days to improve knowledge and experience to progress this agenda.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved 29.09.2023 Further to this as part of the Civica PREM's inclusion and discrimination feedback is captured and if this is a theme will inform any ongoing actions for improvement.
			The health board is required to provide HIW with details of the action taken to complete suitable risk assessments of the Mental Health Assessment rooms and the Triage rooms and develop action plans as appropriate to mitigate any risks identified.	Multiple MDT meetings being held with the care group service managers, clinical leads, nursing leaders, and personal safety advisor to identify risk across the EU footprint and ensure appropriate and timely escalation occurs. If patient are awaiting Mental Health review these are escalated via morning Safe to Start meeting with multi-professional colleagues. A risk assessment for ligature risk has been developed and awaiting approval-this will also be utilised across the inpatient wards.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved 29.09.2023
			The health board is required to provide HIW with details of the action taken to ensure suitable risk assessments are completed and recorded in relation to patients developing pressure damage and in relation to patient falls. Suitable care plans are to be developed and implemented.	18 months ago the EU had the highest incidence of avoidable pressure damage across the Health Board. Targeted work has been implemented to ensure the mandatory risk assessment is undertaken immediately on arrival to ED in order that appropriate intervention is put in place. This is captured via the AMAT audit tool in which we can see an improving trend. A Senior Nurse for Professional Education was appointed in March 2022 as part of the new Nursing Workforce Model. The staff member is integral to supporting staff education around pressure area care including completion of the Pressure Ulcer Training Module on ESR. A new pressure ulcer booklet has been devised by the Critical Care Team to support staff training and development. Each staff member has been provided with a copy and their compliance is being monitored. Pressure damage scrutiny meetings are in place and improvement work across PCH including ED with notable improvements in ED. All members of the nursing team are able to attend pressure Damage Scrutiny to support learning, this has been successful to date. A Tissue Viability Nurse has been resourced to work in ED once a week to support staff education and training to improve the standard of assessments, care planning and implementation of care. We have purchased a camera for all clinical areas in PCH including ED; with robust guidelines in place and includes support from Medical Illustrations to ensure consent-and supports grading of pressure damage. This can be accessed in and out of hours. The internal data has demonstrated continuous improvement in pressure area assessment and care in ED with significant reduction in avoidable pressure damage as well as identifying pressure damage present on arrival to ED. Pressure area audits are undertaken via AMaT and monitored hourly using the "Patient Safety Checklist". Any trends identified are discussed in the ED monthly meeting and the PCH monthly Focus Group meeting to ensure lessons are learned widely. Two Formal Study Days have been undertaken in the last 18 months and the Fundamentals of Care has been key to the agenda. There are 2 further Study Days arranged (by the Senior Nurse for Professional Education) for October and December - these will incorporate Work Stations and Pressure Area Management is included.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved 29.09.2023
			The health board is required to provide HIW with details of the action taken to ensure patients in the Ambulatory Care area have an adequate means to summon assistance, subject to a suitable risk assessment of this area.	Any broken nurse call button has been identified, reported to Estates and fixed. 20 remote call buttons have been procured and in line with IPC guidance for use across the EU. The Senior Nurse has introduced a daily audit to ensure that all nurse call buttons are available for patient use and in correct working order.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved 29.09.2023 Further to this the Welsh Government funding achieved will support integrated nurse call bells in Ambulatory Care.
			The health board is required to provide HIW with details of the action taken to improve staff compliance with the health board's policy for hand washing to help reduce cross infection.	IPC is a key priority for the MDT due to the clinical nature of the EU and the unknown attending. The report has been shared with the MDT to highlight the issues identified and the increase awareness of our personal responsibility as health professionals to ensure compliance with IPC policies and procedures. IPC champions have been identified in the EU. Increased signage is available across the EU to raise awareness. Increased auditing of Hand Hygiene is being undertaken and trends monitored. Targeted training for the MDT and this is supported by the Senior Nurse for Professional Education. Training compliance is monitored 6 weekly via the Unscheduled Care Workforce Meetings-trends are monitored and actions for improvement. The nurse director commissioned an IPC audit with significant improvement demonstrated, compliance has increased to 90%.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved 29.09.2023
			The health board is required to provide HIW with details of the action taken to ensure: •Controlled Drugs used in the EU are subject to regular stock checks •Temperatures of fridges in the EU used to store medication are regularly recorded.	The Nurse in Charge and Unit Manager to check before Safe to Start, Senior Nurse to spot check daily. Allocation of staffing to reflect daily responsibilities as well as daily check lists. Since the previous HIW review of EU, a dedicated pharmacist has started who supports this work and data is captured via the AMAT audit tool. Non-compliance with this is captured via safe to start and a Datix is generated.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved 29.09.2023
			The health board is required to provide HIW with an update on the action taken to repair or replace the locks on the medication cupboards in the CDU.	There was an immediate make safe and both locks escalated following visit and have been repaired/replaced.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved 29.09.2023
			The health board is required to provide HIW with details of the action taken to ensure all staff who need to be are made aware of Patient Safety Notices relevant to their work area.	Patient Safety Alerts are circulated from the Corporate Patient Safety Team and in turn via the Unscheduled Care Governance Team. The alerts and actions required are cascaded to the EU and CDU MDT to cascade accordingly. The alerts are discussed and minutes available; in the department's monthly governance meetings. The Head of Nursing shares all alerts at the monthly Focus Group (a meeting that operationalises the governance agenda) and minutes. Any actions/evidence required is returned to the Corporate Patient Safety Team. The new EU Newsletter is used to share alerts with the MDT.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved 29.09.2023
			The health board is required to provide HIW with details of the action taken to ensure patients have their pain assessed and regularly evaluated.	Initiation of pain score audits by band 7 champion. Senior Nurse EU and CDU have sent wide communication to all staff around the recording and evaluation of pain scores. Pain team to continue with routine pain audits as per AMaT and this is also capture via the patient safety checklist.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved 29.09.2023
			The health board is required to provide HIW with details of the action taken to: •provide patients with meals that are nutritionally balanced, appear appetising, served at a suitable temperature and that meet patients' individual preferences and needs •provide patients with hot drinks at regular intervals •provide patients with suitable assistance to eat and drink.	A full review of the catering model for CTMUHB is underway. With particular attention to the provisions and supply offered to patients within the EU. The menus introduced will ensure the nutritional analysis exceeds All Wales Nutrition and Catering Standards for Food and Fluid Provision for Hospital Inpatient' for both nutritionally well and nutritionally vulnerable patients. The HB's Catering Model has been re circulated in order that staff understand their roles and responsibilities; key to the model is preparing the patients before the catering trolley attends the EU.	Unscheduled Care	01.09.2023		Overdue	April 2023 New catering model implemented with a wider range of food offered to patients across the ED. Ceramic and metal crockery now offered along side access to fresh water in the waiting room and across the Ambulatory Care Unit.
			The health board is required to provide HIW with details of the action taken to ensure patients' clinical and care records are readily available to staff when required.	Notes trolley instigated within Ambulatory care to ensure accessibility for clinical staff. Clinical lead to establish full access for medical team of electronic systems and Unit Manager for nursing staff.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved 29.09.2023
			The health board is required to provide HIW with details of the action taken to review the staffing arrangements within the Triage area and the Ambulatory Care area. The health board is encouraged to engage with staff given the feedback and comments received by HIW in this regard.	Opportunity recognised for the fulfilment of a twilight triage staff member to offer cover within paediatrics and adult areas, covering surge for triage and ambulatory. -Immediate roster review has been initiated. We flexibly deployment of staff occurs within the department in order to meeting the tier 1 target of <15min wait for triage. The senior leadership team are also exploring E-Triage to allow digital enablers to initially assess all patient attending the EU, improving patient safety and allowing triage resources to be used for higher acuity patients.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved 29.09.2023
			The health board is required to provide HIW with details of the action taken to respond to the less favourable staff feedback and comments described throughout this report.	Staff are actively encouraged to disclose concerns and well-being worries to the Nurse in Charge, Unit Manager or Senior Nurse. Senior Nurse is a national advocate for civility saves lives and promoting psychological safety. CTM has strong MDT presence and leadership-BAME and a confidential email address to raise any concerns-this has been re circulated. -Staff are encouraged to attend training days to raise awareness-10.10.2023-Empowering Culture Intelligence. This is part of' Speaking up Safely' which was shared and discussed in the nursing focus group held 28th September 2023.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved 29.09.2023
			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.	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		Overdue	Monthly training offered to staff for fire, Violence and Aggression and DoLS. Compliance with Fire training and Mental Capacity continues to improve. CDU – MCA training compliance is 77% and Fire is 86%. ED MCA compliance is 56% and Fire is 76% (MCA overall compliance is reduced as a result of a number of newly recruited Registered Nurses and Health Care Support Workers, yet to complete training). There are 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% or above within the next 3 months.
			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.	Monthly mandatory training study days and reports now include V & A, DoLs, medications management, safeguarding and MCA training and compliance. Mandatory training compliance is monitored during the 6 weekly Workforce and Business meetings; trends are monitored for improvements, where there is deterioration-action plans are required. V&A compliance is recorded on the Mandatory Training database held by the Senior Nurse for professional Education.	Unscheduled Care	01.04.2024		Overdue	Monthly training offered to staff for fire, Violence and Aggression and DoLS. Compliance with Fire training and Mental Capacity continues to improve. CDU – MCA training compliance is 77% and Fire is 86%. There are 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% or above within the next 3 months.
			The health board is required to provide HIW with details of the action taken to support staff with health and wellbeing matters and raise staff awareness of the help available.	We recognise improved and robust assurances are required to demonstrate compassionate leadership and management, where our staff feel listened to and supported. Civility saves lives 'TEDtalk' style delivery dates booked for 9th October 2023 and 4th December 2023 – site wide. Senior Nurse to acknowledge any staff well-being concerns and manage workload and allocation to best optimise staff outcomes. Implementation of new administrative role to free the Nurse in Charge up to offer real-time leadership and offer psychological safety. Formal debriefs are undertaken with psychologist support. Workforce & OD have a plethora of well-being and mindfulness that can be accessed-regularly cascaded to the teams as well as bespoke access to the Clinical Psychologist who is currently in touch with the MDT.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved 29.09.2023 and ongoing.
			The health board is required to provide HIW with details of the action taken to ensure staff do feel discriminated against at work.	There is continued work to progress the equality and diversity agenda headed by our Workforce & OD colleagues. Staff are encouraged to attend training days to raise awareness; for example-10.10.2023-Empowering Culture Intelligence.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved 29.09.2023 and ongoing.
			The health board is required to provide HIW with details of the action taken to increase staff confidence that when they raise concerns, these will be addressed.	EU staff notice board and EU newsletter under development. Departmental meeting planned for 4th October 2023. Band 7 meetings monthly. This also forms part of speaking up safely and the ongoing work around civility saves lives and psychological safety which is being championed by the senior nurse for EU. We also have a well-being champion who is available to support staff to raise concerns.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved 29.09.2023 and ongoing.

			The health board is required to provide HIW with an update on the implementation of the patient feedback system and how staff will be made aware of the system and how feedback will be used to make informed decisions regarding the service provided.	We recognise improved and robust assurances are required to demonstrate that patient feedback systems are in place on order that patient experience can be continually reviewed and improved. Two new PALS officers have been recruited, and will specifically work within the EU footprint to support patient feedback and explore patient experience. The implementation of CIVICA-SMS (text) Service for ED Survey is in final stages of approval (Concerns Team). We are progressing the use of QR Codes to signpost patients promptly will be included in the above work. Boards are in development for each clinical area pan CTM which will allow patients the opportunity to "Have their Say". Volunteers have been recruited to support EU-patients and families, the service will commence mid October 2023. PCH Acute Services currently receives-1)Patient experience, comment report, 2)Monthly heat map, 3)Survey analysis, 4)Have your Say-as part of CIVICA.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved - as part of the Civica roll out in ED Patient Reported Experience Measures' are captured themes and trends are shared. This form part of an action plan for improvement if there is a key area overserved where improvement is required. This is shared in the Head of Nursing monthly focus group. It also forms part of the QSRE meetings and a 'you said, we did' board is being developed.
			The health board is required to provide HIW with details of the action taken to develop suitable action plans as a result of audit activity.	The HB would like to provide assurances that the audits undertaken using AMaT automatically identifies areas for improvement and signposts immediately to the action plan for completion. The action plans shown on the system are reviewed weekly by the senior EU and CDU Senior Nurses to ensure actions are completed-outstanding actions are shown as a "red flag" alert if there are any delays in completing-these are escalated to the Lead, Head of Nursing and Executive Directors. Trends identified from audits in EU and CDU are shared with the teams during the monthly meetings. The Head of Nursing reports improvements/deterioration from audits during the Unscheduled Care QSRE meeting and discuss the improvement plans in place-"the so what". The EU team discusses the audit results and improvement plans as part of the monthly governance meetings.	Unscheduled Care	01.09.2023		Fully complete (Awaiting approval)	Achieved 29.09.2023
Healthcare Inspectorate Wales (HIW)/2024/165	09.01.2024	**Appendix A 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.	a)Review of Day assessment activity has been undertaken identifying areas where midwifery hours could be re-allocated to cover the night roster (48 hours a month).	Children & Families	12.01.2024		Fully complete (Awaiting approval)	Completed 16/01/2024
				b)Access to electronic roster has been restricted to ensure appropriate oversight of changes to off duty.	Children & Families	12.01.2024		Fully complete (Awaiting approval)	Completed 15/01/2024
				c)Contact has been made with the Assistant Director of Nursing and People's Experience to explore potential recruitment of overseas midwives. Awaiting meeting to discuss.	Children & Families	01.02.2024		Overdue	
				d)Review of all Flexible Working arrangements within the department to ensure that this support is proportionate and appropriate.	Children & Families	31.03.2024		Overdue	Started November 2023, expected completion end of March 2024
				e)Continue to work closely with people services to ensure that the All Wales Attendance at work policy is adhered to and absences are managed appropriately. Senior management meet with HR monthly to discuss Long Term Sickness (LTS) and attend meetings with individuals on LTS at certain intervals and at formal triggers.	Children & Families	12.01.2024		Fully complete (Awaiting approval)	In Place
				f)Work is in progress analysing the staff establishment alongside the birth-rate plus report to ensure appropriate allocation of staff.	Children & Families	01.02.2024		Overdue	In Progress
				g)Working with finance colleagues to develop a new model for obstetric theatre nursing (releasing midwifery time).	Children & Families	01.02.2024		Overdue	Commenced September 2023. Due for completion February 2024.
				h)The Service is moving from the Birth-rate + acuity app to the Health Board's 'Safe Care' acuity system which links with Allocate Health Rosters and ensures wider Organisational scrutiny.	Children & Families	01.03.2024		Overdue	
				i)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		Overdue	
				j)Work with the Corporate Communications department to develop a Comms Recruitment strategy to demonstrate the benefits to attract staff to work in CTM UHB.	Children & Families	29.02.2024		Overdue	
				k)Rolling advert to continue to appoint band 6 midwives, closed and continuous advert for bank midwife.	Children & Families	12.01.2024		Fully complete (Awaiting approval)	In place
				l)Review of specialist and operational roles and required commitment for clinical aspects of role to enhance short fall in acute areas as well as staff currently released on secondment.	Children & Families	12.01.2024		Fully complete (Awaiting approval)	In place
				m)Senior Manager on call out of hours to support the staff on duty and ensure that staff available are redeployed to the areas of greatest need or transfer out if closure of the unit is necessary.	Children & Families	12.01.2024		Partially complete (Overdue)	In place from 22/01/2024
				n) Initiate formal workforce staffing safety briefing twice a week to ensure oversight and forecast of staffing requirements of staffing requirements across the service and sites to allow timely intervention where possible.	Children & Families	13.01.2024		Overdue	
				o)Nursing (and Midwifery) productivity workforce meetings held within the Care Group Structure.	Children & Families	12.01.2024		Fully complete (Awaiting approval)	In place
				p)A corporate nursing and midwifery dashboard is being developed to consistently capture vacancies, sickness, annual leave = to be shared in Care Group Nursing & Midwifery Workforce Productivity Meetings.	Children & Families	30.01.2024		Overdue	
				q)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		Fully complete (Awaiting approval)	In place 16/01/2024
				r)Rotation of Staff from well-established areas to ensure consistent safe staffing across the service and weekly review, meetings in place.	Children & Families	31.01.2024		Overdue	
				s)Temporary cease midwifery rotation to other areas.	Children & Families	13.01.2024		Overdue	
				t)Review annual leave to ensure consistent levels of annual leave at any given time. This a feature on the Allocate e-roster tool.	Children & Families	31.01.2024		Overdue	Timescale 31.1.24 & Monitoring in place
				u)The Health Board continues to work with Welsh Government and Health Education & Improvement Wales to develop a Perinatal Workforce Plan as part of the Maternity and Neonatal Safety Support Programme.	Children & Families	11.01.2024		Overdue	Timescale 11.1.24 & ongoing national meeting attendance
				v)Review night time rosters to determine whether any cultural concerns which may impact attendance at work.	Children & Families	31.01.2024		Overdue	
				w)Bank & Overtime Hours offered to midwives.	Children & Families	17.01.2024		Overdue	
			Control of Substances Hazardous to Health (COSHH) The health board is required to provide HIW with details of the action taken to safely secure COSHH substances used on maternity unit to help prevent unauthorised access.	a)Locks to be replaced an all COSHH cupboards – Estates colleagues contacted during the Inspection. Locks changed on 4 cupboards.	Children & Families	12.01.2024		Fully complete (Awaiting approval)	Completed 15.1.24
				b)1 x Lock ordered for further cupboard awaiting delivery.	Children & Families	19.01.2024		Overdue	
				c)Domestic Supervisors have shared a safety briefing with her team, to ensure they are aware of the requirement.	Children & Families	12.01.2024		Fully complete (Awaiting approval)	Completed 12.01.24
				d)Continued oversight though monitoring through the AMaT ward audit schedule.	Children & Families	12.01.2024		Fully complete (Awaiting approval)	In place
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	**Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)**	Visiting times The health board should review visiting arrangements and communicate timings with families ahead of admission.	Visiting hours within Cwm Taf Morgannwg are in line with other Health Boards in Wales. In response to the service user feedback, an extraordinary My Maternity My Way meeting was held on 22nd January 2024 to discuss visiting and birth partner arrangements. In response to suggestions from service users, visiting hours will be extended for birth partners from 4th March 2024. Visiting hours for the nominated birth partner is being extended until 10pm at night. The service will also facilitate a 30 minute settling in period for partners on transfer to the postnatal ward. Changes to visiting arrangements are advertised via social media, website, communication via all midwifery teams and posters within antenatal clinics (community and hospital).	Children & Families	04.03.2024		Overdue	
			Questionnaires The health board should ensure that patient concerns are taking into consideration based on patient comments throughout the report.	The service regularly reviews themes and trends from Patient Reported Experience Measures (PREM). Overall women and birthing people report a high level of being treated with kindness / understanding / dignity and respect. The service shares stories for learning where women and birthing people feel they have not been treated positively through audit, supervision and governance sessions. The annual PREM report was shared at the Health Board Quality and Safety Committee in May 2023 with plans in place to share again in May 2024. The service is developing a social media campaign to support women and pregnant people to identify signs and symptoms of VTE. Members of staff who are named in concerns / negative feedback are supported to complete customer care training, discussions are also held with clinical / educational supervisors. The Ombudsman supported training for concerns management to team leaders and senior midwives on 11th November 2023. Proactive feedback is sought throughout the ante and postnatal period via PREM (CIVICA). Feedback is analysed and thematically reviewed monthly. Feedback is monitored via service level assurance groups, and Maternity and Neonatal Safety Board in accordance with the Maternity and Neonatal Assurance and Escalation Framework. GMC/NMC attended audit and governance day on 11th October 2023. Lunch and learn facilitated by NMC on 14th September 2023. Both discussion were around professional standards and behaviours. Myth busting – NMC facilitated session on the approach taken when investigating concerns 14th November 2023. Further NMC session planned 29th April for newly qualified midwives.	Children & Families	01.03.2024		Overdue	Due date 1st March 2024 and under continual review

UNICEF Baby Friendly Initiative The health board must work to achieve the UNICEF Baby Friendly Initiative reaccreditation.	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		In progress	
Pain relief The health board should ensure that appropriate pain relief is given in a timely manner.	The ward manager is responsible for ensuring women receive timely analgesia. A service user audit is underway to further explore the concerns raised. The results of which will be shared via clinical supervision, practice development, audit and governance days.	Children & Families	31.03.2024		Overdue	
Mixed cohort wards Whilst we understand that due to staffing issues, mixed cohort wards are a necessity to manage risk, the health board should ensure procedures are in place to ensure they are only used as a last resort.	Mixed cohort wards occur not due to staffing issues, but as a result of acuity, flow and capacity. Whilst ideally ante, postnatal and transitional care should be delivered in separate areas, there are occasions where the midwife in charge is required to review all areas to ensure that there continued flow and timely transfer to and from the intrapartum areas.	Children & Families	12.01.2024		Fully complete (Awaiting approval)	In place and reviewed daily
Informed choice The health board should ensure that all patients are fully aware of all obstetric treatment choices and their risks and benefits, and informed consent should be gained.	The service has invested in Birth rights training for midwives and obstetricians on 11th July 2023 which included choice and informed consent. Informed consent and decision making training was facilitated by the CTM legal team, at a service audit and governance day which took place on 8th February 2023. BRAIN, informed consent and decision-making are referenced within clinical guidelines. Informed decision-making features within PROMPT and Fetal Surveillance training. An induction of labour Quality Improvement collaborative is underway which monitors women and birthing people's experience of informed decision-making. A range of decision-making tools are being developed around indications for induction of labour. Annual PREM data (2022-23) showed that over 80% of women and pregnant people had definitely or mostly been given enough information to help them make choices about their pregnancy care, health and well-being. Consent audit added to the Forward audit plan for June 2024	Children & Families	01.07.2024		Partially complete	In place and monitored via PREM. Audit July 2024
Equality of access The health board is required to provide HIW with details of how it will ensure that mothers and staff members are not disadvantaged due to their protected characteristics under the Equality Act (2010)	Equality and Diversity training for all staff in place. Rates of training were reviewed during the inspection and revealed high levels of compliance. We work in partnership with our trade union, workforce, occupational health and organisational development colleagues to ensure our people are supported. Service partnership forums are in place to ensure any concerns are escalated and discussed. The Care Group are working with Diverse Cymru and cultural competence training has been arranged for senior leaders on 10th April 2024. Following this session, the training will be rolled out across service groups and develop a cultural competence plan for submission in July 2024.	Children & Families	01.07.2024		In progress	
Locked doors The health board is required to provide HIW with details of further action it will take to ensure measures are in place to maintain the safety of babies across its maternity services to prevent baby abductions.	The doors were rectified immediately following the inspection and are now secure. During the inspection the service provided evidence of a recent abduction drill. Abduction drills are annually facilitated and a further drill planned for 2024 as part of the annual audit plan.	Children & Families	12.01.2024		Fully complete (Awaiting approval)	Completed January 2024
Record keeping The health board must ensure that regular documentation audits are conducted, and learning takes place from the findings.	Annual record keeping and documentation audits are in place, actions are monitored via the Health Board AMAT system. Midwives undertake record keeping and documentation audits as part of clinical supervision for midwives.	Children & Families	01.05.2024		In progress	
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.	Review of Day assessment activity has been undertaken identifying areas where midwifery hours could be re-allocated to cover the night roster (48 hours a month).	Children & Families	12.01.2024		Fully complete (Awaiting approval)	Completed 16/01/2024
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.	Access to electronic roster has been restricted to ensure appropriate oversight of changes to off duty.	Children & Families	12.01.2024		Fully complete (Awaiting approval)	Completed 15/01/2024
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.	Review of all Flexible Working arrangements within the department to ensure that this support is proportionate and appropriate.	Children & Families	31.03.2024		Overdue	Started November 2023, expected completion end of March 2024.
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.	Continue to work closely with people services to ensure that the All Wales Attendance at work policy is adhered to and absences are managed appropriately. Senior management meet with HR monthly to discuss Long Term Sickness (LTS) and attend meetings with individuals on LTS at certain intervals and at formal triggers.	Children & Families	12.01.2024		Fully complete (Awaiting approval)	In place
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.	Work is in progress analysing the staff establishment alongside the birth-rate plus report to ensure appropriate allocation of staff	Children & Families	12.01.2024		Overdue	In progress February 2024
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.	Working with finance colleagues to develop a new model for obstetric theatre nursing (releasing midwifery time).	Children & Families	01.03.2024		Overdue	
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.	The Service is moving from the Birth-rate + acuity app to the Health Board's 'Safe Care' acuity system which links with Allocate Health Rosters and ensures wider Organisational scrutiny.	Children & Families	01.03.2024		Overdue	
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.	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		Overdue	
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.	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		Overdue	
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.	Rolling advert to continue to appoint band 6 midwives, closed and continuous advert for bank midwife.	Children & Families	12.01.2024		Fully complete (Awaiting approval)	In place
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.	Review of specialist and operational roles and required commitment for clinical aspects of role to enhance short fall in acute areas as well as staff currently released on secondment.	Children & Families	12.01.2024		Fully complete (Awaiting approval)	In place
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.	Senior Manager on call out of hours to support the staff on duty and ensure that staff available are redeployed to the areas of greatest need or transfer out if closure of the unit is necessary .	Children & Families	12.01.2024		Fully complete (Awaiting approval)	In place from 22.01.24
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.	Initiate formal workforce staffing safety briefing twice a week to ensure oversight and forecast of staffing requirements of staffing requirements across the service and sites to allow timely intervention where possible.	Children & Families	13.01.2024		Overdue	
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.	Nursing (and Midwifery) productivity workforce meetings held within the Care Group Structure.	Children & Families	12.01.2024		Fully complete (Awaiting approval)	In place
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.	A corporate nursing and midwifery dashboard is being developed to consistently capture vacancies, sickness, annual leave = to be shared in Care Group Nursing & Midwifery Workforce Productivity Meetings.	Children & Families	30.01.2024		Overdue	

			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.	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		Fully complete (Awaiting approval)	In place
			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.	Rotation of Staff from well-established areas to ensure consistent safe staffing across the service and weekly review, meetings in place.	Children & Families	12.01.2024		Fully complete (Awaiting approval)	In place
			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.	Temporary cease midwifery rotation to other areas	Children & Families	31.01.2024		Overdue	
			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.	Review annual leave to ensure consistent levels of annual leave at any given time. This a feature on the Allocate e-roster tool.	Children & Families	31.01.2024		Overdue	Due date 31.1.24 & Monitoring in place
			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.	The Health Board continues to work with Welsh Government and Health Education & Improvement Wales to develop a Perinatal Workforce Plan as part of the Maternity and Neonatal Safety Support Programme.	Children & Families	11.01.2024		Overdue	Due date 11.1.24 & ongoing national meeting attendance
			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.	Review night time rosters to determine whether any cultural concerns which may impact attendance at work.	Children & Families	31.01.2024		Overdue	Due date 31.1.24, continues under review
			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.	Bank & Overtime Hours offered to midwives.	Children & Families	17.01.2024		Overdue	
			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.	Agency midwifery introduced to support.	Children & Families	01.03.2024		Overdue	
			Visibility of management Based on the negative comments in the staff survey, there should be serious consideration of the allocation of duties to the midwifery staff. This should include daytime shifts for middle managers i.e. band 7 and above on the wards. This will promote an understanding of the problems on the unit, improve communication and create more cohesion.	Operational and specialist midwives are rostered to support clinical activity.	Children & Families	01.03.2024		Overdue	
			Datix reporting The health board should undertake a review of the processes for reviewing incidents. The reviewing team should include clinicians and practitioners with the appropriate experience and expertise.	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		Overdue	
			Discussion and staff survey results The health board must ensure its senior leaders continue to encourage supportive and inclusive relationships so that staff feel valued, respected, and confident to speak up and raise concerns. It is vitally important that the health board engage more with its staff and work together to become a more cohesive team who communicate, consult, and make decisions together to improve the working environment for all and to optimise patient care.	Partnership forums are in place with staff side colleagues to ensure any concerns are addressed in a timely manner. Quarterly meetings are in place to review the caring for you action plan with colleagues and staff side representatives. Learning needs analysis in place to support team and individual development and learning opportunities. Consultant midwife for Quality Improvement and Innovation in post. Annual quality improvement plan in place. 75 midwives have completed introduction to quality improvement training. 26 members of the multi-disciplinary team have completed improvement in practice training. Further improvement in practice training is planned in March and April 2024. 'QI Wednesdays' are facilitated by the Consultant Midwife for QI and innovation to share ideas for improvement which has positive engagement. Clinical midwives and support workers are involved in several QI projects such as BSOTS, Neurodiversity, Postnatal Contraception, Female Genital Mutilation, Booking by 10 completed weeks, ATAIN, smoking cessation, physiotherapy, induction of labour. By September 2024, all midwives will have completed QI training. Evaluation of QI sessions are completed on each occasion and are very positive. Engagement forums in place led by Head of Midwifery and Senior Midwifery Manager (last meeting 23rd February). Next Head of Midwifery and Band 7 meeting 18th March with trade union representatives Band 7 and 8 away day development sessions held throughout 2023. Maternity support worker away day being developed for Summer 2024.	Children & Families	12.01.2024		Fully complete (Awaiting approval)	In place and reviewed monthly
			GDPR The health board is required to provide Healthcare Inspectorate Wales (HIW) with details of the action taken to provide assurance that documentation is stored in line with GDPR.	This was rectified at the time of the inspection. The ward manager monitors this daily.	Children & Families	12.01.2024		Fully complete (Awaiting approval)	Completed and monitored daily.

Appendix 2 - Audit Tracker Development Work Programme

Development Required	Action Needed (Local or External)	Lead on Action	Implementation Timescale
1. Requirement for additional fields within the AMaT System to capture "Revised Dates" and rationale. Revised dates currently captured in progress update narrative.	External Development led by AMaT. Added to the system Development Log for approval. High priority has been assigned.	AMaT System developers	January 2025
2. Inspection actions to be defined as High Medium or Low in the system.	Local Development led by Clinical Audit Team. The current RAG Rating field can be customised to meet requirements.	CTMUHB Clinical Audit Team	June 2024
3. Introduce theming across inspections.	Local and External Development Quality Assurance & Compliance Team to add theme criteria list and share with Clinical Audit for inclusion. AMaT to design a report that captures recommendations by theme.	CTMUHB Clinical Audit Team and Quality Assurance & Compliance Team AMaT System/Report Developers	June 2024 January 2025
4. Read only access for Audit & Risk Committee Members to view full reports as and when required.	Local Development If Audit & Risk Committee members will find this beneficial individuals will be added as read only users.	CTMUHB Clinical Audit Team and Quality Assurance & Compliance Team	June 2024

Development Required	Action Needed (Local or External)	Lead on Action	Implementation Timescale
5. Requirement for additional fields / coding to capture "Paused" recommendations or individual actions	External Development To be added to AMaT's Development Log and if supported will be taken forward	CTMUHB Clinical Audit Team to request. AMaT System developers	March 2025
6. Requirement to capture in the system where recommendations have not been accepted generating a text box for rationale narrative to be added.	External Development To be added to AMaT's Development Log and if supported will be taken forward.	CTMUHB Clinical Audit Team to request. AMaT System developers	March 2025
7. Notification Alerts – further refinement of sign off stages and at what delegated level	Local Development CTMUHB Clinical Audit Team and Quality Assurance & Compliance Team to define what is required in terms of escalation and approval levels and set permissions accordingly.	CTMUHB Clinical Audit Team and Quality Assurance & Compliance Team	July 2024
8. Fully Automated report in pdf design style addressing all the above requirements.	Local and External Development Quality Assurance & Compliance Team to confirm report criteria AMaT to design a report that captures recommendations by theme.	CTMUHB Quality Assurance & Compliance Team	March 2025
9. Internal Audit Reports – Tracker introductory Sheet to include assurance rating	Completed – now added.	CTMUHB Quality Assurance & Compliance Team	Complete