Quality & Safety Committee

Wed 18 September 2024, 14:00 - 17:00

Virtually via Microsoft Teams

Agenda

14:00 - 14:05
5 min

1. PRELIMINARY MATTERS

1.1. Welcome & Introductions

Information *Carolyn Donoghue, Independent Member/Committee Chair*

1.2. Apologies for Absence

Information *Carolyn Donoghue, Independent Member/Committee Chair*

1.3. Declarations of Interest

Information *Carolyn Donoghue, Independent Member/Committee Chair*

14:05 - 14:45
40 min

2. SHARED LISTENING & LEARNING

2.1. Listening & Learning Story - Learning Disabilities

Discussion *Ana Llewellyn, Care Group Nurse Director*

2.2. Spotlight Presentation - Diagnostics, Therapies, Pharmacy & Specialties Care Group

Discussion *Paula Cornelius and Jane Paxon*

Strategic Goals: Improving Care

2.2 Case Study Presentation to QSC 18 September 2024.pdf (8 pages)

14:45 - 14:50
5 min

3. CONSENT AGENDA

Information *Carolyn Donoghue, Independent Member/Committee Chair*

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

14:50 - 14:50
0 min

4. MAIN AGENDA

4.1. Matters Arising not contained within the Minutes or Action log

Discussion *Carolyn Donoghue, Independent Member/Committee Chair*

14:50 - 15:25
35 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 18 September 2024.pdf (14 pages)

5.2. Care Group Highlight Reports

Discussion *Care Group Leads*

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

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

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

5.2a Children and Families Care Group Highlight Report QSC 18 September 2024.pdf (7 pages)
5.2a Appendix 1 WG Mat stats August 2024 QSC 18 September 2024.pdf (22 pages)
5.2b Primary Care and Community Care Group Highlight Report QSC 18 September 2024.pdf (11 pages)
5.2c DTPS Highlight Report QSC 18 September 2024.pdf (12 pages)
5.2d MHLD Highlight Report QSC 18 September 2024.pdf (11 pages)
5.2e USC Care Group-Highlight Report QSC 18 September 2024 following enquires-VH 050924.pdf (8 pages)
5.2f Planned Care Highlight Report QSC 18 September 2024.pdf (7 pages)

15:25 - 16:25
60 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*

Strategic Goals: Improving Care

Domains of Quality: Safe

6.1a - Org RR Cover Report - QSC September 2024.docx (8 pages)
6.1b- Appendix 1 - Org RR September 24 QSC.xlsx (11 pages)

6.2. HMP Parc and Young Persons Unit A Year on

Discussion *Lucie Williams, Care Group Nurse Director*

Strategic Goals: Improving Care

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

6.2 HMP Parc QSC 18 September 2024.pdf (10 pages)

6.3. Update Dental Services

Discussion *Gethin Hughes, Chief Operating Officer*

Strategic Goals: Improving Care

6.3 Update on Dental Services QSC 18 September 2024.pdf (4 pages)

6.4. Health, Safety & Fire Sub Committee Highlight Report

Discussion *Hywel Daniel, Executive Director for People*

Strategic Goals: Improving Care

Domains of Quality: Safe

6.4 Health Safety Fire Sub Committee Highlight Report 5 September 2024 QSC 18 September 2024.pdf (5 pages)

6.5. Human Tissue Authority Reportable Incident (HTARI) Reporting

Discussion *Dom Hurford, Executive Medical Director*

Strategic Goals: Improving Care

Domains of Quality: Safe, Person Centred

6.5 HTARI reporting QSC 18 September 2024.pdf (6 pages)

6.6. Impact and Governance around the management of Medication Shortages

Discussion *Dom Hurford, Executive Medical Director*

Strategic Goals: Improving Care

Domains of Quality: Safe

6.6a Impact Governance around the Management of Medication Shortages QSC 18 September 2024.pdf (6 pages)
6.6b CTMUHB medicines shortage procedure QSC 18 September 2024.pdf (13 pages)

6.7. Ward Accreditation - Progress Report

Discussion *Becky Gammon, Assistant Director of Nursing and People's Experience*

Strategic Goals: Improving Care

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

6.7 Accreditation Phase 2 update August 24 QSC 18 September 2024.pdf (7 pages)

6.8. Public Services Ombudsman Annual Letter 2023/2024

6.8a Q&S Committee Paper - PSOW - 2024-09-13 QSC 18 September 2024.pdf (6 pages)
6.8b Q&S Committee Paper - PSOW - 2024-09-13 Appendix A QSC 18 September 2024.pdf (10 pages)

16:25 - 16:45
20 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 18 September 2024.pdf (23 pages)

16:45 - 16:50
5 min

8. CONSENT AGENDA

8.1. FOR APPROVAL

8.1.1. Unconfirmed Minutes of the meeting held on 23 July 2024

Decision *Carolyn Donoghue, Committee Chair/Independent Member*

8.1.1 Unconfirmed Minutes Quality and Safety Committee 23 July 2024 QSC 18 September 2024.pdf (23 pages)

8.1.2. Quality & Safety Committee Terms of Reference

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

In light of the Committee Review, the Terms of Reference will be received for noting at the November 2024 meeting

8.1.3. Putting Things Right Annual Report

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

Strategic Goals: Improving Care

Domains of Quality: Safe

- 8.1.3a PTR Annual Report 2023-2024 QSC 18 September 2024.pdf (3 pages)
- 8.1.3b PTR Annual Report 2023-2024 Final QSC 18 September 2024.pdf (11 pages)

8.1.4. Energy Policy

Decision *Sally May, Executive Director of Finance*

Strategic Goals: Sustaining Our Future

Domains of Quality: Efficient

- 8.1.4a Cover Report - Energy Policy Sep 2024 QSC 18 September 2024.pdf (4 pages)
- 8.1.4b Energy Policy FINAL 11-July-2024 QSC 18 September 2024.pdf (18 pages)

8.1.5. Management of High Voltage Electrical Systems Policy

Decision *Sally May, Executive Director of Finance*

Strategic Goals: Improving Care

Domains of Quality: Safe

- 8.1.5a Cover Report - HV Policy Sep 2024 QSC 18 September 2024.pdf (4 pages)
- 8.1.5b High Voltage Electricity Supply Systems CL Final Sep24 QSC 18 September 2024.pdf (31 pages)

8.2. FOR NOTING

8.2.1. Action Log

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

- 8.2.1 Action Log QSC 18 September 2024.pdf (11 pages)

8.2.2. Committee Annual Cycle of Business

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

- 8.2.2a Cover Report Committee Annual Cycle of Business QSC 18 September 2024.pdf (3 pages)
- 8.2.2b Quality Safety Committee Cycle of Business QSC 18 September 2024.pdf (4 pages)

8.2.3. Committee Forward Work Programme

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

- 8.2.3 Quality & Safety Committee Forward Work Programme QSC 18 September 2024.pdf (5 pages)

8.2.4. Healthcare Inspectorate Wales Action Plan Tracker

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

Strategic Goals: Improving Care

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

- 8.2.4a -HIW Tracker Inspection Improvement Plans- QSC Sept 24.pdf (6 pages)
- 8.2.4b- App 1 HIW Inspections Recommendations Tracker Final.pdf (36 pages)
- 8.2.4c App 2 Audit Tracker Development Work Programme LIVE as at 31.07.2024.pdf (5 pages)

8.2.5. Joint Commissioning Committee Quality & Patient Safety Committee Chairs Report

Information

- 8.2.5a JCC Quality Patient Safety Committee Chairs Report QSC 18 September 2024.pdf (6 pages)

8.2.5b Appendix 1 - Services in Escalation Summary QSC 18 September 2024.pdf (8 pages)

8.2.6. Infection, Prevention & Control Annual Report

Information *Richard Hughes, Deputy Executive Director of Nursing*

Strategic Goals: Improving Care

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

8.2.6a IPC Annual Report Cover Paper QSC 18 September 2024.pdf (6 pages)
8.2.6b IPC Annual Report 2023-2024 (1) QSC 18 September 2024.pdf (29 pages)

8.2.7. Individual Patient Funding Request Annual Report

Information *Linda Prosser, Executive Director of Strategy & Transformation*

Strategic Goals: Improving Care

Domains of Quality: Safe, Effective, Efficient

8.2.7 IPFR Annual Report 2023-24 QSC 18 September 2024.pdf (11 pages)

8.2.8. All Wales Learning from Events Framework

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

Strategic Goals: Improving Care

Domains of Quality: Safe

8.2.8a All Wales LFE Framework Sept 2024-SM QSC 18 September 2024.pdf (5 pages)
8.2.8b All Wales Learning from Events Framework CTM QSC 18 September 2024.pdf (59 pages)

16:50 - 16:55
5 min

9. CLOSE OUT BUSINESS

9.1. Any Other Business

Discussion *Carolyn Donoghue, Independent Member/Committee Chair*

9.2. Highlight Report to Board - Verbal

Discussion *Carolyn Donoghue, Independent Member/Committee Chair*

9.3. 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

9.4. Identification of Future Spotlights and Thematic Presentations

Discussion *Carolyn Donoghue, Independent Member/Committee Chair*

16:55 - 16:55
0 min

10. PRIVATE/IN COMMITTEE SESSION

No items have been identified for In Committee discussion at the time of drafting the agenda

16:55 - 17:00
5 min

11. DATE AND TIME OF NEXT MEETING

The next meeting will be held on Tuesday 19 November at 2pm as an In Person meeting at The Hub, Royal Glamorgan Hospital site.

Agenda Item 2.2	(18/09/2024)	(Quality & Safety Committee)	(DTPS Spotlight Presentation)

Report Details:	
FOI Status:	Please select: Open (Public)
If closed please indicate reason:	
Prepared By:	Paula Cornelius
Presented By:	Paula Cornelius – Head of Occupational Therapy Services Ana Hemborough – Clinical Specialist Occupational Therapist
Approving Executive Sponsor:	Lauren Edwards
Report Purpose	Please Select: For Noting
Engagement undertaken to date:	Model developed following collaboration with local authority partners and Primary Care and community

Impact Assessment:	
Indicate the Quality / Safety / Patient Experience Implications:	Patient experience
Related Health and Care Standard	Safe, timely effective and efficient
Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	No – service can be delivered in Welsh and English
Are there any Legal Implications /Impact.	No
Are there any resource (capital/Revenue/Workforce Implications / Impact?	No
Link to Strategic Goals	Please Select: Improving Care

Rapid Assessment and Prevention (RAP) Occupational Therapy Service

Rapid Assessment and Prevention OT Service

Rapid assessment and preventative interventions to patients within their home to prevent hospital admission.



WAST stack	@Home	OOH
• Duty response to Navigation Hub 10 am to 4 pm. • Joint visits with GP / Paramedic to stand down Ambulance calls	• Same day assessments for urgent priorities (Red calls) to prevent admission 8am to 4 pm. • Joint visits with MDT or OT only visits follow clinical triage.	• Assessments next working day for therapy only needs • Direct access to Navigation hub GPs to review medical concerns • Direct access to @Home triage.

Benefits & Realisation KPIs

- Reduction in ambulance conveyance rates
- 85% compliance with 4 hour OT response to Navigation Hub
- 85% compliance with 24 hour (Red) OT response in the @Home service
- 85% compliance with transfer of ongoing care needs within 48 hours of OT assessment

Next steps



Trusted Assessor:
Discussions with Local Authority partners for OTs to have direct access to commissioning packages of care to commence the same day for admission avoidance.



Transfer of ongoing care:
Utilising intervention plans for community rehabilitation services to follow to reduce the need for reassessment and commence interventions in a more timely manner



Shared systems access and record sharing:
WCCIS access across the Local Authorities
Pathways to share RAP assessments with Front door and in-patient teams to reduce duplication and highlight strengths and barriers at the earliest opportunity to expedite discharges.



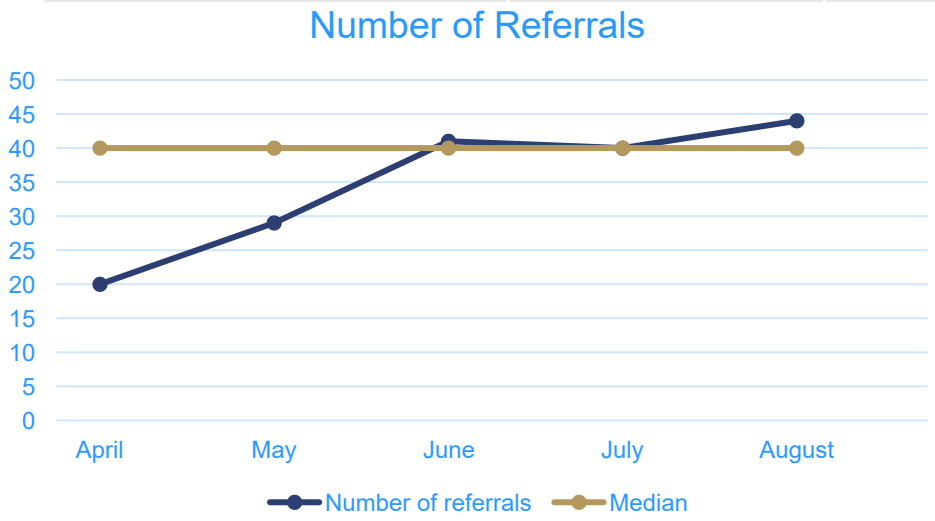
Extended hours and service cover:
Current offer is core hour service. Plans to explore extending service hours to 6pm, with a view to a 7-day model

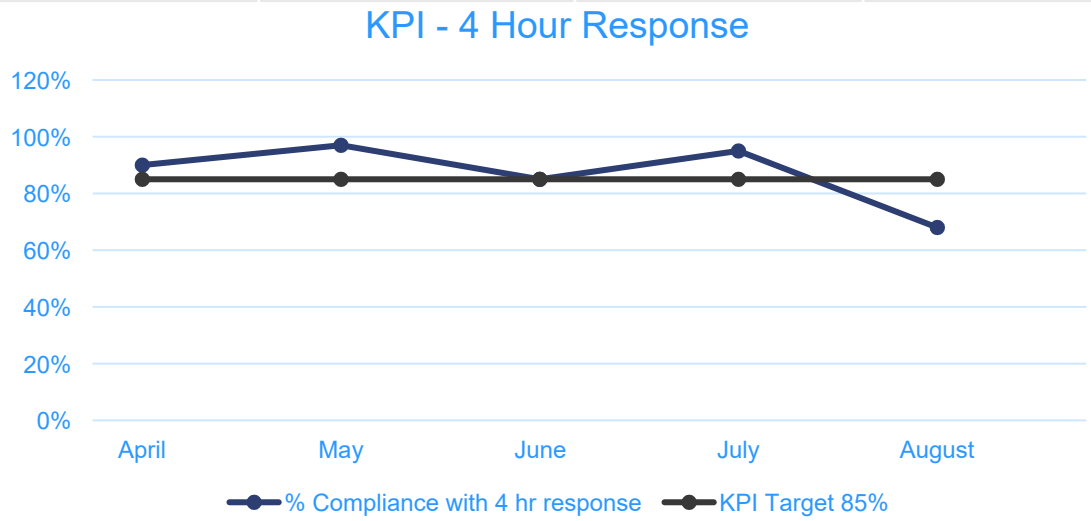


Skill mix:
Band 7 OT Clinical Lead OT appointed July 2024. Static Band 6 OT post recruitment pending.
Explore GTAP support for urgent reviews and brief interventions to enable risk threshold contingency planning.

Benefits and Outcomes

	April	May	June	July	August	Total
Conveyances avoided	20	25	35	28	23	131
Conveyance costs	£19, 940	£24, 925	£34, 895	£27, 916	£22, 931	£150 547
B6 OT month cost	£3.961	£3.961	£3.961	£3.961	£3.961	£19 805
Savings						£130, 742





Case Study

999 call due to increased pain in left leg, struggling to weight-bear, reduced mobility. Struggling to cope at home.

→ Triaged by Navigation Hub Doctor

→ Doctor on triage contacted mobile doctor requesting doctor and OT attend.

→ Mobile doctor completed examination.

→ Doctor determined no medical need for conveyance.

→ OT commenced assessment.

Occupational Therapy

Barriers identified during OT assessment

Patient's view – wanting admission	Discussion between doctor, OT, patient.
Stairs	Set up on one level.
Accessing kitchen	Carers and nephew to support.
Washing and dressing	Carers to support
Access to property for care staff	Care and Repair for key safe.
Reduced independence.	Reablement referral

Actions to overcome these

Clinical Navigation Hub GP

Joint working the RAP OTs:

- The benefits to Clinical Navigation Hub / Out of Hours
- Joint visit resulting in conveyance avoided and patient being able to remain at home

Recommendation:	**The Board or Committee are asked to:**
	• *The purpose of this presentation is to update and share information regarding the development of a new service model within Therapies*

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Agenda Item
5.1

Quality & Safety Committee

Clinical Executive Directors Report

Dyddiad y Cyfarfod / Date of Meeting	18/09/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	1. Richard Hughes-Deputy Executive Director for Nursing and Midwifery 2. Dom Hurford-Executive Medical Director 3. Lauren Edwards-Executive Director for Therapies and Health Sciences, 4. Philip Daniels-Executive Director Public Health
Cyflwynydd yr Adroddiad / Report Presenter	Greg Padmore-Dix-Executive Director for Nursing and Midwifery • 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 for Nursing and Midwifery • 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	
AHPs	Allied Health Professionals
CTM UHB	Cwm Taf Morgannwg University Health Board
HB	Health board
ED	Emergency Department
FNF	Florence Nightingale Foundation Academy
HCID	High-Consequence Infectious Diseases
OD	Organisational Development
IPC	Infection Prevention and Control
PPE	Personal Protective Equipment
LFER	Learning from Events Record
HCSW	Healthcare Support Workers
NNAP	National Neonatal Audit Programme
PCH	Prince Charles Hospital
RGH	Royal Glamorgan Hospital
POW	Princess of Wales
HEIW	Health Education in Wales
MMR	Measles Mumps Rubella

1. Situation /Background

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 & Midwifery
- Dom Hurford-Medical Director
- Lauren Edwards-Executive Director of AHPs and Health Science
- Philip Daniels-Executive Director of Public Health

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

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 Director updates: Nursing & Midwifery

Section 2.1 Specific Matters for Consideration:

2.1.1 Sexual Safety, an All-Wales approach

Cwm Taf Morgannwg University Health Board (CTMUHB) is actively collaborating with partners across Wales to address sexual safety issues within healthcare settings. This initiative involves a diverse stakeholder group, including our Deputy Executive Director of Nursing and representatives from the NHS, social care, and the third sector, ensuring a comprehensive approach to improving sexual health services and patient safety.

Recent evidence has underscored concerns about sexual safety, prompting this focused collaboration. The stakeholder group is designed to be inclusive, considering various perspectives to develop effective strategies. This effort is part of CTMUHB's broader commitment to enhancing healthcare services and addressing inequalities in access to care.

2.1.2 Nursing Leadership in Emergency Care

CTMUHB is implementing a strategic approach to enhance nursing provision within the Unscheduled Care Group, specifically in the Royal Glamorgan Hospital (RGH) Emergency Department. This initiative reflects the current demand for nursing services and aims to ensure parity and calculated demand across the board.

The revised establishment levels, led by the Unscheduled Care Nurse Director, are designed to support the staffing needs at the front door of our three Emergency Departments (EDs). This includes a focus on enabling substantive recruitment,

particularly by enhancing leadership roles through an increase in Band 6 and Band 7 nurse leaders. These roles are crucial for providing high-quality, patient-centred care and leading teams effectively within the dynamic environment of the NHS.

Key components of this approach include:

1. **Revised Establishment Levels:** Ensuring staffing levels are aligned with clinical priorities and demand supports the efficient operation of EDs.
2. **Leadership Enhancement:** Increasing the number of Band 6 and Band 7 nurse leaders to strengthen leadership in EDs, thereby improving patient care and staff support.
3. **Substantive Recruitment:** Facilitating the recruitment of permanent staff to reduce reliance on temporary or agency workers, essential for maintaining consistent and high-quality care.

2.1.3 Florence Nightingale Foundation (FNF) Academy in CTMUHB

CTMUHB is proud to announce the launch of its partnership with the Florence Nightingale Foundation (FNF) Academy, marking a significant step in our commitment to leadership development within nursing and midwifery. This collaboration offers a unique opportunity for our staff to engage in comprehensive leadership programmes designed to enhance their professional growth and improve clinical outcomes.

Six staff members have recently been awarded fellowship opportunities with the FNF Academy as part of this initiative. These fellowships provide an invaluable platform for personal and professional development, allowing participants to explore their leadership potential and make a meaningful impact on healthcare delivery. The fellowship programme includes:

1. **Leadership Development:** Fellows engage in a 12-month programme, including individual coaching, mentorship, and community practice sessions. This is designed to empower them to discover their unique leadership styles and navigate the complexities of healthcare leadership.
2. **Networking and Collaboration:** Fellows can connect with peers and leaders in the field, fostering a community of practice that encourages shared learning and innovation.
3. **Impact on Patient Care:** The fellowship aims to equip participants with the skills and confidence to lead change and improve patient care and health outcomes, aligning with the FNF's mission to develop future nursing and midwifery leaders.

2.2.1 Collaborative Response to High Consequence Infectious Diseases (HCIDs)

CTMUHB are addressing evolving community and public health challenges, particularly concerning high-consequence infectious diseases (HCIDs) such as the mpox virus and other communicable threats. In response, CTMUHB is developing

a cohesive and consistent approach to Infection Prevention and Control (IPC), public health, and health protection.

Key challenges and strategic responses include:

Infection Prevention and Control (IPC): Implementing consistent infection control measures across all healthcare settings. This includes rigorous hand hygiene, appropriate use of personal protective equipment (PPE), and ensuring safe care environments and equipment management to minimise the risk of HCID transmission.

Public Health Preparedness: Enhancing readiness to respond to HCIDs like the m.pox virus requires robust surveillance, diagnostic capabilities, and clinical management and communicable disease management plans. These efforts ensure adequate public health preparedness and response to emerging infectious disease threats.

HCIDs: Developing operational protocols to manage HCIDs, which pose significant risks to public health and healthcare systems. This includes establishing pathways for rapid identification, isolation, and treatment of cases and prophylaxis for contacts to prevent widespread transmission.

Intersectoral Collaboration: Engaging with various stakeholders to ensure a coordinated and effective response to infectious disease challenges. This collaboration is crucial for strengthening the health protection framework and enhancing the overall resilience of the healthcare system.

2.2.3 Present Challenges

CTMUHB is committed to strengthening its public health and infection control strategies, ensuring a robust response to current and future high-consequence infectious disease challenges through these efforts.

2.2.4 Legal and Risk

CTMUHB faces several challenges within its legal team, primarily due to staff sickness and the need to recruit for numerous vacancies. These staffing issues are compounded by a managed backlog of redress cases and claims, alongside the complexities involved in Learning from Events Reports (LFERs) and coronial matters such as inquests.

To address these challenges, CTMUHB is adopting a holistic approach supported by Organisational Development (OD) to evaluate the service as a whole, including its structure and job roles. This approach aims to improve efficiency and effectiveness within the legal team.

Through these efforts, CTMUHB is committed to strengthening its legal services, ensuring that they are robust, responsive, and capable of meeting the demands of the healthcare environment.

2.2.3 Working positively to influence a reduction in sickness absence

We seek to address the challenges of consistent sickness levels among nursing and healthcare support workers (HCSW) groups. Our strategic approach, informed by recent data, focuses on enhancing staff wellbeing and engagement through several key initiatives.

Recent data from the Nurse Sickness Absence Timeline highlights a noticeable trend in sickness rates, necessitating targeted interventions. Here, we want to outline the high-level priorities that guide our response.

Data-Driven Interventions

Data analytics can be used to identify trends and high-risk areas, allowing for targeted interventions and resource allocation. This approach ensures that efforts are focused where they are most needed. The Donabedian model can help evaluate the impact of these interventions by assessing changes in health status and reducing sickness absence.

Regular Monitoring and Feedback

Systems are in place to regularly monitor sickness absence data and provide feedback to care group managers. This ensures timely and effective management of absence issues. The timeliness of data reporting and qualitative feedback are crucial to this process, allowing for continuous improvement.

3.0 Conclusion

In conclusion, this period at CTM UHB has been marked by a blend of achievements and challenging endeavours. The successes achieved reflect our commitment to continuous improvement and excellence in healthcare, while the challenges identified necessitate strategic focus and dedicated efforts. The ongoing development of these initiatives is critical to the future growth and success of our healthcare services, ensuring that CTM UHB continues to be a leader in the healthcare sector.

Section 3.1 Medical Directorate-CTM UHB 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:

- Bowel Screening
- National Neonatal Audit

3.1.1 Achievements

Bowel Screening

We recently received a letter from Public Health Wales complimenting CTMUHB on the excellent service provided for patients requiring a bowel colonoscopy for suspected cancer. The letter reported a high-quality service and thanked the health board for the warm welcome shown to the Bowel Screening Wales team during their visit in June. Our thanks have been passed on to the teams who work extremely hard to deliver this.

National Neonatal Audit

The National Neonatal Audit Programme (NNAP) undertakes annual reporting to identify and highlight variation and enable local review of the causes of those variations to improve quality.

We recently received a report which identified Prince Charles Hospital as 'Outstanding' for the NNAP 2023 audit measure two year follow-up. PCH neonatal service has been identified as scoring 100% (National average result was 77%).

Our thanks are given to Dr Al-Muzaffar and his team in PCH.

3.1.2 Areas of Focus

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

- Stroke
- Rate Card and Non-engagement

Stroke

This has been raised across other committees and relevant forums. The stroke service provision continues to remain fragile due to vacant posts and an unexpected issue with locum cover. Patient safety remains our utmost priority and urgent discussions are in place with C&VUHB and mitigation plans are in place for 3 months until a longer-term plan is adopted to settle the service and provided the care which is required.

Rate Card and Non-engagement

Despite the compelling need to set a rate card to provide some much-needed tighter financial control in an escalating area, we have met some issues in one Care Group particularly. The impact is hopefully short-term however, it will affect patient waiting lists until it is resolved. We are monitoring this closely and ensuring patient care and safety are considered. We have a number of mitigating actions to manage this but this may entail a short-term impact.

Section 4.1 Allied Health Professions and Health Science - Executive Director of AHPs and Health Science

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

4.1.1 Successes

Operating Department Practitioners Creation of a Critical Events Trolley for Crises in Anaesthesia

Operating Department Practitioners at RGH have undertaken a project to create a trolley that consists of treatment and guidelines to the following incidents

- Severe Local Toxicity,
- Anaphylaxis,
- Malignant Hyperpyrexia,
- Bronchospasm.

The intention of creating a critical events trolley was to centralise and standardise the correct equipment and treatment algorithms necessary in these emergencies along with easy access to provide quick vital treatment.

The effectiveness of these trollies was assessed through a randomised staff questionnaire undertaken before and after implementation, where staff were asked the location of emergency drugs required in the event of local toxicity or malignant hyperpyrexia. The results showed an improvement in knowledge after the implementation of the critical events trolley with compliance improving and reaching 100% for the three tested drugs.

The critical events trolley has allowed a standardised approach to these emergency events, maximising patient safety. Governance and sustainability have also improved preventing over and under stocking. Critical Event Trollies are in place in RGH and PCH, with POW looking to implement too.

Redesign of Physiotherapy Respiratory On-Call Training

A recent redesign of physiotherapy respiratory on call training as been undertaken in recognition of concerns raised by staff around their ability to maintain respiratory competencies and how delays in completing respiratory rotations was negatively impacting on their upskilling and potential career progression.

Following a comprehensive benchmarking exercise of the current on call service, the training model was redesigned through full collaboration with physiotherapy staff. This redesign enabled staff to move from a model which required a 4-month respiratory rotation to a new model which negated formed delays through:

- Initial self-directed e learning
- 3 days in-person learning (2 in classroom, 1 in simulation suite)
- 5 mandatory sessions, on acute site, with respiratory team

- Agreement that first 2 shifts on rota to be shadowed with support from senior member of staff

Evaluation of the changes has shown confidence and competence improved significantly after training undertaken with the redesigned model. Most significant improvements were seen after three days of training with 66% of trainees (4/6) reporting that they would recommend the training to other new Band 5s. A further 17% of trainees reported they would recommend the programme after slight adjustment to the method of delivery as e-learning was found to be the least useful and there was a requirement to spread out the 3 day in-person learning to reduce the intensity of the sessions.

The above evidences a good example of benchmarking, collaboration, listening to staff feedback and changing how we deliver essential training with positive outcomes.

Change of Name

There has been agreement at National level that former Executive Directors/Assistant Director of Therapies and Health Science will now be known as Executive Directors/Assistant Directors of Allied Health Professions (AHPs) and Health Science. This is effective from 01 August 2024.

HCS Advanced Study

Several HCS staff have received HEIW funding for postgraduate studies. These opportunities benefit CTM through increased retention of staff and improved quality of patient care through advanced clinical practice.

AHP Staff Advancement
AHP staff continue to develop both in and out of service with:

- Two physiotherapists undertaking the Advanced Clinical Practice roles for the new HB fracture liaison service
- A Physiotherapist has been offered the position of Independent Member Trade Union Role

Both of these demonstrate the importance of AHP roles within the HB.

Staff Survey

There has been excellent engagement from AHPs on the staff survey feedback with our AHP Wellbeing lead working with the People team to facilitate focus groups/feedback sessions to contribute to CTM Wellbeing Action Plan.

4.1.2 Areas of Challenge/Risk

AHPs are awaiting a decision on a proposed Speech and Language Therapy and Podiatry clinical administration teams relocation from Pontypridd Cottage Hospital.

AHPs have put forward several options to facilitate the move cognisant that any deviation from the planned joint move will impact on the ability to maximise the shared use of this resource.

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 Promotion Strategic Plan
- Internal Audit
- Longer Term funding for Health Promotion in CTM UHB
- Assurance
- Measles Preparedness
- Mpox Preparedness
- Continuing Risks-pertussis, winter program delivery
- Fluenz delivery

5.1.1 Health Protection Strategic Plan

The CTM Health Protection Strategic Plan has been developed through a collaborative process with all partners across the system with two multi-agency workshops in June and August 2024 to determine the local objectives and local action plan. The Strategic Plan and the Year 1 Action Plan were agreed by the CTM Health Protection Board on 16th August.

5.1.2 Internal *A*udit

An internal audit of health protection, vaccination and immunisation will be occurring in September 2024. This will identify any current key gaps in governance, assurance, implementation and equity. It will focus on 3 key programmes: MMR, Hepatitis B and Pertussis and will focus on risks around increased levels of avoidable disease within communities, inequalities and risks of staff absence impacting delivery of services and increasing risks to patients. An update on the findings of this audit and resulting action plans will be brought to the relevant committees in 3Q 2024.

5.1.3 Longer term funding for Health Protection in CTM

Currently CTMUHB has been awarded the lowest allocation per head in Wales for health protection (£13.65 per head compared to an average of £17.57 per head), despite likely higher need due to deprivation and population demographics. This is a difference of approximately £1.74m annually.

5.1.4 Assurance

A Task and Finish Group has been established to address rapidly any preparedness gaps for communicable disease response and will report back to ELG and the Health Protection Board. Mitigation of longer-term sustainability and effectiveness risks are being delivered through the Year 1 action plan of the Health Protection Strategic Plan and will be delivered through a system operational group and assurance given through the Health Protection Board.

5.1.5 Measles Preparedness

National and International Measles risk remains similar. In Wales the outbreak in Gwent has been declared closed and there are no confirmed cases in Wales currently. Rates in England have reduced slightly since the peaks in April and May1. There remains the possibility of sporadic introductions especially post travel over the summer holidays.

5.1.6 Vaccination prevention in Cwm Taf Morgannwg is excellent in young children (up to age 2 years) with 95.6% vaccination rates for MMR dose 1 (up to quarter 1 2024), which is higher than all other Health Boards in Wales. This is also true for children reaching their 16th birthday, with 96.4% MMR 1 vaccination rate. MMR 2 rates are better for CTM than Wales total with rates at 91.2% and 93.7% for residents at their 5th and 16th birthdays, respectively[2]. However, there are variations across CTM, with rates about 10% lower in more deprived areas and lower in some vulnerable groups. There is ongoing outreach work to address these gaps.

5.1.7 Measles preparedness in Cwm Taf Morgannwg Health Board

Currently gaps still remain to ensure that services are prepared to respond to a measles case and surge requirements. A recent desktop exercise highlighted further work is needed around CTMUHB staffing resilience to a measles outbreak. There are considerable outreach efforts being made to establish the full vaccination record of staff and to address any gaps. Staff contacts with unknown vaccination status would require 21-day isolation considerably impacting service delivery.

5.1.8 Mpox Preparedness

Given the request of the CMO, work is ongoing to ensure mpox preparedness in CTMUHB and wider system. The emergence of Clade 1 has the potential to impact different vulnerable groups to Clade II, including children. A review of CTMUHB preparedness has identified some areas for improvement including healthcare identification and appropriate use of the HCID and non-HCID pathways

[1]UKHSA Measles data dashboard ukhsa-dashboard.data.gov.uk/topics/measles
[2] Public Health Wales (May 2024). COVER report: Vaccine uptake in Children in Wales, January to March 2024. Accessed: https://phw.nhs.wales/topics/immunisation-and-vaccines/cover-national-childhood-immunisation-uptake-data/cover-archive-folder/quarterly-reports/cover-150-january-to-march-2024/

respectively, a single and well socialised protocol for High Consequence Infectious Disease protocol in the acute settings, a lack of out of hours procedures and preparedness for rapid post-exposure vaccination of children and adults and a need for clear communications for staff. A Task and Finish Group has been established to address these gaps.

5.1.6 Continuing risks – pertussis, winter program delivery

Pertussis continues to pose a risk to very young babies and there have been local cases this year requiring admission to intensive care. Most babies under two months who acquire pertussis will need hospital admission. There were 228 pertussis notifications in people of all ages in 2023/24 in CTMUHB compared with 14 the year before. Most women (92%) are offered the vaccine in CTMUHB during pregnancy with 71% accepting it. This is in line with the Wales average of 71.3%. Health care workers working with pregnant women and babies under 3 months who have not been given a pertussis vaccine in the preceding five years should also be offered a vaccine according to national guidance and this is offered by the Occupational Health team.

5.1.7 Fluenz delivery

Fluenz delivery in school-based nursery settings is creating capacity issues and a long-term sustainable model is required. CTM's approach to vaccinate in these settings has had a considerable impact on vaccine uptake[3] and is held up as gold standard by Vaccine Programme Wales.

6. Specific Matters for Consideration

Matters for consideration are detailed in the sections above.

7. Key Risks / Matters for Escalation

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 Director.

[3] Published evaluation of school based nursery setting pilot A pilot intervention to improve uptake and equality of childhood influenza vaccination in an area of Wales, through the introduction of a mixed delivery model including nursery school immunisation sessions - PubMed (nih.gov)

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 Clinical Executive Directors report.

10. Next Steps

10.1 Members of the Quality and Safety Committee will continue to receive progress updates, 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 in attendance at the meeting.

Agenda Item
5.2a

Quality & Safety Committee

Highlight Report from the Children & Families Care Group

Dyddiad y Cyfarfod / Date of Meeting	18/09/2024
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	
ANC	Antenatal Clinic
C&V	Cardiff and Vale University Health Board
CNS	Clinical Nurse Specialist
COO	Chief Operating Officer
CYP	Children and Young People

DATIX	Incident Report Management System
DHCW	Digital Health and Care Wales
DMC	Digital Maternity Cymru
IPAAF	Integrated Performance, Assurance and Assessment Framework
ISH	Integrated Sexual Health
MMR	Measles, Mumps, Rubella
PoW	Princess of Wales
QSE	Quality, Safety & Experience
RCM	Royal College of Midwives
RCN	Royal College of Nursing
SLA	Service Level Agreement
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 8th August 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 and Experience Meeting (QSE) will:

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

3. Highlight Report

Alert / Escalate	• **Princess of Wales Maternity and Neonatal temporary unit closure.** Project meetings continue weekly with key stakeholders. Closure now scheduled for phase down week commencing 2nd September, fully vacate by 6th September to hand areas over to contractors. Paediatric outpatient move at Prince Charles Hospital completed to enable plan to increase capacity. Staff engagement, briefings and wellbeing support continues. • **Unite Health Visiting Industrial Action** Industrial action (action short of strike) has been ongoing since February 2024. Positive conversations regularly held with Unite colleagues. Part one of the dispute (Job Description) locally resolved. Improvement plan in place, inaugural meeting of Care Group Improvement and Oversight Board 10th September 2024.

Advise	• Infant Feeding strategy with being designed by medical illustration team. Delivery plan and outcome measures in development to support implementation. • School Entry Hearing Service (SEHS). Cwm Taf Morgannwg (CTM) remain in breach of their responsibility to implement direction from Welsh Government (WG) to handover the governance arrangements of the programme to audiology services. Paper outlining requirements to rectify this is with the Chief Operating Officer for further conversation. • Aneurin Bevan University Health Board (ABUHB) have implemented the digital maternity information system 'Badgernet' and removal of paper records. This is causing clinical concern for women and birthing people choosing to transfer maternity care to CTM. Incident capture via DATIX, Early Warning Notification submitted to Welsh Government on 19th August 2024. Digital Health Care Wales (DCHW) and Digital Maternity Cymru (DMC) aware of concerns. • Meetings held with Cardiff and Vale (C&V) colleagues regarding endometriosis service due to concerns with referrals (acceptance and treatment). 12 patients awaiting treatment update from Cardiff. Agreement from C&V Chief Operating Officer (COO) that they will accept tertiary referrals. • Special school nursing – There are currently some workforce vacancies and sickness absence (long term). Service Level Agreements (SLA) SLA have expired with Local Authorities. Children and Young People Services are leading on a work programme with Local Authority colleagues and exploring models of delivery and gaps in service provision. • Annual maternity record keeping audit presented at Care Group QSE in August. Wider learning shared via SWAG, Governance and Audit.
Assure	• Maternity Stats Wales 2023 report published 20th July 2023. Self-Assessment benchmarking exercise completed (Appendix 1). Maternity and birth statistics: 2023 [HTML] | GOV.WALES • Ysbyty Cwm Cynon (YCC) Service moved 15/04/24 including Antenatal Clinic (ANC), Urogynaecology and Integrated Sexual Health (ISH) services. Still some issues that are now causing disruption, patient concerns and safety issues which are being captured via Datix. Care group, site and service meeting held at YCC on 15th August with potential solution sought.

	• Health Inspectorate Wales (HIW) letter received 25th July 2024 confirming assurance that all improvements following the unannounced inspection of Tirion Birth Centre in October 2023 (published January 2024) are complete. • Childhood immunisation data for CTM performing well when compared to Wales average. An area of notable improvement is Measles Mumps Rubella vaccination uptake (MMR) by 16 years now at 93%. • National Neonatal Audit Programme (NNAP) letter received 9th July 2024. Identifies PCH neonatal unit as a positive outlier for the measure 'two year follow up' (100% vs national average 77%). • Maternity and Neonatal Safety Board held 12th September 2024. **Risk Register** There are currently four risks risk scoring 'high' with 15 or more.

Risk ID	Description	Score
5755	POW Air Handling Unit and Electrical Infrastructure, LW/NNU	20
5763	Lack of special school nurses – unfulfilled SLA	16
5712	Industrial action – 67 HV SCPHN members of Unite Union	15
2808	Waiting times for performance - Neurodevelopmental team	15

Inform	• Integrated Performance, Assessment and Assurance Framework (IPAAF) for Maternity and Neonatal Services deferred until November due to temporary closure planning of PoW Maternity and Neonatal Units. • 2 Midwives shortlisted for Royal College of Nursing (RCN) Wales Nurse of the Year Awards in November. • 1 Maternity Support Worker (MSW) shortlisted for national Royal College of Midwives award in October. • A student health visitor awarded the Dora Roylance Queens Nursing Institute award for excellence in studentship and health visitor practice.

	• Child Poverty Grant application the Infant Feeding Team (joint with Public Health Wales and Aneurin Bevan University Health Board) awarded. This will support bilingual promotion of information, volunteer recruitment and training. • Work commenced with support of the Strategy group to develop a Children and Young People (CYP) strategy. • Bereavement room opened at Prince Charles Hospital (PCH) paediatric ward, kindly sponsored by the charity 'To Wish'.
Appendices	• Appendix 1 - Maternity Stats 2023.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below: • Creating Health • Inspiring People • Sustaining our Future
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Starting Well
	If more than one applies please list below: • Growing Well
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 or guideline
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please include rationale below: Not a policy or guideline
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

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

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

CTM Maternity Metrics:

A review in comparison to Welsh Government (WG) Maternity and Birth Statistics 2023

Maternity and birth statistics: 2023 | GOV.WALES (published July 31st 2024)

August 2024

NB. Unless otherwise stated, time series charts show data from August 2021- July 2024

Background and Purpose

The purpose of the WG release is to provide a statistical overview of maternity and births in Wales including analyses of mothers' characteristics.

The release focusses on statistics for births using data sourced from Maternity Indicators dataset (MIDS) and the National Community Child Health Database (NCCHD).

CTMUHB data in this presentation are sourced from QlikSense and the Maternity data which utilises data input into MITS (former CT) and WPAS (Bridgend). This does not always align with WG data.

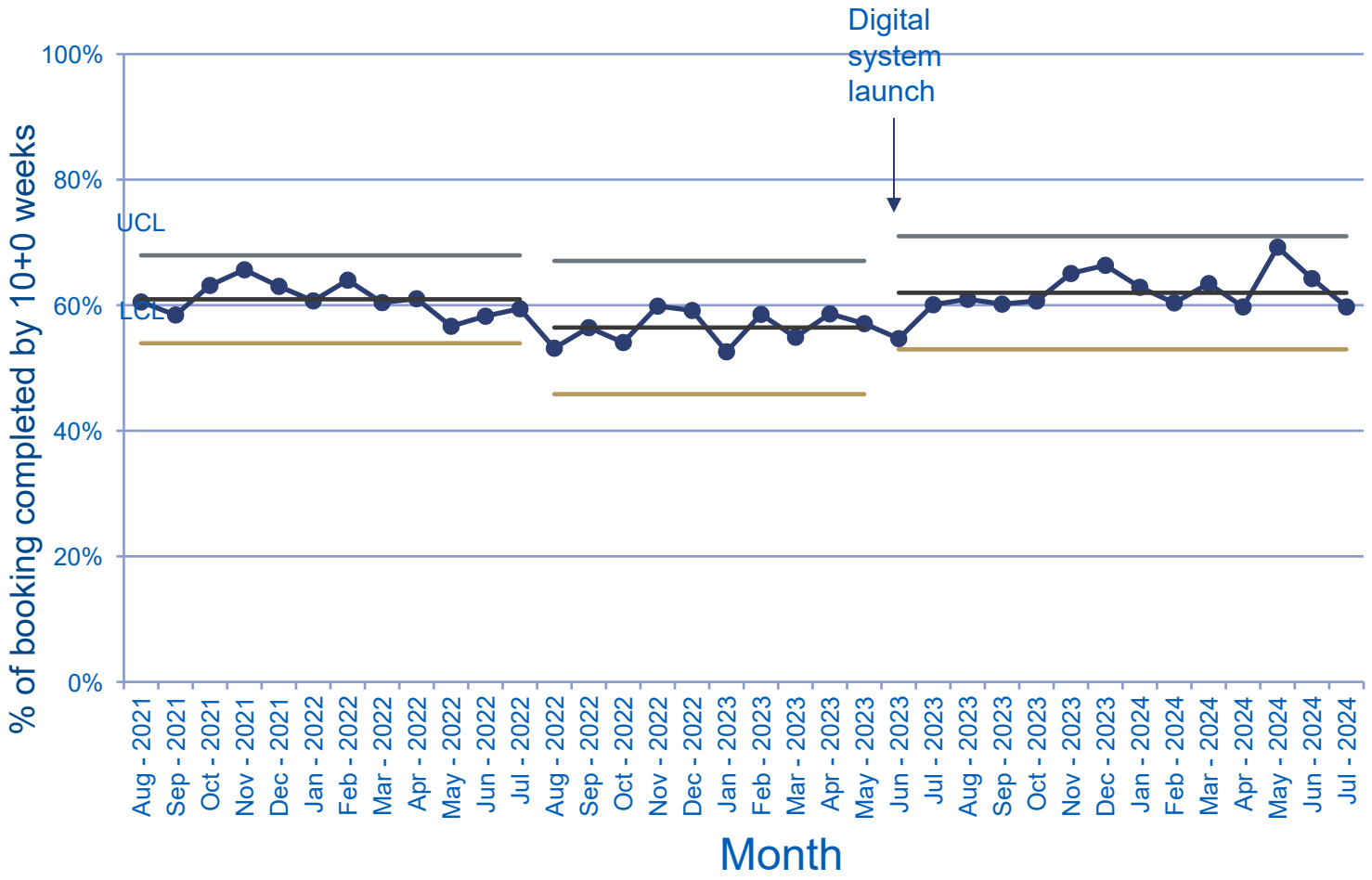
Aligning clinical and coding data is an ongoing project.

NB. Breastfeeding statistics are published in a separate annual release, which was published on 31 July 2024.

Section One: Antenatal Care

- Initial assessments by gestational age
- Mental health
- Obesity
- Smoking at initial assessment
- Smoking at time of birth

Initial Assessment by 10 Completed weeks gestation



CTM 2023

The median rate in 2023 was 59.4%.

Since the launch of the digital maternity services self referral system in August 2023, median compliance increased from 56% to 61%.

77% of appointments took place before 12 weeks gestation.

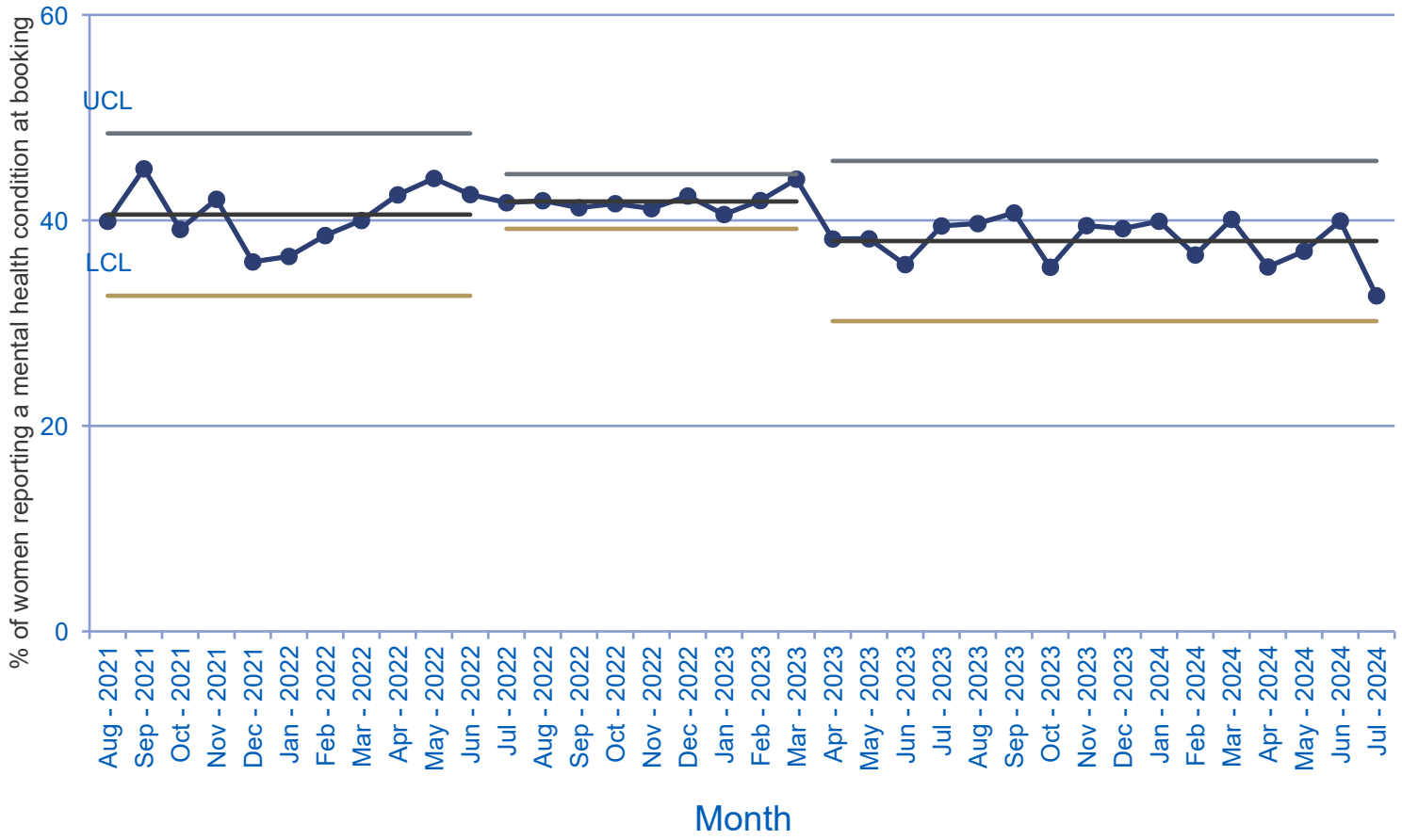
NB. The WG reported CTM rate of initial assessment by 10 weeks was 73%
(appears to not be working to same definition)

WG Maternity Statistics 2023

77% of women in Wales had their initial assessment appointment by 10 completed weeks gestation (unchanged from 2022).

86% of appointments took place before 12 weeks gestation.

Mental Health Condition at Booking



CTM 2023

The median rate of women reporting a mental health condition at booking in 2023 was 41%.

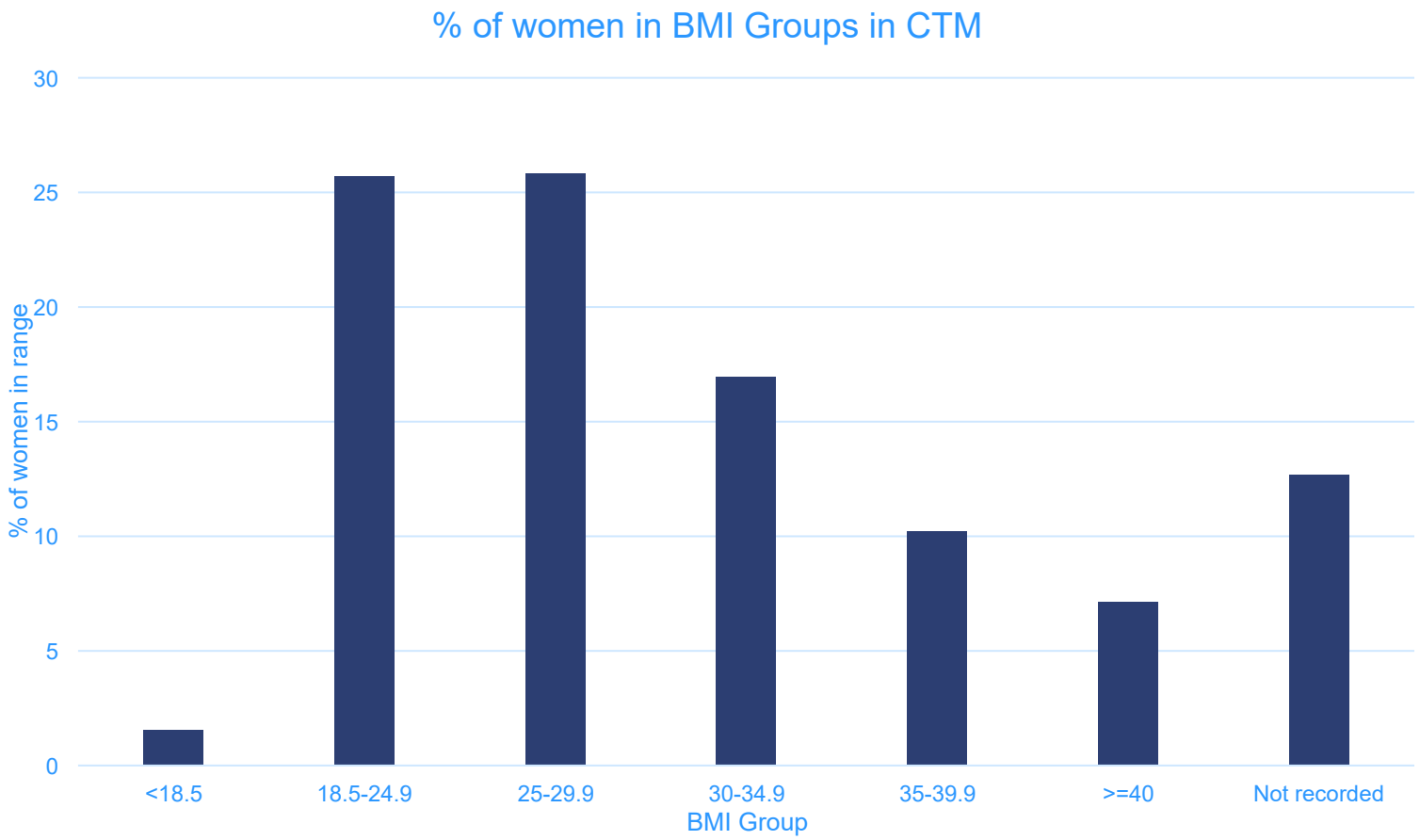
The median decreased significantly in April 2023 from 44% to 37%

WG Maternity Statistics 2023

In Wales, 32% of pregnant women reported a mental health condition at their initial assessment in 2023. This is an increase of 1.4 percentage points from the previous year, and an increase of 12.2 percentage points from 2016. The percentage of women ranged from 25% to 40%. CTM data were not included.

WG stats break this down by ethnic group but acknowledge much of the data is not valid.

Obesity: BMI at Initial Assessment



CTM 2023

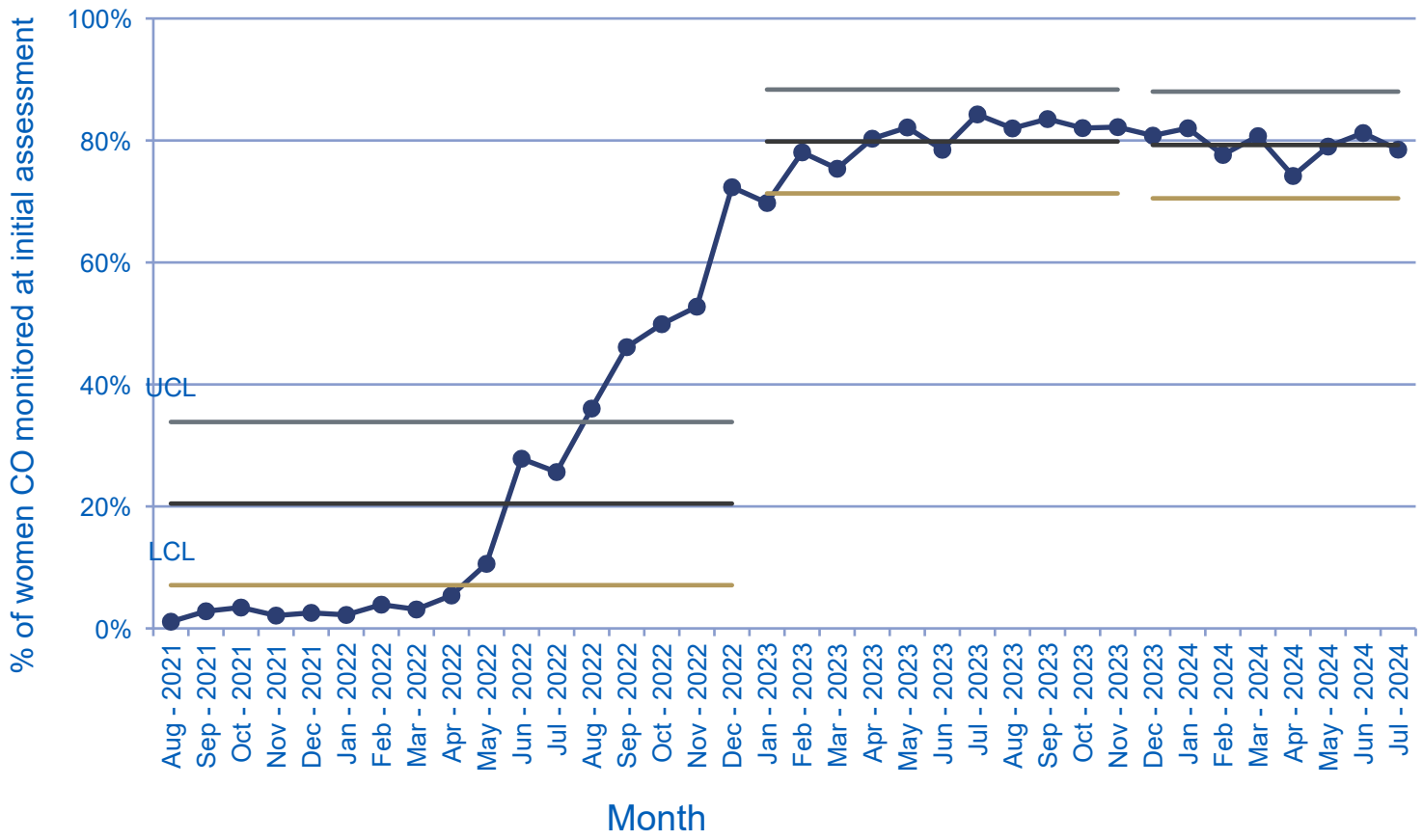
34.2% of women booking for maternity care at CTM had a BMI of 30 or over at their initial booking appointment. This is a slight decrease from 2022 (36.7%)

WG Maternity Statistics 2023

In 2023, 32% of pregnant women had a BMI of 30 or greater at their initial assessment, an increase of 0.8 percentage points from the previous year.

The percentage was 5.8 percentage points higher in 2023 than in 2016.
There was minimal variation across ethnic groups.

CO Monitoring at Initial Assessment



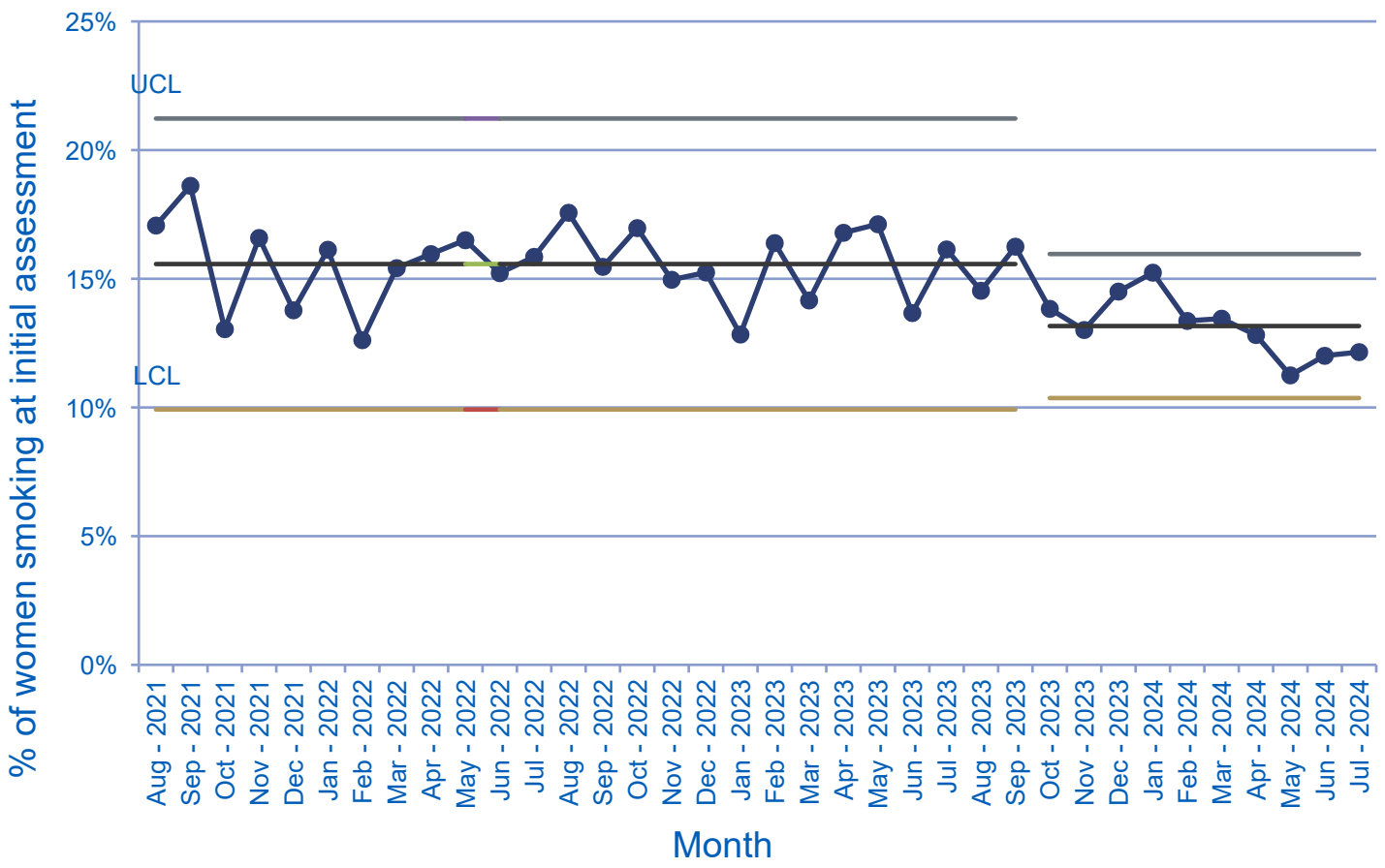
CTM 2023

The median compliance with CO monitoring at the initial assessment appointment was **80%.** This compares extremely favourably to the All Wales data.

WG Maternity Statistics 2023

CO monitoring has been largely suspended since the COVID-19 pandemic. CO Monitoring resumed in 2023 and the percentage of women CO monitored at initial assessment rose to **17%.**

Smoking at Initial Assessment



CTM 2023

14.5% of women in CTM were smoking at the time of initial assessment.

As of October 2023, the median rate of women smoking at the time of initial assessment decreased from 15.5% to 13%

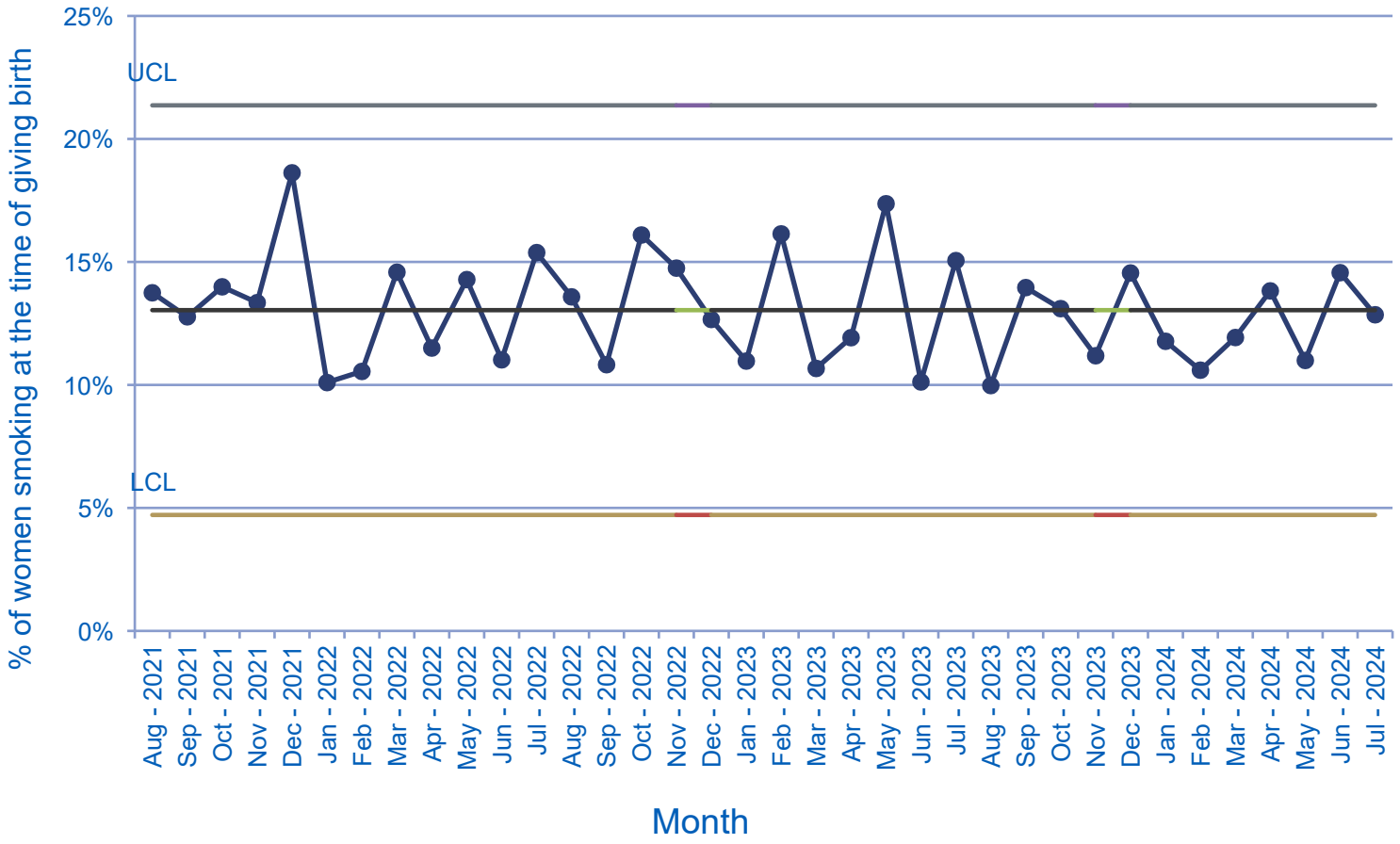
Vaping is now captured via the digital self referral system, but is not recorded in maternity datasets.

WG Maternity Statistics 2023

In 2023, 14% of pregnant women were recorded as smokers at their initial assessment (similar to the previous 2 years). The decreases in smoking rates at initial assessment since 2020 coincide with nearly all data being self-reported, rather than being CO monitored.

CTM data is largely CO validated and likely to be of high quality.

Smoking at the Time of Giving Birth



CTM 2023

12.7% of women were reported as smoking at the time of birth

WG Maternity Statistics 2023

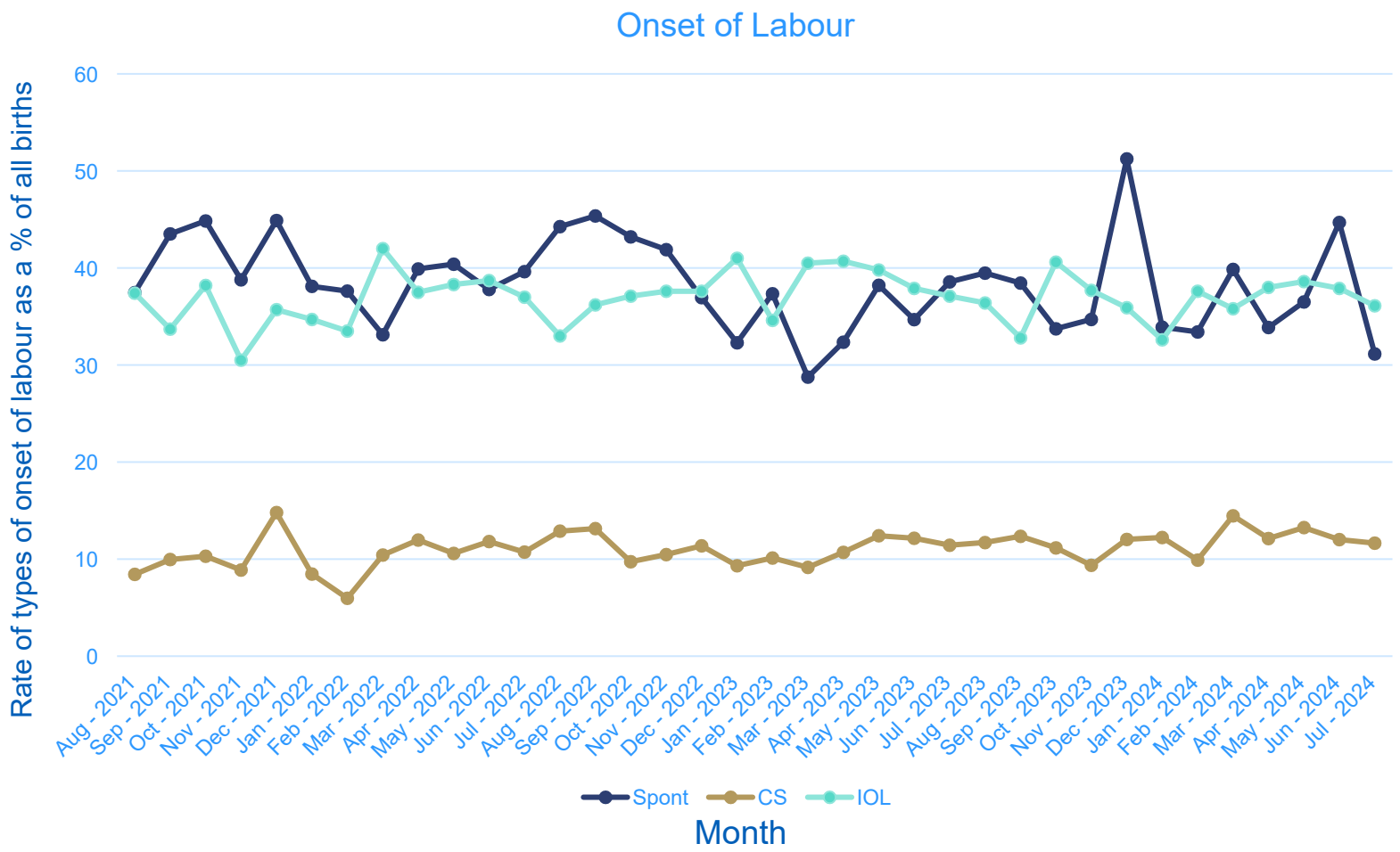
11.7% of women were reported as smoking at the time of giving birth. Smoking rates at birth have fallen over the last 5 years in all age groups.

NB. Vaping is not reliable captured and reported.

Section Two: Birth Characteristics

- Onset of labour
- Pain relief
- Mode of birth
- Home births

Onset of Labour



CTM 2023

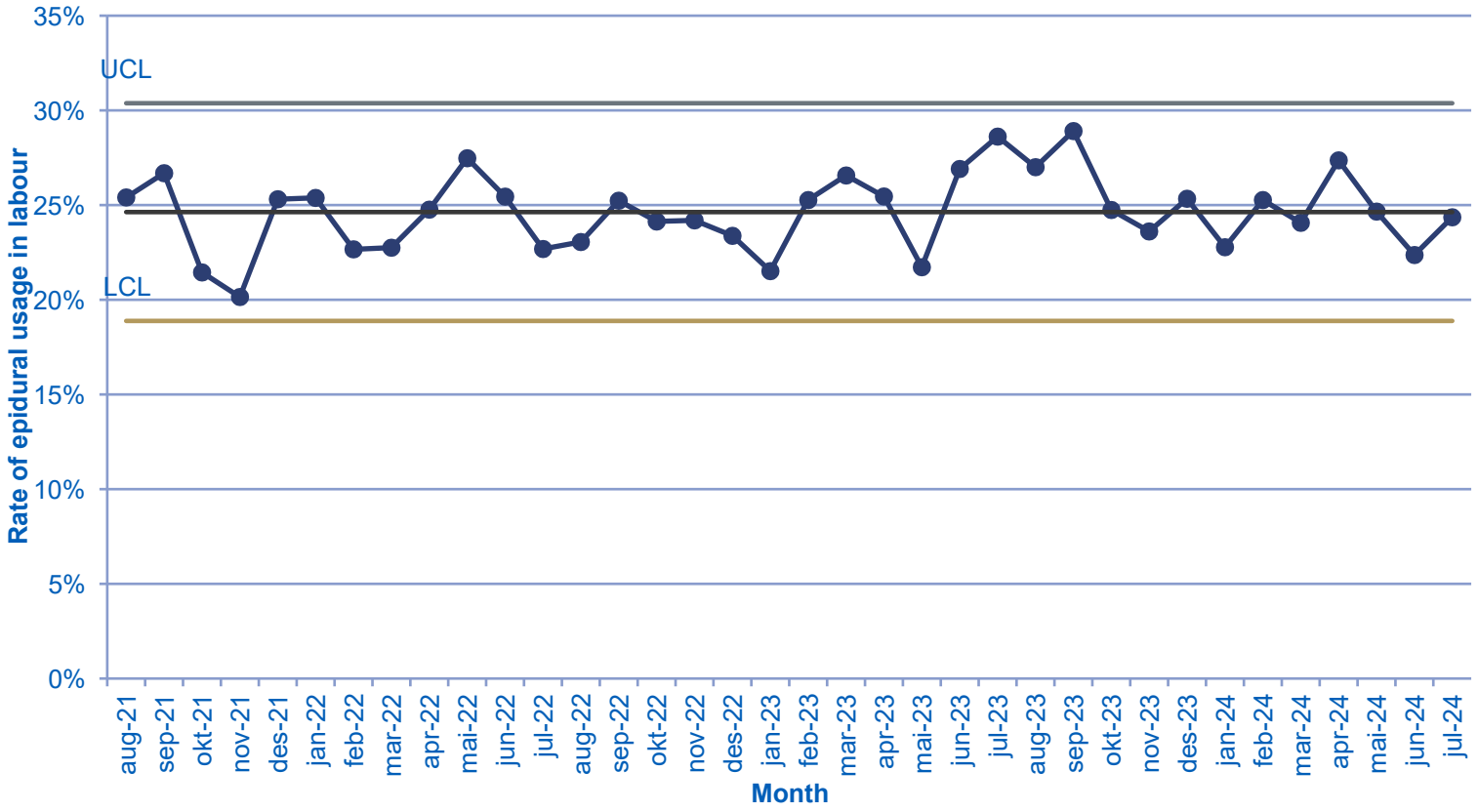
- 37% of labours had a spontaneous onset
- 38% of labours were induced
- 11% of labours had no onset (planned CS)

NB. The remainder of data were not stated

WG Maternity Statistics 2023

In 2023, 45% of labours began spontaneously. This is 8.6 percentage points lower than in 2016. 35% of labours were onset by induction, 4.0 percentage points higher than in 2016; and 20% were onset through caesarean section, 4.6 percentage points higher than in 2016.

Pain Relief: Epidural in labour



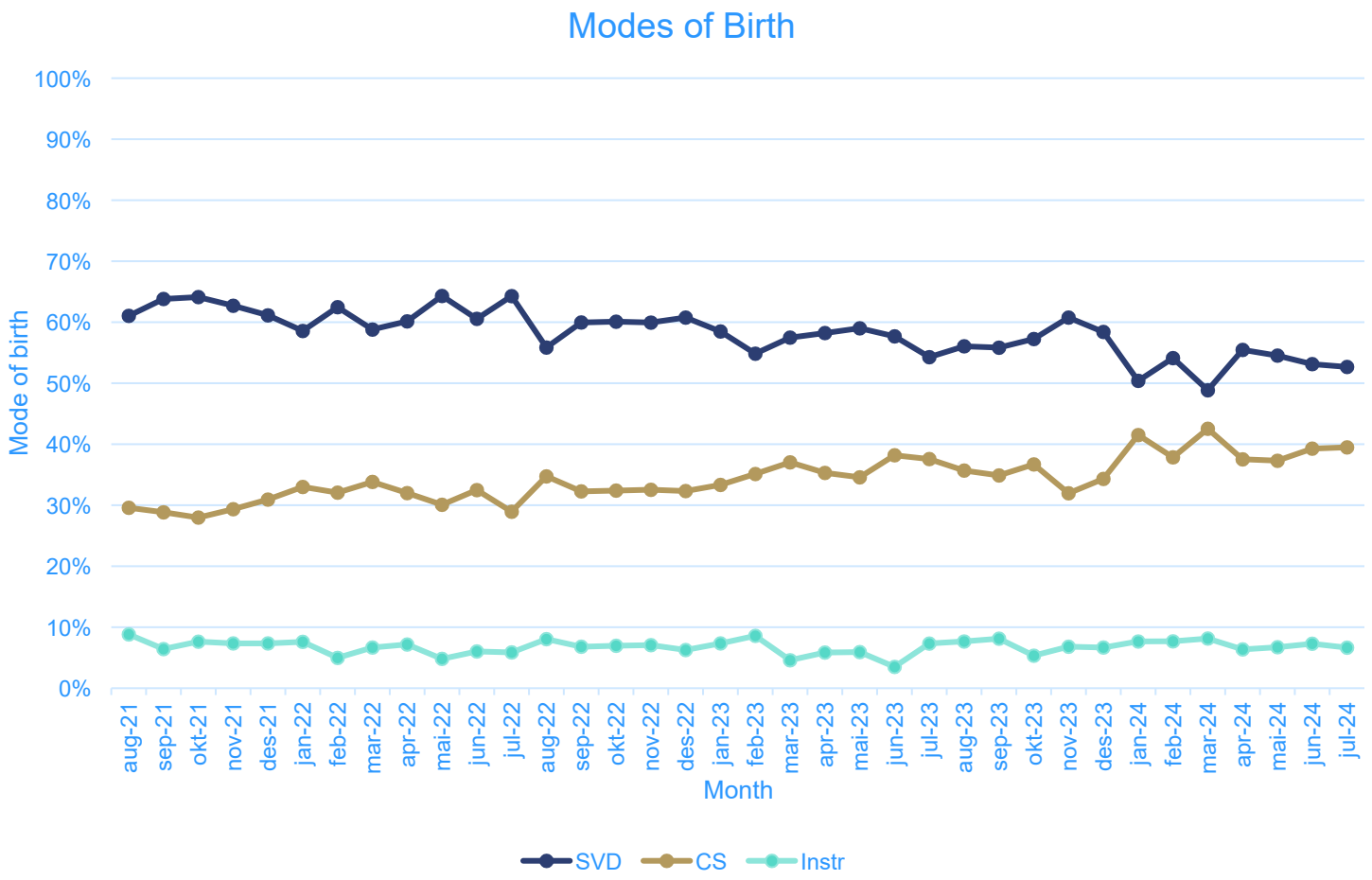
CTM 2023

25% of women had an epidural for labour. There has been no significant increase since 2022.

WG Maternity Statistics 2023

In 2023, an epidural was administered in 26% of births. This is 1.3 percentage points higher than the previous year, and 2.9 percentage points higher than in 2016.

Rate of Modes of Birth (Spontaneous, Instrumental and Caesarean Section)



CTM in 2023

57.5% of births were spontaneous

35.9% of births were by caesarean section

6.6% of babies were born with instrumental assistance

The trend of rising intervention is being seen across Wales.

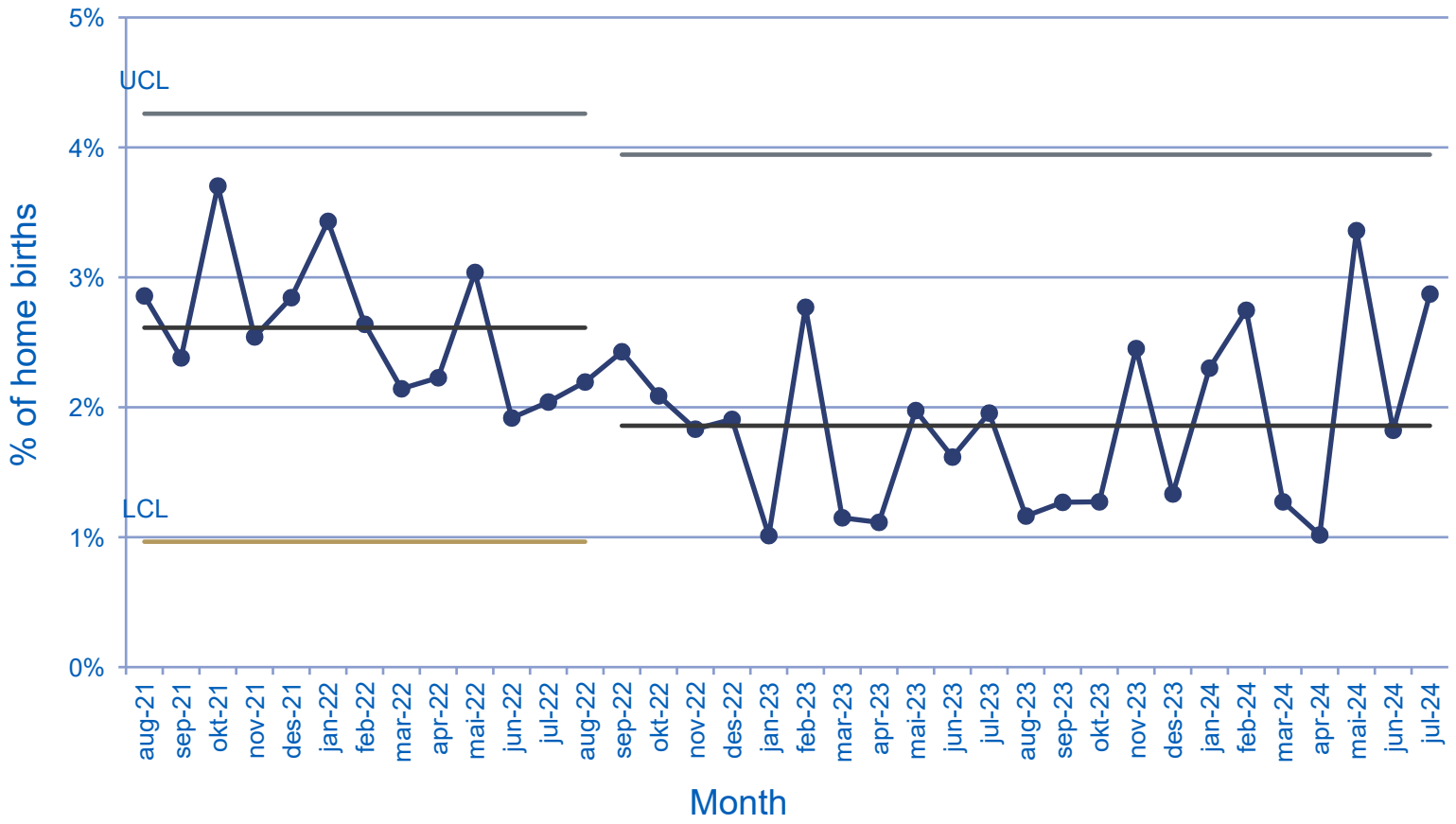
WG Maternity Statistics 2023

In 2023 54% of births were spontaneous vaginal births, 9.0 percentage points lower than in 2016.

37% were born by caesarean section, this highest on record, 10.7 percentage points higher than in 2016.

9% of births required the use of either ventouse or forceps, this has remained largely constant in every year since 2016.

Home Births



CTM 2023

1.6% of babies were born at home in 2023. Similarly to the rest of Wales, this is the lowest rate of all time.

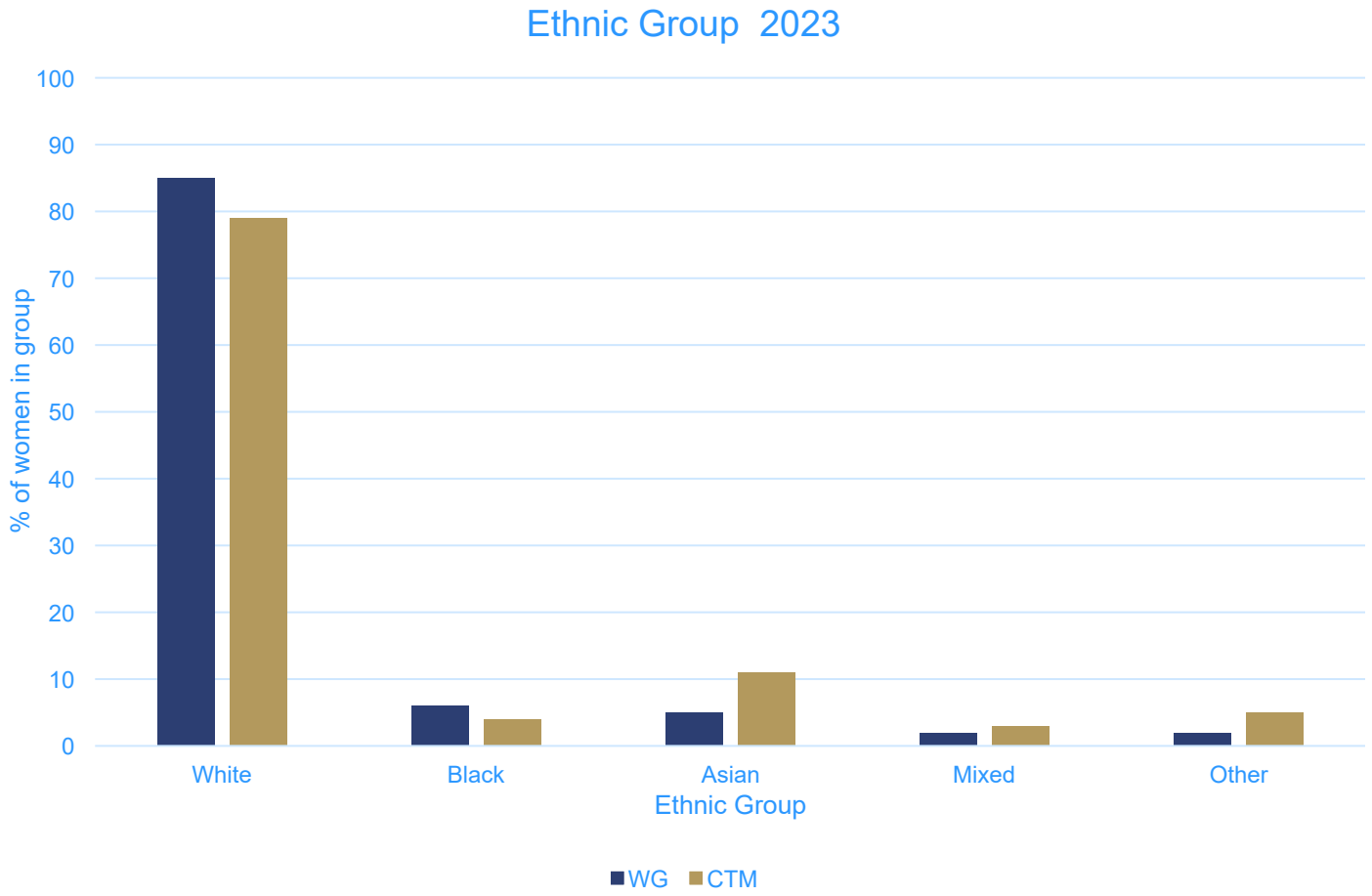
WG Maternity Statistics 2023

The home birth rate has been on a slight downward trend over the long term and in 2023, just under 2% of live births happened at home, the lowest rate ever.

Section Three: Birth Outcomes and Characteristics

- Ethnicity
- Age profile of mothers
- Gestational age
- Birth weight
- APGARs

Ethnicity



CTM 2023

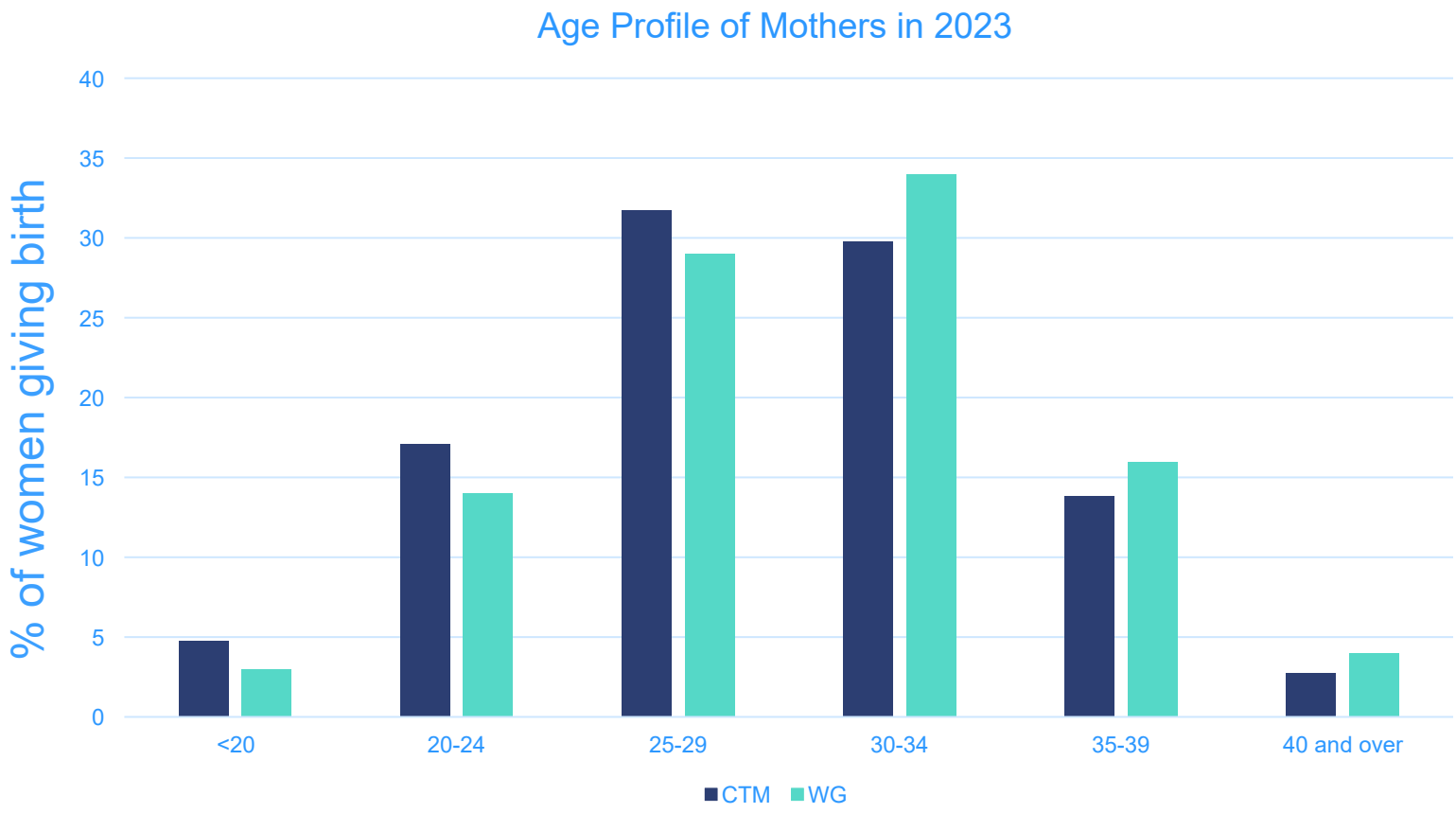
79% of babies born were of a white ethnic background; 4% were black; 11% were Asian; 3% were form mixed background and 5% from other ethnicities. Data completion was 56%.

WG Maternity Statistics 2023

In 2023, there were 9,975 records (36.3%) which had missing or invalid data for this data item.

85% of babies born in 2023 were of White ethnic background; 6% were of Black backgrounds; 5% were of Asian backgrounds; 2% were from Mixed/multiple backgrounds and 2% were from other ethnicities.

Age Profile of Mothers



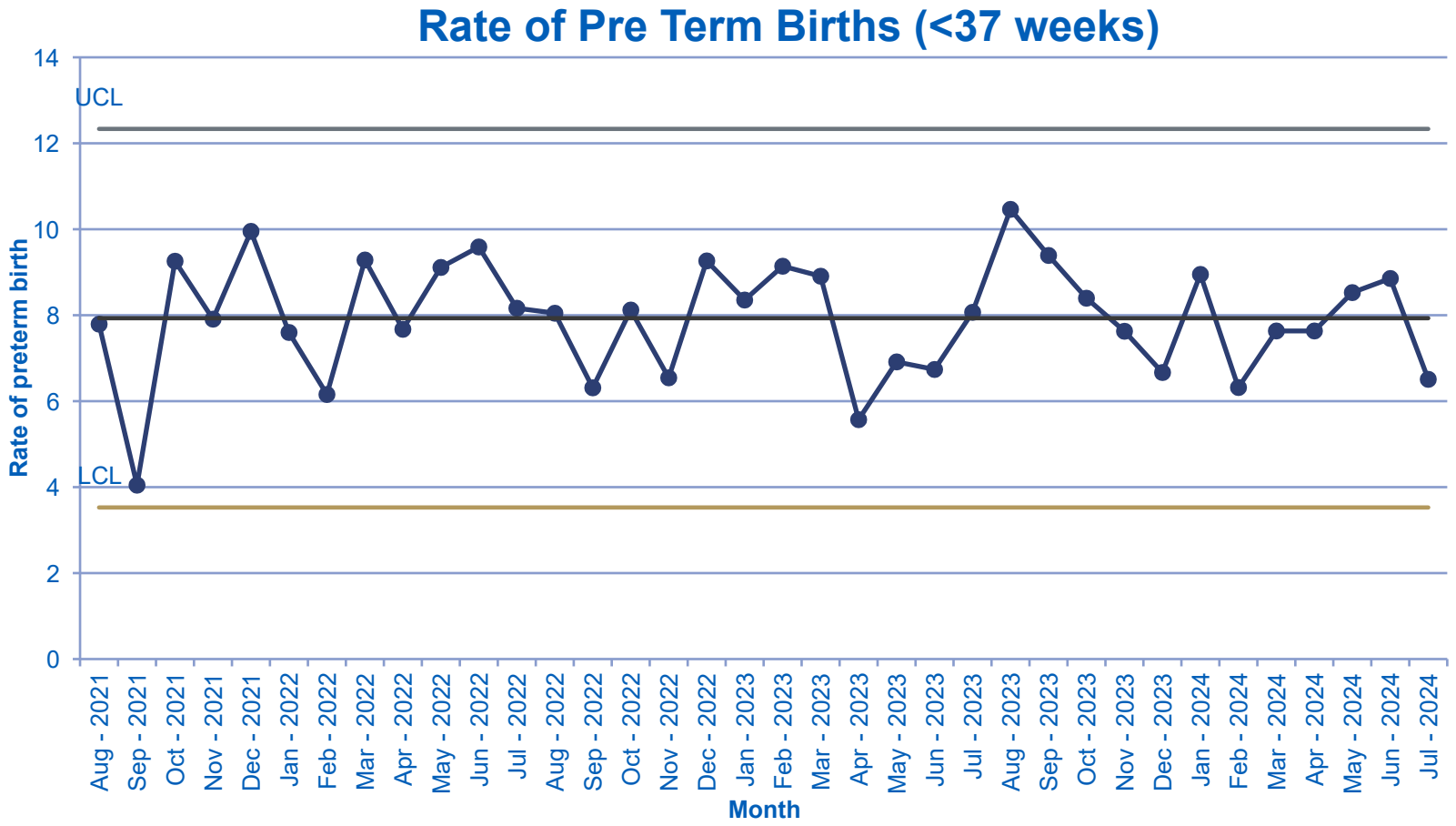
CTM 2023

CTM have proportionately more women in the under 20 to 29 years age categories than All Wales. There was little change from 2022.

WG Maternity Statistics 2023

Since 2021, there have been more mothers birthing aged 35 to 39 than there were aged 20 to 24. In 2023, 14% of births were from mothers aged 20 to 24 and this number has fallen every year since 2009.

Gestational Age



CTM 2023

59% of births occurred between gestations of 38 and 40 completed weeks of pregnancy

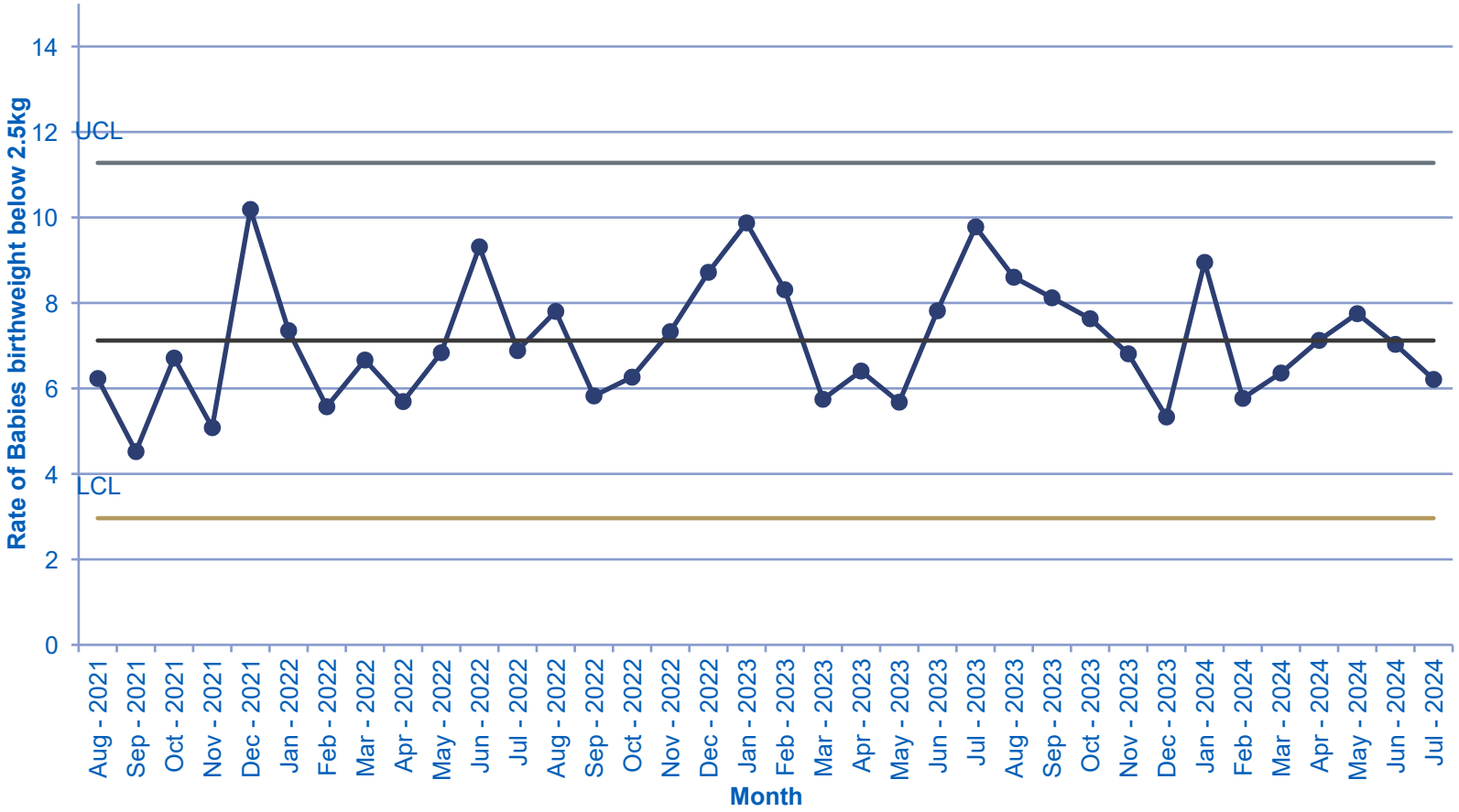
7.7% of live births occurred before the start of the 37th week of pregnancy.

WG Maternity Statistics 2023

67% of live births arrived between gestations of 38 and 40 completed weeks of pregnancy.

8% of live births occurred before the start of the 37th week of gestation

Low Birthweight (<2500g)



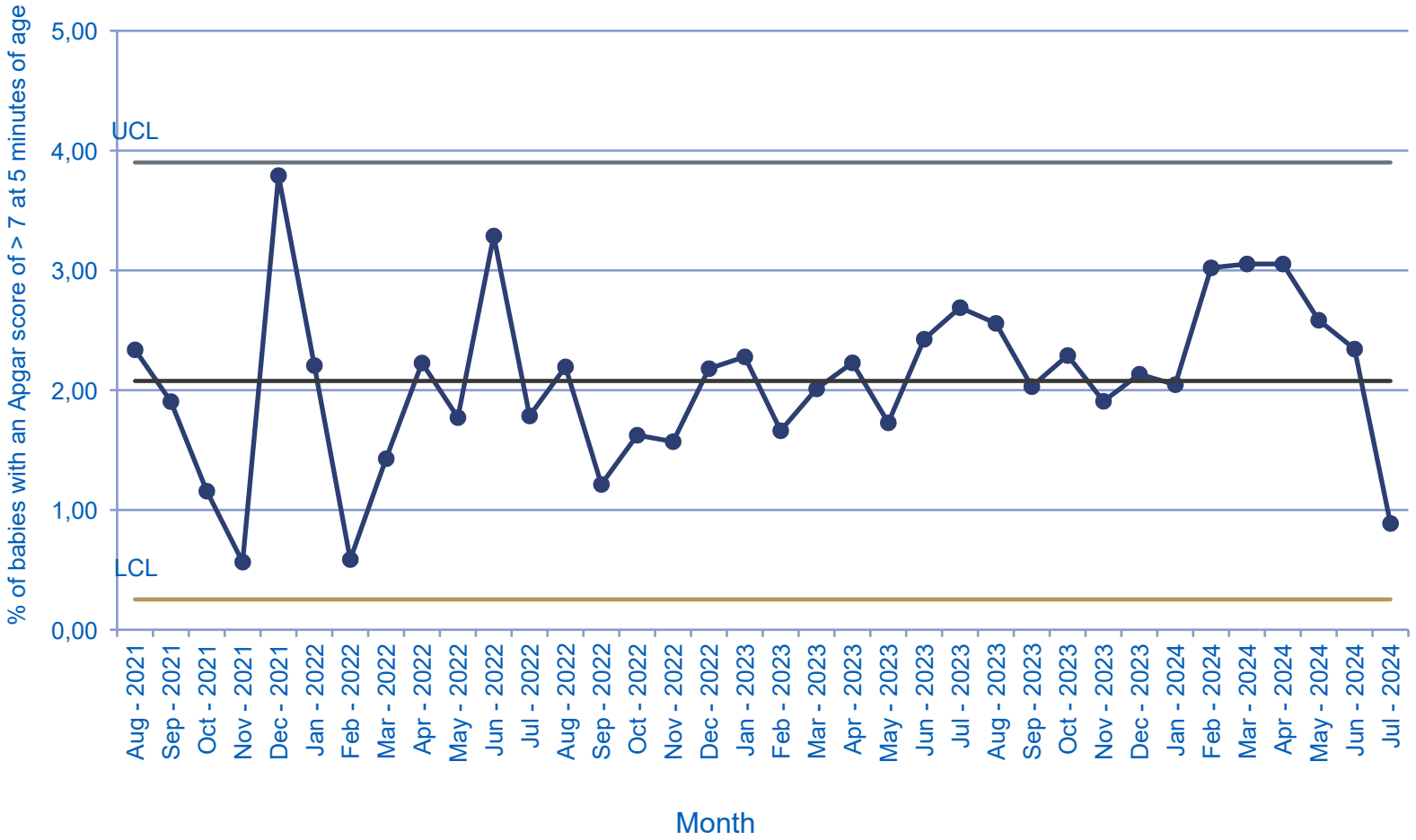
CTM 2023

7.5% of all births had low birth weight. The rate of babies with a birthweight below 2500g has remained stable over the past 3 years.

WG Maternity Statistics 2023

In 2023, 7% of all births had low birthweight, and is the highest on record.

Apgar of > 7 at 5 Minutes 2023



CTM 2023

2.1% of babies born in 2023 had an APGAR of less than 7 at 5 minutes of age.

WG Maternity Statistics 2023

In 2023, the large majority (98%) of live births had an APGAR score of 7 or over at 5 minutes, including 78% of babies who had a score of 10.

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

Summary of CTM Data in Comparison with WG Stats (2023)

Measure	CTM	WG Stats
Rate of bookings undertaken by 10 completed weeks	59.4%	77%
Overall CS Rate (all categories)	35.9%	37%
IOL Rate	38%	35%
Instrumental birth rate	6.6%	9%
SVD Rate	57.5%	54%
Home births	1.6%	2%
Median rate of women CO monitored at the start of pregnancy	80%	17%
Smoking at start of pregnancy	14.5%	14%
Smoking at end of pregnancy	12.7%	11.7%
Percentage of term singleton babies born with a birthweight <2500g	7.5%	7%
BMI ≥ 30 at booking	34.2%	32%
Rate of babies with an APGAR score of 7 or over at 5 minutes	97.9%	98%
Women reporting a mental health condition at booking	41%	32%
Epidural for pain relief	25%	26%

In Summary

The data quality is variable for All Wales data, and the CTM data did not always align with locally held data. This is due to data sources used. This is an issue that has been acknowledged locally and is being addressed.

Although there are some differences, for much of the data, broadly speaking CTM is in line with the rest of Wales. There are a few notable exceptions:

- CTM is performing significantly better than the rest of Wales for CO monitoring compliance at initial assessment (80% v 17%)
- There are around 25% fewer instrumental births in CTM compared to All Wales
- The rate of women reporting a mental health condition at booking is significantly higher in CTM than All Wales (41% v 32%)
- There were 20% fewer homebirths in CTM than All Wales
- Although the rate of booking by 10 completed weeks appears low, this is due to differing data definitions

The data provides some assurance to CTM Maternity services.

Agenda Item
5.2b

Quality & Safety Committee

Highlight Report from the Primary Care and Communities Care Group

Dyddiad y Cyfarfod / Date of Meeting	18/09/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Lucie Williams, Nurse Director for Primary Care and Communities
Cyflwynydd yr Adroddiad / Report Presenter	Lucie Williams, Nurse Director for Primary Care and Communities
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For 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	
ABUHB	Aneurin Bevan UHB
ADHD	Attention deficit hyperactivity disorder
CAVUHB	Cardiff and Vale UHB
CHC	Continuing Health Care
CNS	Clinical Nurse Specialist
COPD	Chronic obstructive pulmonary disease

CTM	Cwm Taf Morgannwg
D2RA	Discharge to assess
DN's	District Nursing
GA	General Anaesthetic
GMS	General Medical
HMP	His Majesty's Prison
HMPPS	His Majesty Prison and Probation Service
HO	Home Office
LMC	Local Medical Council
OMB	Operational Management Board
PCOSO	Persons convicted of sexual offences
PGD's	Patient Group Directive
POWH	Princess of Wales Hospital
SBAR	Situation, Background, Assessment and Recommendation
SDS	Standard Determinate Sentences
SLT	Senior Leadership Team
SOP	Standard Operating Procedure
TTH	Take Home medication
WG	Welsh Government
YB	Y Bwthyn
YBN	Y Bwthyn Newydd
YCC	Ysbyty Cwm Cynon
YOU	Young Offenders Unit

1. Introduction

1.1 This report had been prepared to provide the Committee with details of the key issues considered by the Quality, Safety, Risk and Experience Primary Care and Communities Care Group at its meeting on the 9th August 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 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	**Prison Demographic/Category Variation** G4S have been asked by HMPPS to change the prisoner population category (and as a result it's demographic), initially to support HMP Dartmoor (following a recent radon scare) however this has developed into a permanent change. This change will involve the re-categorisation of one of the prison house blocks and an increase of PCOSO at HMP Parc (no increase to overall population).
Advise	**Early Release Scheme/Prison Overcrowding** To tackle the ongoing overcrowding crisis in prisons across England and Wales, the Lord Chancellor recently laid a draft statutory instrument that – if approved – would see a reduction in the time served in prison for certain people currently serving SDS from 50% of their sentence to 40%. Working in partnership with prison operational colleagues (G4S), a Task and Finish Group has been established with key individuals across Prison Healthcare to ensure that the additional 75 releases on 10th September are completed without delay ensuring that TTH medication is available and ongoing records are shared with community services. **Dental Service** Paediatric General Anaesthetic 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. There are over 760 patients that require GA and the current timescale to clear the backlog would be approx. 70 weeks. There are ongoing discussions with the lead for planned care programme to secure additional list capacity, to reduce the current waiting time. **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 the lead for planned care programme who has agreed to work with us regarding this issue.

CDS Orthodontics – there are 267 patients who have been assessed and waiting to start treatment for over 2 years, plus 105 waiting for assessment. This has occurred due to retirement of 2 specialists and recruitment issues due to shortage of specialists. GDS budget will be utilised to procure a temporary contract to deliver this care practice.

GMS - A proposal for the closure of two branch surgeries belonging to Taff Vale Practice has been discussed at Board on the 25th July where approval was given.

Lymphoedema Service – Ongoing action plans to ensure the backlog of the referrals are managed in a timely manner. All patients that are experiencing delays are being contacted to ensure they are being kept updated.

Wound Clinic Service – LMC reporting that GP supported antibiotic prescribing is proving unsustainable for Primary Care to support. Work underway with antimicrobial pharmacists to utilise PGDs for initial antibiotic cover, which will then be followed up by prescriptions completed by antimicrobial pharmacists upon swab result. Plan is to engage with LMC regarding proposed changes for agreement – this has been delayed due to ongoing work with antibiotic cover which was a priority.

District Nursing activity – a Business Intelligence dashboard is being developed in liaison with our informatics team due to difficulties in obtaining accurate data.

Ward 21, POWH – SBAR completed to highlight urgent works for the ward as not suitable for patient group. Issues with flooring and shower facilities impacting manual handling for teams. IPC concerns identified so the need for executive review and reduction of beds to support this is required. Risk assessments completed on ward – reviewed by Senior Nurse. Discussion with Care Group Directors to explore further. Meeting to be scheduled with unscheduled care to discuss.

Community Nursing specification – funding received to increase workforce. Peer review planned for August with ABUHB and CAVUHB, work to be completed in providing an update for WG.

District Nursing support for patient flow – following recent community event to explore community support for secondary care

	pressures, District Nurses undertaking 4-week pilot to support flow processes in YCC. DNs will be attending weekly flow meetings to explore how they can expedite discharges. Data to be collected and evaluated after 4-week period. **CHC** - There is a training day planned for October where there will be guest speakers such as the RCN and some of the care homes will present innovations for their own services to share good practice. The nursing homes have a statutory obligation under the regulations to provide core training for their teams, the larger companies have their own training departments and trainers and will offer a very wide range of training. However, the CHC team also share CTM training dates with the care homes which allows the care home staff to attend, as an example the trading packages are Dietetic, Speech and Language Therapy, safeguarding etc. Additional training is also provided when a learning need has been identified. The CHC team attend the quarterly Nursing home forum where the care home managers will request that guest speakers in attendance, which usually has a clinical element. They have also undertaken a scoping exercise on training needs and have compiled a list for training on Mental capacity and DoLs via the Local Authority
Assure	**Prisoner Escorts to Healthcare Services** Due to the ongoing challenging nature of the staffing levels for G4S (prison operational officers), prisoners requiring healthcare appointments either within the prison setting or at one of the acute hospital sites, are at risk of experiencing access delays. Issue added to CTM risk register (risk score 12) and incidents raised and shared with G4S on each occasion. Incidence information added to internal information dashboard and internal SOP to be developed to detail clinical review and escalation triggers. **National Shortage of ADHD Medication** From October 2023, the department were made aware of a shortage of several medications for the treatment of ADHD across the UK. It was hoped that these shortages would only be short term, and the pharmacy department with HMP Parc have attempted to manage the ongoing shortages, whilst prioritising best quality care, by switching between brands of medication and on some occasions adjusting the dose or product to best support symptoms. However, these shortages are ongoing, and Pharmacy are now unable to source many medications used to treat ADHD. Communication has been provided to prisoners who are prescribed these medications to make them aware that we might need to reduce dose or stop medication

until the shortage is resolved. Priority for the supply of these medications are to those patients who are already on treatment and stabilised on a dose.

Pressure Ulcer panel – 3 separate locality panels have now been amalgamated into 1 CTM panel. We are delivering additional panels for a month in order to address the backlog of incidents requiring scrutiny.

D2RA meetings established with service Group managers to improve flow and communication from acute sites.

Transfers between HMP Parc and the DGH Following partnership working between PoWH, Prison Healthcare, Health & Safety and G4S colleagues, a suite of action cards and flow charts have been developed to improve the communication and processes when prisoners are transferred to an acute hospital.

The action cards have been approved by Prison Healthcare SLT, CTM Security and Violence Operational Group and will be presented to OMB for final approval (as a joint paper). It is important to note that there is no formal procedures in place with neighbouring health boards to cover HMP Cardiff and HMP Swansea and as a result these action cards/flowcharts have been highlighted as areas of good practice and will be basis of a national policy. The next policy being developed is the VIP Policy for prisoners who are transferred to the emergency department.

Datix Incident Scrutiny Panel HMP Parc – A panel to review the incidents received on a fortnightly basis to review themes and trends has been established. A report from this panel will be included in future QSRE reports.

Dental - The Home Office Controlled Drug License application – HO visits took place on 29th and 30th May in Talbot Green and DSH, these will determine the approval for the licenses. A pre-site visit with pharmacy took place on 21st May. Both visits went well. Further information is required by the HO before the applications can be approved. Submission date for additional information was 12th June. The team is awaiting the feedback. To mitigate the risk in the interim whilst waiting for the licence, all Community Dentists are now responsible for the controlled drug Buccal Midazolam which has been individually assigned to them by the HB's Chief Pharmacist.

Optometry - Occupational Health Service commenced in CTM from end July. Under the new optometry contract- all optom's and Dispensing opticians can access this service- templates currently

	being returned by practices to understand vaccination status of all optometry. A paper setting out the governance framework for the new optometry contract was discussed in the national eye care Wales committee on the 5th August, this was to unify some of the processes that are in place under other contractor professions contracts.
Inform	**District Nursing patient experience** – work being done to encourage more patient feedback on the service. QR code linked to the CIVICA feedback system being added to patient information leaflet to encourage more proactive patient feedback. Positive feedback from many families as part of the mortality reviews regarding care in YBN and YB **Palliative Care** in-patient units. **Health and Social Care Needs Assessment HMP Parc -** has been commissioned to better understand the health needs of the resident population in HMP and YOI Parc and to assess the extent to which the current need and demand for health and social care in the prison establishment were being met. An initial assessment was presented to the Prison Healthcare and the Deputy Director for HMP Parc on 12th July with the full report due September/October 2024. **Over-55 Health Promotion Event -** The nursing team at HMP Parc organised a health promotion day for those prisoners over 55 years of age. The event was well attended with health professionals providing advice and support promoting good health, immunisation and health checks. **Clusters** - First Contact Physiotherapy, following notification in March that there were issues with funding and service provision, the clusters have now been informed that this will continue with existing funding arrangements until March 2025. Cluster leads are now keeping in contact with service leads and it has been noted that where jointly funded, discussions around future funding and service provision should involve all contributors before decisions are made. **Alternative Treatment scheme -** Under Welsh government directive, Health Boards are required to provide GMS services for patients who have been immediately off listed from their practice due to an aggressive or violent incident albeit in a controlled environment. Within CTM there are two practices that provide this service one based in Bridgend and the other in the Rhondda. These provisions throughout Wales are dealing with more complex patients and the risks associated with these patients are increasing. The

Cluster Development Manager who manages the scheme is involved in an All Wales group where these concerns have been raised and is part of an All Wales security group which is led by a security representative from Welsh Government

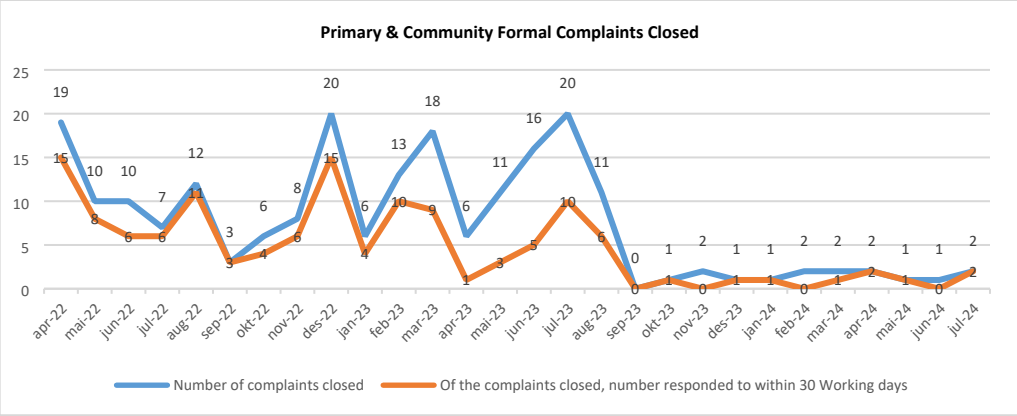
Dental - Positive meeting on 12 July to discuss additional GA list for paediatric dentistry. Theatre teams identifying potential increased lists across various sites to support reducing the backlog. Due to the level of backlog [617 children] and ongoing demand of 576 children need GA each year - this problem will take years to reduce waiting. If waiting times can be significantly reduced, likelihood conversion rate to GA will also reduce meaning less children require a GA for treatment.

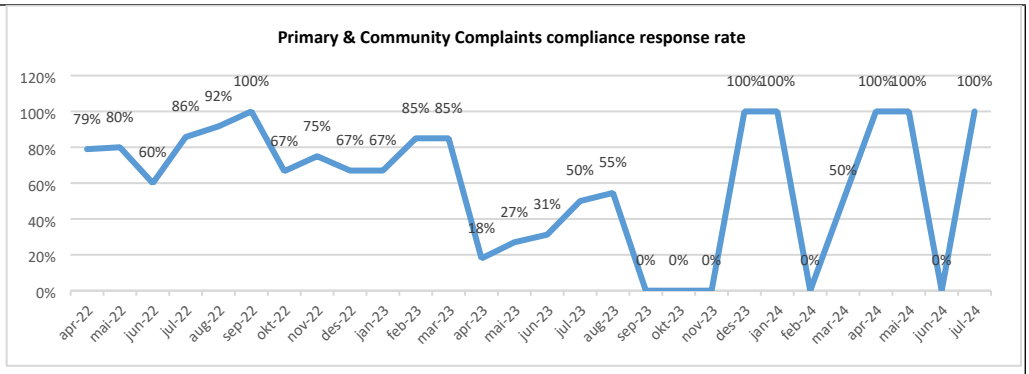
Taff Ely Cluster Frailty Service - 2 x band 7 Frailty Nurses have been appointed on a permanent basis. The nurses will continue to work in Taff Ely for the foreseeable future, whilst the Frailty model for CTMUHB is planned and rolled out across CTM.

GMS - Health Inspectorate Wales visit for Treharris Primary Care Centre planned for 6th August but practice requesting a change of date.

Optometry - Roll out of M365 to all practices has commenced - this will give access to NHS email. Cwm Taf Morgannwg will be first health board to go live. This will enable practices to refer using email rather than using secure file share- this will improve efficiency for referral and referral tracking.

Concerns





AMaT

Project overview

Project	No. audits	Current compliance	Improvement
Health & Safety	1	G 97.6%	▲
Health and Care Standards	2	G 98.8%	▶
Infection Control	9	G 98.9%	▶
Medicines Management	3	G 97.7%	▲
Patient Safety	16	G 97.7%	▶

Appendices	Nil

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
	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))*	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:
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 Quality & Safety 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	18/09/2024
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 Allied Health Professionals & 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
ANP	Advanced Nurse Practitioner
AWLP	All Wales Lymphoma Panel
CDs	Controlled Drugs
CT	Computed Tomography
CIED	Cardiovascular Implantable Electronic Devices
DHCW	Digital Health and Care Wales
DTPS	Diagnostics, Therapies, Pharmacy & Sciences
FUNB	Follow Up Not Booked
HIW	Healthcare Inspectorate Wales

IR(ME)R	Ionising Radiation (Medical Exposure) Regulations
ISO	International Organisation for Standardisation
KPI	Key Professional Indicators
LIMS	Laboratory Information Management System
LHP	Llantrisant Health Park
NLPHL	Nodular Lymphocyte Predominant Hodgkin Lymphoma
NOUS	Non-Obstetric Ultrasound Scan
MHRA	Medicines & Healthcare products Regulatory Agency
MRI	Magnetic Resonance Imaging
MH&LD	Mental Health & Learning Disabilities
OOH	Out Of Hours
PCH	Prince Charles Hospital
PIFU	Patient Initiated Follow Up
POW	Princess of Wales Hospital
PPM	Planned Preventative Medicine
QSPE	Quality, Safety, Patient Experience
RGH	Royal Glamorgan Hospital
RSI	Repetitive Strain Injury
RTT	Referral to Treat Time
SDEC	Same Day Emergency Care
SLA	Service Level Agreement
SBUHB	Swansea Bay University Health Board
SON	Statement of Need
SOS	See on Symptom
UKAS	United Kingdom Accreditation Service
USC	Urgent Suspected Cancer
WCP	Welsh Clinical Portal
WD	Working Days
WLI	Waiting List Initiative

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 19th August 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>Healthcare Scientist</u>** **<u>Backlog for Medical Illustration</u>** ▪ Demand is consistently exceeding available capacity. ▪ Further constraints on capacity have been exacerbated by high levels of sickness within the small team however this is now mostly resolved. ▪ This is impacting on patient care due to increased waiting times with referrals waiting for images ▪ Currently urgent work is being prioritised, through a triage process undertaken by Head of Service.

Options to reduce waits include funded overtime, outsourcing (if available), review of referral criteria compliance. These options are currently being considered along with a review of referral compliance.

Management of Beds

- Regular meetings are being held, to discuss issues around increased demand and future risks of decreased supplies due to stock age within the Bed Management Service.
- Work continues on the development of a paper for Operational Management Board, which will describe future service options, the impacts of these options and stronger controls that will need to be put in place for all users and requisitioners. DTPS will require support from all other Care Groups that have input into bed requesting, usage and provision.
- DTPS will be in contact with Care Group Directors across secondary and community care to discuss.
- A three-year Bed Management strategy to be developed to demonstrate long term options for providing this service along with the impacts of proposed changes.

Radiology

Radiopharmaceutical provision (Risk ID 5590) Risk score 20.

- Ongoing business interruption for Radiopharmaceuticals provision. All patients are being seen based on a clinical prioritisation basis. The reduced level of production has impacted on non-urgent patient care.
- Mitigations include, support from SBUHB and Bristol for additional vials during planned firebreaks. 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 but if shown to be effective, will need to develop a case to support this longer term. Continuing to work with stakeholders to minimise any patient risk as above.

No Health Board MRI Pacemaker Service (Risk ID 5730)

- Ongoing risk
- 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 Corporate Risk Register. • Pacing defibrillator to be purchased. Capital SON in development to support. • With cardiac physiology being available on the PCH site, service will begin in September 2024 offering a limited provision on three afternoons per week initially. • An evaluation of this will be undertaken after 3 months to inform demand and capacity and future workforce models.
Advise	**<u>Healthcare Scientists</u>** • Changes to Medical Device Regulations are coming in to force this year. Some support has been given from Swansea Bay experts to advise on readiness at CTM and provide recommendations to help with implementation of these regulations across care groups. These recommendations have been shared with Operational Management Board and are currently being reviewed to understand the implications. **<u>Pharmacy and Medicines Management</u>** • **Controlled Drugs licences:** Supply licences are now in place in PCH and POW, with RGH pending. This means we are in a position to resume supply to our sites outside the acute hospital sites, pending possession licences being granted. The dental team have started this process and have had 2 of their 5 sites inspected; GP Out of Hours were the first to obtain their licence, so normal service has now been resumed. The Community Drug and Alcohol Teams' clinics are still outstanding. Dispensing for this patient cohort has been taken on by dispensaries on acute sites in order to maintain compliance with legislation. This is having a significant impact on workload in the acute sites, and we are working with MH&LD to possession licences are obtained as soon as possible. • **Community Pharmacy:** Ongoing concerns about pharmacies' lack of robust access to shared NHS email inboxes raised at

Community Pharmacy Digital Applications Board. DHCW are actively progressing work intended to identify the most appropriate way of addressing the current NHS email shared inbox issue. Options being explored include the creation of "practice" email addresses. No timescales available for the resolution at this point.

- **HMP Parc- impact of population change etc**
- Population due to be reduced and then gradually increased back to operational capacity. There will be an increase in 'vulnerable prisoners'.
- This will mean that there will be an increase in daily discharge rate within a short space of time compared to the normal rate of 5 a week. This is a significant increase in numbers and will need to be managed in order to ensure that patients having continuing supply to medication upon release.

Radiology

HIW IR(ME)R Inspection

Action plans have been finalised following the POW Nuclear medicine inspection, and are available on request.

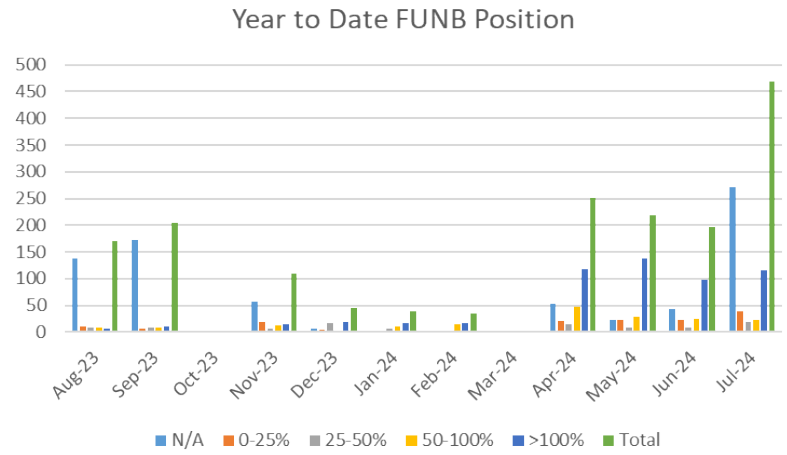
Backlog in imaging (Risk ID 4152)

- 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 prioritization. All USC are being scanned within 10-15 days.
- The mobile MR scanner on the LHP site has made a significant difference to the waiting time for a routine MRI scan, as well as ensuring timely scanning of urgent and urgent suspected cancer cases. We are planning to switch this to a mobile CT scanner when the MR leaves at the end of September in order to address the significant demand for CT scans.

Pathology

Pathology Clinical Director:

- There is concern regarding the vacant Pathology Clinical Director. The position has been advertised three times internally, and unfortunately there has been no response. The advert has been rewritten and we will be advertising more widely to see if can recruit. At present the Medical Director for DTPS is supporting clinically where required.

	Haematology FUNB Position:  • Numbers of patients waiting have increased due to a consultant leaving and being replaced with a part-time consultant. A list of patients is currently being reviewed for clinical urgency; potential additional clinics may need to be supported by WLI requests and work ongoing to better embed the use of SOS/PIFU across the teams. A paper is currently being written for an additional Haematology consultant and ANP to support the increasing demand on Clinical Haematology.
Assure	**<u>Pharmacy and Medicines Management</u>** **<u>Controlled Drugs Management</u>** Current figures for completion of CD audits are: **<u>PCH</u>**: 9% This has been highlighted and a new system implemented around how this figure will be improved **<u>POW</u>**: 71% **<u>RGH</u>**: 71% both sites aware of what is outstanding and working through the issues. **<u>Radiology</u>** **Non-Obstetric Ultrasound (NOUS)** Previous concerns re Sonographers and RSI and impact on the service which deteriorated from April 2024 level. The position has improved and there are 3 colleagues now returning with the appropriate support in place. Of the 3 sonographers affected;

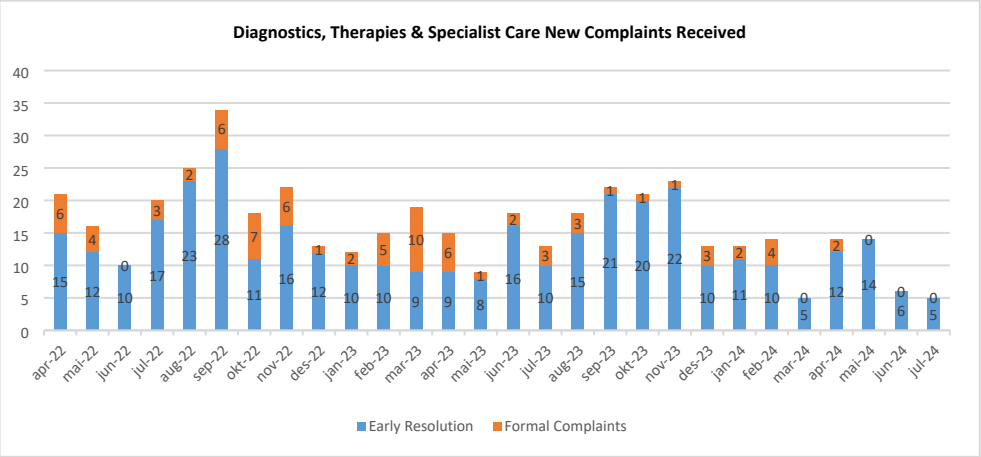
- Sonographer 1 – increased scanning, still some limitation, but improving
- Sonographer 2 – back to full scanning
- Sonographer 3 – Back to limited scanning

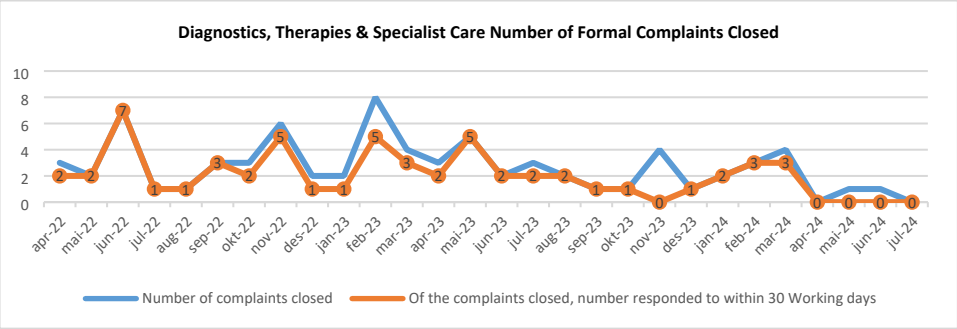
Pathology UKAS inspection:

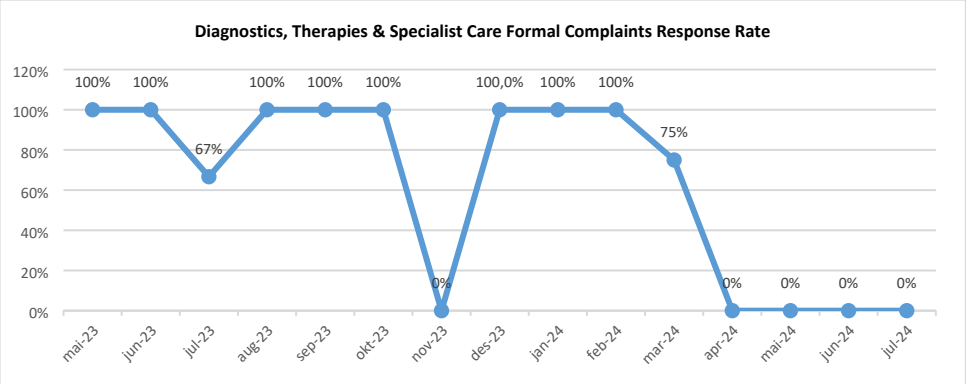
- Assessment commenced on June 3rd and ended on June 26th. This was a 4 year re-assessment and transition to ISO 15189:2022 standards (previously ISO 15189:2012). There were 59 findings across eight pathology departments (average of 7 per department), none of which were significant in nature. Evidence for all findings has been submitted and we are starting to receive feedback from the assessors as to whether findings have been cleared. All findings from Cellular Pathology have been cleared, three findings from Microbiology and one from Biochemistry have been re-opened for submission of further evidence. The appropriate teams are currently working on these to re-submit evidence by 27th August.

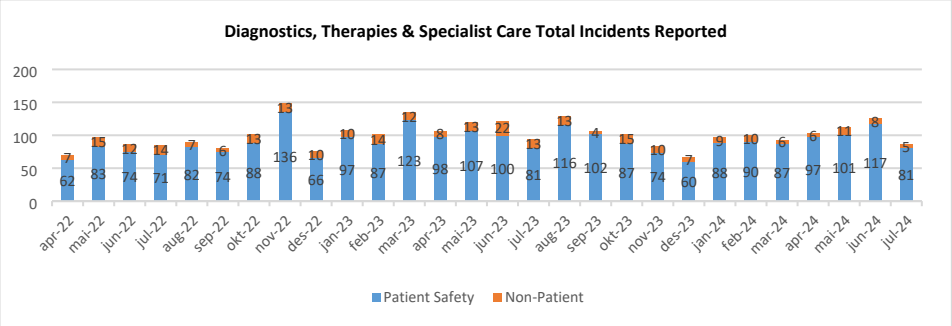
Inform

DTPS Complaints received and Compliance









NB re formal complaint response rate: no formal complaints received, so no responses submitted within the 30 WD KPI response date, which the system calculates that as zero %.

Therapies

Twilight clinic model success for Podiatry service

The redesign of the Podiatry service clinic model due to unprecedented staff absence has led to improvements for service users and staff. A number of clinics were temporarily cancelled due to staff not being available, with a proportion of lost capacity being allocated via additional slots within 3 existing clinics. This resulted in new clinic capacity between 4.30 – 7pm.

Uptake of these appointments has been much higher than expected, despite this resulting in patients travelling further for their appointment. Patients had previously preferred to decline the first available appointment in favour of waiting for a clinic that was geographically closest to their home. However the late afternoon/early evening clinic slots were a popular option, with these slots being fully utilised. Staff were happy to work a different clinic pattern so this is a potential service model which would support flexible-working patterns whilst maintaining clinic capacity. Further work will now be undertaken to explore the factors that have influenced the patients' choice, to support the development of future service models.

Therapies at the National Eisteddfod

A number of professions embraced the opportunity for community engagement at the CTM stand at the National Eisteddfod. They focused on our shared goal of building healthier communities, and aligned health awareness with management strategies throughout the life cycle from children to older adults. The Starting Well day included practical support for children's health and development, including physical activity, healthy eating and communication.
The Living well and thriving in life including cardiovascular advice and included our podiatrist screening for risk of Atrial Fibrillation. Over 100 people were screened, resulting in 10 people being signposted to their GP for consideration. The Aging Well day focused on confidence and including falls prevention and dementia support.
Those visiting the stands fed back that they had enjoyed the practical activities and the staff reflected that it had provided a unique opportunity to engage with our communities.

Pharmacy and Medicines Management

Community pharmacy identifies prescribing/safeguarding incident

Pharmacy visited GP practice to pick up monthly prescriptions for local care homes. Observed that prescriptions included several from up to 6 weeks ago, which the pharmacy had not been informed about. Prescriptions had not been transferred to a pharmacy or dispensed, and patients had not received medication, including acute antibiotics. One patient had passed away in the interim, but not clear if death related to medication.

Flagged by pharmacy as potential safeguarding incidents. Raised by Community Pharmacy lead with safeguarding team, who advised that the primary care team should investigate the incidents. This is being managed by Primary Care senior team

Business continuity management guidance
Head of Pharmacy (POW) leading on work to do with the business continuity. There is a review of business continuity document and a major instant document. That work is tied in with the site leads for each acute site, to make sure that they know exactly what's required, when there's a major incident.

Sharing and learning from primary care – peer support network

	Independent Prescriber Peer Support network implemented in CTM. This is being looked at now on all Wales basis and trying to make sure that all Community pharmacists have got access to a health board wide peer support network. **Compliment** Feedback has been received of a clinical examination conducted in the welsh language noting of the person's 'mam' being able to communicate in her first language. The care group are continuing to highlight to staff around the importance of wearing the Cymraeg badges/lanyard.
Appendix	• 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 *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality**	Effective
	If more than one applies please list below: Person centred Timely

(Duty of Quality Statutory Guidance (gov.wales))	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.

Agenda Item
5.2d

Quality & Safety Committee

Highlight Report from the Mental Health and Learning Disabilities Care Group

Dyddiad y Cyfarfod / Date of Meeting	18/09/2024
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
BCUHB	Betsi Cadwaladr University Health Board
CDAT	Community Drug and Alcohol Team
CMHT	Community Mental Health Team
CST	Cognitive Stimulation

HIW	Health Inspectorate Wales
HMP	His Majesty's Prison
IPC	Infection Prevention and Control
LA	Local Authority
MHA	Mental Health Act
MHIRT	Mental Health Inreach Team at HMP Parc
MHLD	Mental Health and Learning Disability
MHU	Mental Health Unit
NRI	Nationally Reportable Incident
OPMHS	Older Peoples Mental Health Services
PICU	Psychiatric Intensive Care Unit
PMVA	Prevention and Management of Violence and Aggression
POW	Princess of Wales Hospital
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 (MHLD) Care Group at its meeting on 14th August 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 MHLD Care Group QSRE Board will:

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

3. Highlight Report

Alert / Escalate	• **Door Security on Inpatient Wards** There is increasing concern about the security and reliability of some doors on the inpatient units. Capital funding has been secured to replace a number of doors on but the procurement and manufacturing process will cause delays of up to 3 months before these are installed. Until these doors are replaced the risk of the current doors being breached remains high, the risk register has been updated to reflect this. To mitigate this additional door checks are being completed and extra staff used where necessary.

	• **Clozapine Monitoring** A recent clinical incident has exposed the significant variation in practice in relation to the monitoring arrangements for Clozapine (an anti-psychotic medication). To mitigate, all patients prescribed Clozapine have had blood tests to ensure that Clozapine Serum levels are up to date and the Pharmacy Lead has been working to improve clinician's knowledge and understanding. A paper exploring the additional resources required to standardise practice has been developed for consideration in PPPF. • **PMVA Training** It has become clear that a previously agreed model of PMVA training has now become unsustainable. This has been compounded by an emerging need for the OPMHS inpatient staff now need to have enhanced training due to their changing client group and sustained increased acuity. The care group are working on a paper to outline options, which will be presented to PPPF for consideration. The current arrangements remain in place for the rest of 2024.
Advise	• The Care Group is reviewing the anti-ligature audits of all 15 MHLD wards, the results will be presented at the Care Groups Health, Safety and Facilities meeting in September. The Ligature Policy has been updated and is out for comments. The Care Group has facilitated Anti-Ligature Awareness training in conjunction with BCUHB for over 60 members of staff with further sessions planned for the rest of the year. • IPC issues continue to be prioritised within the Care Group. Estates issues have been identified across all areas and the Care Group is working with the IPC and Estates teams to resolve these, SON's have been developed where capital work is required. Through the Senior Nurses, there has been a "back to basics" focus on Hand Hygiene and Bare Below the Elbow guidance and IPC requirements and standards have been included in induction information for bank and agency staff. • The Inpatient Improvement Board continues to meet, latest meeting scheduled for 09/09/2024.

The programme has been refreshed to align with the National Inpatient Improvement Programme from which key deliverables are now becoming clearer.

Of the 40 recommendations of the HIW Discharge Review, only 2 remain open.

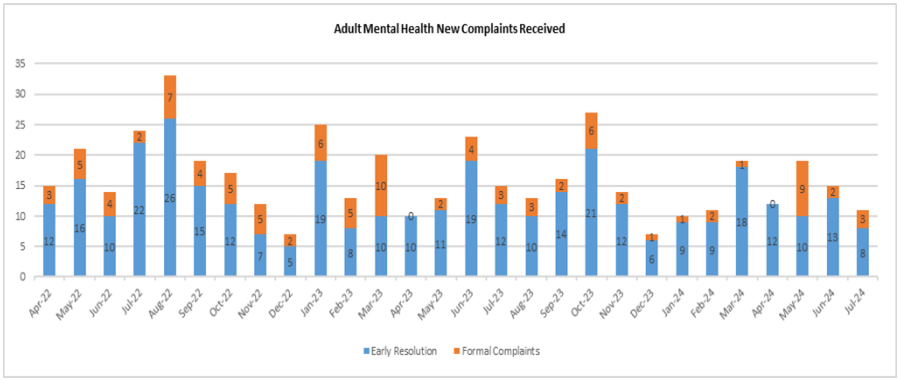
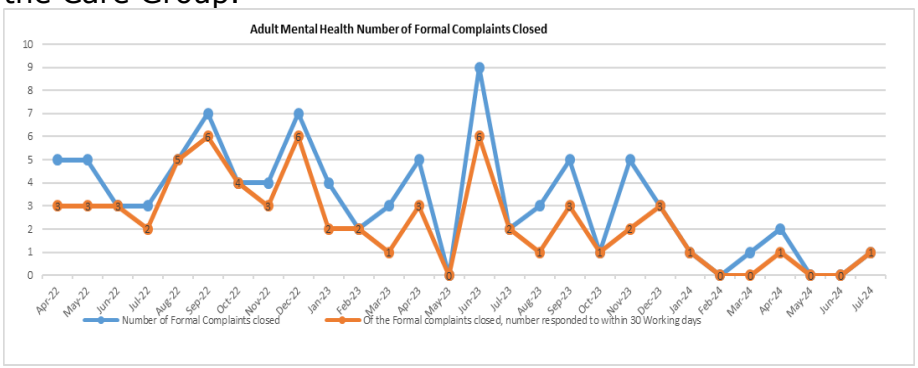
Rec. No	Requirement	Timescale	Update
19	Clinical Record System	End 2024	The Health Board is currently exploring the procurement of mental health information systems and is meeting with providers and users of those information systems.
36	Policies and Procedures	~~1/6/24~~ Revised timescale 1/9/24	The detail and trajectory for improvement is monitored by the Improvement Board and the Care Group Quality and Safety Committee

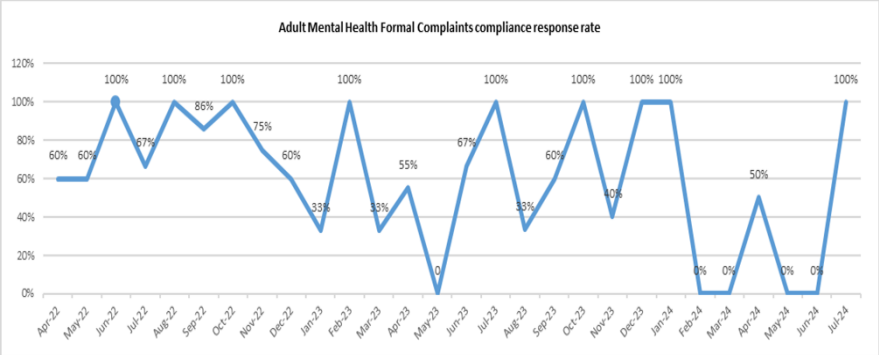
- The Prison In Reach Team at HMP Parc still have considerable capacity issues, which has led to a waiting list. To mitigate this the primary care team are completing welfare checks on everyone on the waiting list until the MHIRT are able to increase their caseloads. A triage tool is being used to assess those on the waiting list with weekly reporting of clinical issues to the Senior Lead Nurses and Clinical Director.

- Registered nurse recruitment that has been included in the alert section of previous highlight report is improving with previously difficult to recruit RN posts being filled and an uptake in student nurses applying to take up posts through student streamlining. There are a number of factors that have positively influenced this, including; changes to shift patterns, bed numbers and operating models. The recommendations of the nursing establishment review to increase the ration of band 6 to band 5 RNs in RGH has been accepted and recruitment is progressing which it is anticipated will have a further positive impact on the adult inpatient wards at RGH.

  The Care Group has been working with the HB Recruitment and Retention leads to better understand the experience of the band 5 RN staffing group with positive feedback received from the Adult inpatient wards in RGH;

  "It came across strongly from all nurses we spoke to that working in MH&LD is tough and unique but the team support built around them is outstanding. There was a real sense of comradery from all and it was very nice to have conversations

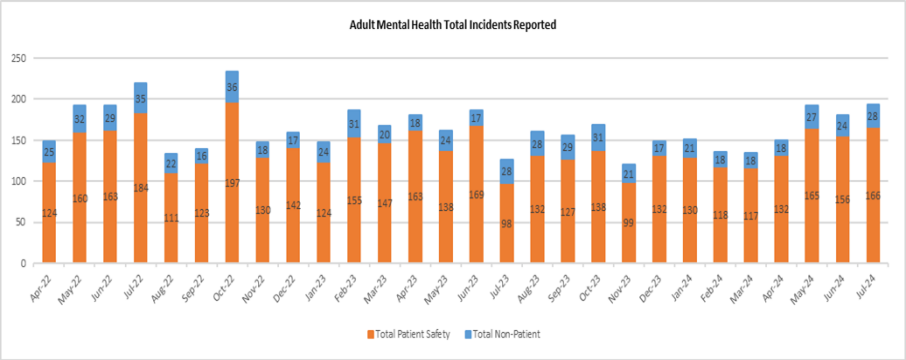
	with staff who feel they are working in a positive, flexible and support culture." • The MHLD Lived Experience Board met for the first time in August. The ambition is to plan, deliver and monitor MHLD services with service users' views, needs and experiences embedded throughout.
Assure	• The number of complaints received by the Care group remains consistent with the mean (16 per month over the last 2 years), this period the number received was 15 in June and 11 in July.  Complaint closure compliance in the Care Group was 0% in June and 100% in July, however, the low volume of formal complaints (5 received in total in June and July 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 July there are 5 open formal complaints (the care group mean over the last 2 years is 5). Of these 4 are on track to close with the timescale with 1 delayed due to waiting for an expert opinion.

- There has been an increase in Datix incidents this period, 193 in June and 210 in July compared to a 2 year mean of 175, this is largely due to the acuity in OPMHS.

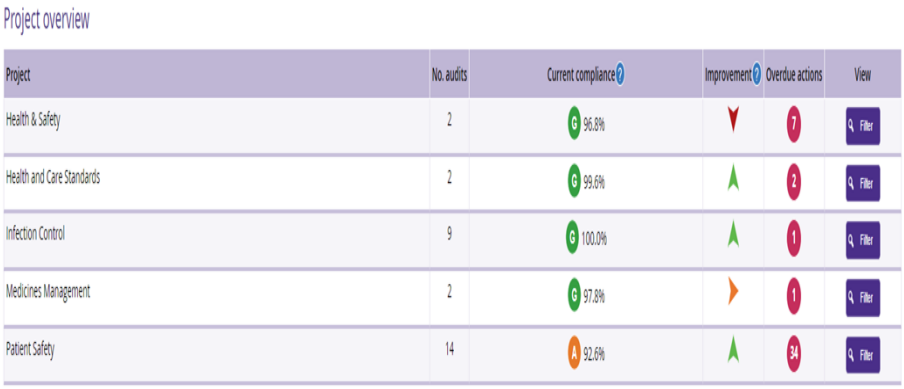
  The HoN is working with the Business Intelligence Manager in the Patient Care and Safety team on the development of a Quality Dashboard, the mapping of the new Care Group structure is complete and we are awaiting implementation.



- There are 6 open NRIs (up from 4 since the last report).

  There were 2 new NRIs reported during this period.

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



There are 34 overdue actions in the Patient Safety category, which are causing the amber grading, these all relate to IPC and NEWS audit, and have been escalated through the Lead Nurses to be addressed within the next month. Performance against these audits is monitored in the individual directorate's QSRE meetings.

Inform

- A nurse from Merthyr CDAT won the "Most Inspiring Educator" award for his work with student nurses on placement at a recent USW awards event.

- The PMHS Directorate has had 2 staff shortlisted for RCN Nurse of the year awards,

  A HCSW from the OPMHS Memory Service in Merthyr has been shortlisted for the RCN Wales Nurse of the Year Awards in the HCSW Category in recognition for her work setting up and running of Cognitive Stimulation (CST) groups.

  A Nursing Team Lead in Bridgend OPMHS Memory Service has been shortlisted in the MH Nurse of the Year Category for her work introducing Clinical Nurse Specialists and CST Groups

- The Adult Acute directorate recently held a training session delivered by a person with lived experience called "The Borderline Patient". The session was attended by 30 people and is designed to improve staff's knowledge, understanding and confidence when caring for people diagnosed with a Personality Disorder. More sessions are planned for the future.

- The Care Group has a programme of "Purposeful Visits" where members of the care group leadership team spend time in clinical areas and teams listening to feedback, these are then shared through QSRE

	• Seren Ward which is an OPMHS ward in RGH received the following compliment following a mortality review from the family of someone who sadly passed away on the ward; *"the care received on Seren ward was first class and that was down to the people who worked there, who were fantastic"* • Ty Llidiard held a garden party to celebrate the completion of a garden mural and planting, the event was well attended and positively received by all involved.
Appendix	Nil

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:

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:
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
5.2e

Quality & Safety Committee

Highlight Report from the Unscheduled Care Group Quality & Safety Committee

Dyddiad y Cyfarfod / Date of Meeting	18/09/2024
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	07/08/2024	

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

1. Introduction

1.1 This report had been prepared to provide the Committee with details of the key issues considered by the Quality, Safety, Risk and Experience meeting on 7th August 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.

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

3. Highlight Report

Alert / Escalate	Through comprehensive data analysis, several potential risks have been identified relating to the environment, themes from concerns, and workforce metrics. In order to address these risks and provide assurance, the following measures have been implemented: 1. A detailed and robust action plan has been developed collaboratively by the Senior Nurse and Ward Manager. 2. Progress on this action plan will be closely monitored through weekly meetings with the ward manager to ensure timely implementation and formally reported to the USC QSRE meeting to give assurance on improvement. 3. Specific improvement trajectory slides have been developed and will be regularly assessed to track progress and ensure sustainability for improved patient care and safety. We are confident that these measures will address the identified risks and support the area in delivering safe and high-quality patient care.

Advise	Complaints have been transferred to a central quality governance team within the organisation since February 2023. This has ensured that we maintain equity, consistency and strengthen resilience. USC compliance with the 30 target has slightly decreased in July 2024 from 94% to 89%. This is due to the high acuity and changes within the senior nursing leadership teams which had a negative impact on response times. Currently there are 30 open complaints and 7 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. During the August QSRE meeting analysis of concerns and incidents are being triangulated. Ensuring that there is targeted intervention when any themes or trends have been identified. **AMaT** 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 by the corporate team and a re-fresh of the outstanding actions from July 2024, these are now discussed as part of each acute sites Safe to Start morning meeting. On review common themes included Fluid Balance completion and Pain Scores. In response to this Senior Nurses are targeting training with the relevant areas with support from the Outreach and Pain teams, 2 bespoke work stations have been planned for August. A ward based AMaT key learning report is being developed, to allow sharing with all ward teams on key findings, themes and trends and to thank them for all the positive audit work they are undertaking. There are no outstanding AMaT actions for the PCH Acute Site as of the 1st August 2024 - there is a rigorous approach to daily assurance checks by either the HoN or Lead Nurse. For RGH and POWH as part of their ward assurance the Lead and Senior Nurses reviewing AMaT a minimum once weekly to ensure compliance with the audits and action plans. Support has been put in place for ward managers to utilise existing systems to raise estates work as large amount of actions pertaining to estates issues. A standardised 1:1 template for ward managers up to Heads of Nursing, AMaT audits are a standing agenda item.

The Ward Accreditation Programme at Cwm Taf Morgannwg University Health Board (CTM UHB) aims to enhance patient safety, care effectiveness, and quality through a continuous improvement framework. The programme evaluates wards based on set standards and awards accreditation levels ranging from Bronze to Gold.

Unannounced visits were conducted across the unscheduled care wards followed by a detailed assessment. The evaluation covered six quality domains; safe, timely, effective, efficient, equitable, and person-centred care, and the six enablers; leadership, workforce, culture, information, learning improvement & research, and whole systems approach.

This report evaluates the ward's performance, culminating in a Bronze accreditation, through a detailed analysis of key performance indicators.

Site	Ward	Result	Date of Visit
Princess of Wales Hospital	18	Bronze	23/4/2024
Princess of Wales Hospital	20	Bronze	28/5/2024
Prince Charles Hospital	11	Bronze	30/4/2024
Prince Charles Hospital	2	Bronze	24/4/2024
Royal Glamorgan Hospital	5	Bronze	14/5/2024

On 12th August we commenced a 'reset fortnight' across all of our hospital sites within CTM. Over the next two weeks, we look to adjust our daily working practices to ensure that the right number of staff are able to do the right thing, at the right time, to support the safe, effective and timely discharge of patients.

A particular focus was on finding solutions to difficulties in managing demand and capacity across all hospital sites. Significantly, by examining any avoidable causes of long patient stays in emergency departments, which create less than optimum patient experiences and increase levels of stress for staff.

The focus at PCH & RGH was on resetting the AMU's, with PCH doing some additional work linked to broadening their SDEC offering in their newly developed unit.

	Daily briefing sessions took place as well as local Care Group and site meetings, allowing immediate feedback and a holistic approach, capturing improvements on the overarching control document.
Assure	The Emergency Department (ED) national PREM survey continues to have excellent service user engagement, with the patient experience team providing a monthly report via CIVICA. This patient feedback is reviewed by the department leads and actions are undertaken accordingly with positive and constructive feedback shared. 
Inform	During the August QSRE meeting, the Head of Nursing for Princess of Wales Hospital shared a moving patient story highlighting the impact of the Dare to Dream Welsh Charity. This charity is dedicated to supporting the emotional health and well-being of adults in Wales living with physical illness by creating non-clinical, interior-designed 'safe havens' in hospitals for patients, their relatives, and the staff who care for them. The charity recently introduced weekly music sessions for patients in the Care of the Elderly (COTE) ward, where two musicians play and encourage interaction among patients and their relatives. The Head of Nursing recounted the experience of a patient from Ward 18 who had been hospitalised for several weeks and had experienced significant cognitive and medical decline. The patient was ultimately diagnosed with Alzheimer's disease, and her

	condition had progressed to the point where there was minimal recognition of her husband, causing him considerable distress. As the patient's condition deteriorated and she entered the final stages of her life, verbal communication became increasingly rare. However, during the first music session provided by Dare to Dream, the patient was brought to the session in her bed, with her husband by her side. They held hands and listened to the music together. Remarkably, by the third session, the patient began to sing clearly to her husband while the musicians played—a moment that moved him to tears. This interaction during the music sessions became the only time the patient connected with her husband, bringing immense joy to both of them in her final days. This story illustrates the profound impact that the Dare to Dream charity's initiatives can have on patient care, particularly in enhancing emotional well-being and providing comfort during the most challenging times.
Appendix	Nil

4. Assessment

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

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

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

5. Recommendation

5.1 The Quality & Safety 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	18/09/2024
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	
CNS	Clinical Nurse Specialist
ERCP	Endoscopic Retrogade Cholangiopancreatography

1. Situation/Background

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 19th August 2024.

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

2. Specific Matters for Consideration

2.1 Purpose of this Meeting

The purpose of the Planned Care/Surgery Quality, Safety, Risk & Experience Group (QSRE) is to provide assurance to the Care Group and the Health Board's Quality & Safety (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. Key Risks/Matters for Escalation

Alert / Escalate

Gastroenterology

- Urgent review of GI Bleeding roster across CTMUHB to be undertaken
- ERCP service review being undertaken across CTMUHB.
- Draft SOP for Patients requiring Endoscopy and admission from Emergency Department – Pan CTM is being finalised.
- Review of appropriate and safe clinical areas to support the out of hours service and workforce required.

Advise

Incidents – Care Group Overview (June & July 2024)

Incidents	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Total Number of Incidents Reported	255	288	280	267	266	278	249	249	298	274	**266**	**264**
Total Patient Safety	223	254	242	238	240	239	223	217	273	238	**232**	**237**
Total Non-Patient	23	22	26	20	26	20	16	24	10	26	**17**	**11**
Total Organisational Incidents	9	12	12	9	7	19	9	8	15	10	**17**	**16**
Total Number of Incidents Closed this month	245	293	294	309	384	371	504	273	291	282	**267**	**245**
Total Number of Open Incidents on Datix Cymru	1320	1438	740	1569	1491	1403	1117	1110	1120	1124	**1117**	**1117**
New Incident	1317	780	781	783	770	715	669	669	636	631	**638**	**608**
Management review/Make it safe plus	469	45	48	50	67	50	34	47	71	80	**114**	**143**
Under Investigation	396	613	602	553	545	578	365	335	321	284	**264**	**254**
Awaiting Closure	186	198	183	183	109	49	49	59	92	131	**101**	**112**
Number of Nationally Reportable Incidents	46	5	6	10	3	2	1	7	2	6	**0**	**4**
Number of Never Events reported	0	0	0	0	0	0	0	0	0	0	**0**	**0**
Number of Open Nationally Reportable Incidents	27	33	31	31	36	36	33	38	39	45	**35**	**31**

Nationally Reported Incidents June & July 2024

NRI's reported to NHS Wales Exec during June & July 2024:
4 in total:-

3 x Avoidable pressure damage (2 x PCH / 1 x RGH)
1 x ward closure (POW ward 7 – norovirus outbreak)

TOTAL NRI's Open for Planned Care = **32** (reduction of **14** since last QSRE)

7 x Avoidable PUs identified at Panel remain open

6 x POW (3 x ward 11 / 2 x ward 9 / 1 x ward 8)
1 x RGH (ward 8)

- Continued focus on reducing 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.

	Concerns compliance June & July 24 Concerns Compliance June was 83% • 12 closed;10 within time Concerns Compliance July was 83% • 10 closed; 7 within time Themes from concerns • Communication - Most common theme • Clinical issues/medical procedures • Falls • NEWS calculation & escalation • Fluid balance monitoring Actions regarding themes • Heads of Nursing across the 3 sites have ensured themes are key focus for their Professional Nursing Group monthly meetings. • Corporate Nursing supporting focused piece of work on Falls on Ward 3 in RGH • Ward 9 in PoW has introduced 'Baywatch' by night where a member of their staff remains in the bay by night to monitor patients & this has decreased falls • Outreach Services supporting bespoke training regarding NEWS, Fluid Balance Monitoring and the Recognition of the Deteriorating Patient • PCH wards running a pilot of use of coloured fluid balance charts to improve compliance with completion.
Assure	Working in partnership with the iCTM, PCH have developed a series of 5 minute improvements on Wards 5, 6, 7, 8.To date 9 have been completed using an MDT approach & have included:

	  • Endoscopy Unit in PoW has submitted the evidence required for JAG accreditation. The final report and outcome will be sent early September **Productivity, Improvement and Transformation (PIT)** • PIT Programme launched in June 2024. • Cross-cutting Improvement Boards to be established across Theatres, Outpatients, Pre-Assessment, Diagnostics, Therapies/Audiology and Cancer. • All elective care services to establish clinically led improvement groups, responsible for reviewing baseline/ongoing performance and overseeing plans/actions to drive productivity.
Inform	Ward Accreditation – July • Ward 11 PoW – Bronze • Ward 15 RGH – White • Ward 10 RGH – Bronze. Lead Nurses working with Senior Nurses and respective ward managers regarding action plans, shared learning and areas for improvement. Aim to present at each of the HoNs Professional Focus Groups.
Appendix	Nil

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

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

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	18/09/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Cally Hamblyn, Assistant Director of Governance & Risk
Cyflwynydd yr Adroddiad / Report Presenter	Gareth Watts, Director of Corporate Governance & Risk
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Approval

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Service, Function and Executive Formal Review	August 2024	RISKS REVIEWED
Operational Management Board	August 2024	ENDORSED RISKS WHERE APPLICABLE FOR ELG
Executive Leadership Group	9th September 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 5th July 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.

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

2.8 To date **701** members of staff trained to date since training commenced in 2021. Based on the Risk Management Awareness Training Needs Analysis all attendees completed Training Profile 2.

2.9 In addition, the Health, Safety & Fire Directorate have run Managing Safely Courses during the period which has a designated section on risk. These sessions were held as follows:

- June 2024 – 7 attendees
- August 2024 -13 attendees

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

2.11 65 attendees have provided formal feedback (using the URL Code for the Evaluation Form, which was introduced in November 2023). The average rating for the course is 4.74 out of a maximum score of 5.

2.12 100% of the 65 attendees providing formal feedback found that:

- The session provided the right amount of information.
- They gained more confidence and knowledge in risk management having attended.
- They would recommend this training to a colleague.

2.13 97% of the 65 attendees providing formal feedback said they felt more confident to escalate a risk through the organisation.

2.14 Some of the recent comments from the session in June, received through evaluation, have been included below:

- *"Using the live example on Datix was very helpful."*
- *"Being a fairly new team leader, and new to Datix etc., I feel this has given me a little more insight into who should be doing what and when. I feel confident enough to share information with the team."*
- *"As a board member I wanted to understand how risk was identified, assessed and scored across the organisation. The training achieved that and I now feel I have further context to the risk reporting I see at Board."*
- *"An accessible, clear and succinct session which provides a valuable understanding of all things risk."*
- *"I've done a risk assessment before and really had no clear guidance but this is really informative and I'd feel more confident to do another one"*
- *"I felt it had good amount of information without overloading and good cadence"*
- *"Pacing was great so easy to follow… Information was provided at a level accessible to all"*
- *"Gave a good overview of how to register a risk and the scoring expectations"*

3. Key Risks / Matters for Escalation

3.1 NEW RISKS

Nil.

3.2 CHANGES TO RISKS

Risk Score Increased

There were no increases in risk score for those risks escalated to the Organisational Risk Register on this occasion.

Risk Score Decreased

Patient, Care and Safety Directorate

- **Datix Risk ID 4906 - Failure to provide evidence of learning from events (Incidents and Complaints.** This risk score was proposed for de-escalation from the Organisational Risk Register in June 2024, however, the Audit & Risk Committee challenged this reduction and requested further information. This risk is now proposed for closure with the following additional narrative:
  "Risk reviewed both narrative and risk rating following a query raised by the Committee on receipt of the losses paper which informed members of recent LFER penalties. The update was approved and the risk rating remains at 12 due to the revised and improved processes in place, which despite the Health Board receiving 3 penalties in July 2024, these were the first penalties received since May 2023. These penalties are felt to be one-off penalties, as the current processes for LFERs are resulting in an improved trend. Therefore, the risk should remain at a score of 12 and be re-reviewed and re-scored, if necessary, at the next risk review."

- **Datix Risk ID 3133 - Poor compliance with Medical Gas Safety Training.** Likelihood risk score reduced from a 4 to a 3 in August 2023 as a result of a notable improvement in compliance. Over 1000 CTMUHB staff having completed the course in the past 3 months, as opposed to the 180 staff from across the entire CTMUHB in 2023, for the face to face training. Medical Gases training also changed from a classroom based session to an ESR E-Learning course which is being advertised via flyer and other mechanisms to raise awareness.

Children & Family Care Group

- **Datix Risk ID 5755 - Princess of Wales (POW) Air handling unit and electrical infrastructure for Labour ward and Neonatal Unit.** Risk reviewed and with mitigations in place since risk was identified. Reduced consequence to a 4 (so overall score of 16 until September 6th) From September 6th units will be fully vacated so risk will be further reduced and

work will commence to remove the risk entirely after the 12 week programme of refurbishment.

Unscheduled Care

- **Datix Risk ID 1133 - Sustainability of the Emergency Department at the Royal Glamorgan Hospital.** Risk score reduced to a 12 from 15. SMT risk reviewed, nurse establishment invest to save paper completed unitising the RCN BEST tool (same tool used to review the PCH nursing workforce 2021). To substantiate 2 additional registered nurse. Invest to save paper approved and recruitment tracker in place and interviews are due the 1st week of September. Risk is currently mitigated by staffing to the agreed level by using bank and agency staff.

3.3 CLOSED RISKS REMOVED FROM THE ORGANISATIONAL RISK REGISTER

Patient, Care and Safety Directorate

- **Datix Risk ID 5254 - Failure to manage Redress cases efficiently and effectively in respect of Duty of Candour.** Risk reviewed with the Assistant Director of Quality & Safety following discussion with the Executive Director of Nursing/Deputy CEO. It was agreed to close this risk and amalgamate it with risk 4907 and the Duty of Candour element has been added as a new risk with a rating of 12 (ID 5895).

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

Consequence						
	5			3337 3993 4080	4664 5276 5730	
	4			5820	4337 4152 4809 4417 5374 4671 4908 4907 5755 5646 5579 5669 5658 5761 5417 5764 5765 5691	4491 4071 4103 3826 5590 5462 5821 4632
	3					4672 2808 4691 5040
	2					
	1					
CxL		1	2	3	4	5
		Likelihood				

3.5 EMERGING RISKS

Planned Care – Care Group
The Planned Care - Care Group Senior Leadership Team are undertaking a risk assessment relating to inequalities in orthopaedic paediatric services aligned to the risk identified by the Wales Orthopaedic Network (National Clinical Strategy for Orthopaedic Surgery). It is anticipated that this risk once assessed and a mitigating action plan developed will be escalated to the Organisational Risk Register as appropriate.

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)*
1a	**Sufficient capacity to meet elective demand**	**Improving Care**	Chief Operating Officer / Executive Director of Strategy and Transformation	Quality and Safety; Planning, Performance and Finance	**16**	⟷
1b	**Sufficient capacity to meet emergency demand**		Chief Operating Officer / Executive Director of Strategy and Transformation	Quality and Safety; Planning, Performance and Finance	**20**	⟷
2.	**Ability to deliver improvements which transform care and enhance outcomes**	**Improving Care**	Executive Dir. Of Nursing, Midwifery / Executive Medical Director	Quality and Safety	**16**	⟷

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):	If no, please include rationale below: Not required for the organisational Risk Register. Individual risks may have been subject to an Impact Assessment.

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

5. Recommendation

5.1 The Committee are asked to:

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

6. Next Steps

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

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
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
2	5730	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Service Director - Diagnostics, Therapies, Pharmacy and Specialties Care Group	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	No Health Board MRI Pacemaker Service	IF there is no MRI pacemaker service THEN patients that require urgent imaging for serious conditions e.g. cauda equina, stroke and Unscheduled Care can not be imaged using the appropriate modality RESULTING IN poor patient outcomes, (life limiting conditions where alternative imaging (CT,US does not answer the clinical question)	Care Group director discussing situation with cardiac team to resource and support this service provision. Escalation to Clinical and Medical Directors as appropriate. Prince Charles Hospital site will offer the service as cardiac physiologist available.	Pacing defib to be purchased - Capital Statement of Need ongoing. Update August 2024 - Defibrillator ordered and should be arriving w/c 26th August 2024. DTPS Care Group have been working on a new policy to allow Patients with a Conditional Cardiac Implantable device to access MRI scans in CTM (which will initially be at Prince Charles Hospital) . This has required considerable work between Radiology, Cardiology and Cardiac Physiology Teams. Care Group Medical Director has been chair of this working group. DTPS Care Group have now pulled together a policy document which is just being finalised with support and help from the appropriate teams. As soon as the defibrillator arrives they will be planning to run the service at PCH within the next fortnight on Monday, Wednesday and Friday afternoons with support of Cardiac Physiology, Cardiologist and Radiology . Whilst they have not had the service consultant Radiologist input has been given to suggest other imaging options. No Harm has been recorded to patients as a result of not having this service at present.	Planning, Performance & Finance Committee Quality & Safety Committee	20	C5xL4	4 (C4xL1)	⟺	21.03.2024	27.8.2024
3	5821	Executive Director of Strategy & Transformation	Central Corporate Directorate - Commissioning	Assistant Director of Transformation, Strategic and Operational Planning	Improving Care	Service / Business interruption	Provision of secondary care immunology services by external provider (this is a service that is not provided by CTM UHB).	If: CTM is unable to secure a new contract with an alternative commissioned provider; Then: CTM residents will have no access to secondary care immunology provision. Resulting in: unacceptable level of clinical risk for both routine and urgent referrals that are currently without any available referral option. Patient experience will be impacted by delays in onward referral for investigation, diagnosis and definitive treatment/management plan. This could lead to both informal and formal concerns being submitted to the health boards.	Working group in place to seek and secure service (meets monthly), although more regular communication and updates is sent in between meetings. Exploration of suitable providers within the NHS and also private providers undertaken. Short term contract being sought for urgent referrals and expected by end July 2024. CTM UHB Referral Management Centre currently maintaining database of both urgent and routine referrals received. CTM GP's have been informed of the challenges currently experienced with immunology provision and delays can be expected.	Establish short term contract with NHS provider for urgent referrals. Secure provision for routine cases. Work collaboratively with health boards across the SE Wales and SW Wales region to secure immunology provision in the longer term. Update August 2024 - awaiting costed proposal from provider. Currently no change to risk score whilst this is explored.	Planning, Performance & Finance Committee Quality & Safety Committee	20	C4xL5	4 (C4xL1)	⟺	08.07.2024	28.08.2024
4	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 July 2024 Risk reviewed by Unscheduled Care Senior Management Team, stroke services options appraisal has been submitted to Executive Leadership Group. The Stroke consultants within CTM cover Stroke services on two acute sites (Princess if Wales Hospital (POWH) and Prince Charles Hospital (PCH). They also provide a 1:6, seven-day stroke on-call advice service. However, due to vacancies within the consultant workforce the ratio for the on-call rota is currently 1:4 to mitigate gaps. There are currently 4.0 WTE stroke consultants and 4.8 WTE CNS in post across CTM, broken down as follow: • PCH – 2.0 WTE consultants with 1.0 WTE vacancy • PCH – 2 WTE Clinical Nurse Specialist • POWH – 2.0 WTE consultants with an additional 0.6 WTE agency locum Consultant • POWH - 2.8 WTE Clinical Nurse Specialist The Stroke consultants at POWH also have a GIM on call commitment on a 1:21 rota, comprising of weekday evening and full weekend day cover resident cover with non-resident overnight cover. The service becomes increasingly more fragile from September 2024 when one consultant at PCH will be commencing maternity leave for a 12-month period, from July they will also be coming off the on-call rota. This will leave just 3 substantive consultants undertaking a 1:6 rota with a 50% less workforce, as well as leaving just one consultant at PCH from September which will significantly impact being to deliver a safe and sustainable stroke service at PCH. Update August 2024 - In order to try and mitigate this, a locum Consultant started at PCH on Tuesday 27th August to cover maternity leave, with a second fixed term locum due to start at the end of October, this will allow adequate time for the care group to work through more sustainable options. No change to risk score.	Quality & Safety Committee	20	C4xL5	12 (C4 x L3)	⟺	11.05.2021	28.08.2024
5	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. Update June 2024 - risk reviewed on the 17th June 2024. No change to mitigation or risk score. Update August 2024 - risk reviewed with no change. The Care Group have a list of dates/days that SBUHB will not be manufacturing during June to December.	Quality & Safety Committee	20	C4xL5	4 C4xL1	⟺	23.10.2023	21.08.2024
6	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 July 2024 - The 8a post is now filled and pathology/IT team is working on delivering the LIMS Project. No change to risk scoring due to resource limitations across Wales. Update August 2024 - On progress, UAT testing on begins on the 2nd Sept and will last for two months.	Digital & Data Committee Quality & Safety Committee	20	C5xL4	5 (C5xL1)	⟺	26.10.2022	22.08.2024
7	4491	Chief Operating Officer	Deputy Chief Operating Officer - Acute Services.	Deputy Chief Operating Officer - Acute Services.	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to meet the demand for patient care at all points of the patient journey	**IF:** The Health Board is unable to meet the demand upon its services at all stages of the patient journey. **Then:** the Health Board's ability to provide high quality care will be reduced. **Resulting in:** Potential avoidable harm to patients	Controls are in place and include: • Technical list management processes as follows: - Speciality specific plans are in place to ensure patients requiring clinical review are assessed. - All patients identified will be clinically reviewed which will include an assessment of avoidable harm which will be reported and acted upon accordingly. - A process has been implemented to ensure no new sub specialty codes can be added to an unreported list, this will be refined over the coming months. - All unreported lists that appear to require reporting have been added to the RTT reported lists - All unreported lists that are to remain unreported (as they do not form part of the RTT criteria) are being reviewed and will be visible and monitored going forward. • Patients prioritised on clinical need using nationally defined categories • Demand and Capacity Planning being refined in the UHB to assist with longer term planning. • Outsourcing is a fundamental part of the Health Board's plan going forward. • The Health Board will continue to work towards improved capacity for Day Surgery and 23:59 case load. • A Harm Review process is being piloted within Ophthalmology – it will be rolled out to other areas. • The Health Board has taken advice from outside agencies especially the DU when the potential for improvement is found. • Appropriate monitoring at ILG and Health Board levels via scheduled and formal performance meetings with additional audits undertaken when areas of concern are identified Planned Care board established. - The Health Board is exploring working with neighbouring HBs in order to utilise their estate for operating.	Update August 2024: **Elective Demand-** There has been continuous improvement against trajectories for elective demand for a range of services including Mental Health and Learning Disabilities. The risk score has been reviewed and remains unchanged on this occasion, due to the following potential impacts. The financial and economic challenges faced by the third sector and local authority partners has an impact on the Health Boards ability to mitigate this risk, as capacity cannot be protected. The large-scale capital programme at Prince Charles Hospital will temporarily reduce the number of operating theatres by 2. An ongoing work programme continues to review options to mitigate this. The current Fire enforcement notice at Princess of Wales hospital will reduce the number of operating theatres. Plans are ongoing for the temporary location of the theatres. Workforce recruitment continues across the care group to enable a sustainable capacity model. There continues to be a reduction of ADH and WLI activity attributed to standardisation of pay. Regional working continues and the positive and negative impact of this will be continuously reviewed. It is anticipated that the risk score may remain quite stagnant as the pace of improvement is constrained by workforce, financial and environmental constraints on the service. Update sept 2024 - Risk remains the same given the ongoing constraints above but good progress is being made across all specialties to manage planned care position. Notably, as at the end of august, as per plan, 156 week waits have been cleared. The Single Cancer Pathway (SCP) will remain a key focus with a target of 70 % compliance by March 25 **Emergency Demand -** There has been some improvement against trajectories for emergency demand. Specifically in total reduction of lost ambulance hours. The risk score has been reviewed and remains unchanged, due to the following potential impacts. There remains a high number of clinically optimised patients in core capacity that is impacting on patient flow. The financial and economic challenges faced by the third sector and local authority partners has an impact on the Health Boards ability to mitigate this risk, as capacity cannot be protected. Workforce recruitment continues across the care group to enable a sustainable capacity model. There continues to be a reduction of ADH and WLI activity attributed to standardisation of pay. The conversion from locum to substantive and establishing COVID uncommissioned capacity remains a priority. Regional working continues and the positive and negative impact of this will be continuously reviewed. It is anticipated that the risk score may remain quite stagnant as the pace of improvement is constrained by workforce, financial and environmental constraints on the service. Update Sept 24 - renewed focus on 1 hour ambulance handovers and 12 hour waits in ED. Reset fortnight extremely successful in resetting PCH Acute medicine to better facilitate the flow of patients out of ED and utilise SDEC resources. This work, which comes under the STAMP project, will roll out into POW and RGH in a phased approach. Strategies to reduce Delayed Transfers of Care (DToC) across CTM footprint continue through the 6 goals workstreams inc roll out of optimise and progression of the CTM 'Hospital at Home' service model.	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4xL5	12 C4 x L3	⟺	13.7.2023	29.08.2024
8	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 July 2024 - risk ongoing, mitigation continues to be : ongoing increased scrutiny of pathways, focused work with urology, Gynae and colorectal, enhanced monitoring with Velindre Cancer Centre. Update August 2024 - risk ongoing, no new updates in addition to those reported in July 2024, to be reviewed in September 2024.	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4 x L5	12 (C4 x L3)	⟺	01.04.2014	23.08.2024

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
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
9	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, OOTC'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 Update July 2024 - risk ongoing, no new updates in addition to those reported in April 2024, to be reviewed in September 2024. Update August 2024 - risk ongoing, no new updates in addition to those reported in April 2024, to be reviewed in September 2024.	Quality & Safety Committee	20	C4 x L5	12 C4 x L3	⟺	01.04.2014	23.08.2024
10	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 August 2024 - Current mitigations remain in place: Pathway redesign and Demand and Capacity (D&C) oversight- Pathway redesign: 74% of level 3 patients identified as suitable for group education, this group delivery model is in progress, which has resulted in an 50% increase in annual capacity compared to the original service model of 1: 1 MDT treatment. Despite this efficiency demand exceeds capacity. D&C: Real time validation of waiting lists ensures appropriate signposting according to service specification, alongside implementation of partial booking. Referral rates continue at approx. 100/mth with service capacity of 40/mth. A business case to propose an expansion of the staffing model is in progress, and is due for completion by the end of Q3.	Quality & Safety Committee People & Culture Committee Population Health & Partnership Committee	20	C4xL5	8 - (C4xL2)	⟺	07.06.2023	20.08.2024
12	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 July 2024 The Unscheduled Care SMT reviewed current ambulatory pathways and the site based clinical teams are in the process of developing an SOP relating to fit2sit. We continue to explore the potential to expand ambulatory footprint at the Princess of Wales site. Quality statement baseline assessment has been completed, part of this work, will result in the development of an overcrowding score which should help reduce the risk of harm with overcrowding in the emergency department. 1. Currently developing a standardised approach to our huddle capture and reporting. 2. Proof of concept has been completed with engagement from operational and clinical stakeholders. 3. Move to development of software project. 4. This will support a consistent approach to recording and reporting escalation levels across all our acute sites. 5. USC Dashboard which provides daily and ongoing trend data for performance metrics I Emergency Care. 6. Developing data intelligence Emergency department acuity levels, including risk stratification and also clinical frailty score for all attendances in each of our Emergency Departments. 7. CTM IMTP describes development of a predictive data model to enhance current systems (we already have predicted attendance) 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. August 2024 - Risk remains unchanged in terms of mitigation and scoring.	Quality & Safety Committee Planning & Performance Committee	20	C4xL5	12 (C4xL3)	⟺	24.09.2019	28.08.2024
13	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. A Project plan is in place with support from Corporate Planning. Weekly planning meetings held with teams and external stakeholders including WAST, JSS, Network. Neighbouring Health Boards have been informed, meetings between Care Groups arranged. FAQs to staff are out, one to one meetings with affected colleagues taking place, meetings with community midwives / ANC staff underway. FAQs external to women and birthing people are out, drop in sessions underway for any one with any concerns.	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. Update June 2024: • Start date for the work (2nd September 2024). • Clinical pathways are being finalised. Update August 2024 - Risk reviewed and with mitigations in place since risk was identified. Reduced consequence to a 4 (so overall score of 16 until sept 6th) From Sept 6th units will be fully vacated so risk will be further reduced and work will commence to remove the risk entirely after the 12 week programme of refurbishment . Service Director for Children and Family Care Group has confirmed that they now know through the project and deeper assessment of the equipment batteries that they will sustain power for a minimum of 2 hours to give time for emergency electrician to attend. Since the risk was added the Care Group have looked at their contingency plans which currently now would lessen the consequence and impact of the risk as well as the likelihood of occurrence. The Care Group did not have confirmation of these points when the risk was first assessed. On this basis they would reduce the consequence score to 4 from a 5 in terms of the target score. This update will be reflected in the September iteration of the Organisational Risk Register.	Planning, Performance & Finance Committee Quality & Safety Committee	16 Decreased from a 20 in September 2024	C4xL4	C4xL2	⬇	18.04.2024	02.09.2024
14	5691	Chief Operating Officer	Facilities Directorate	Assistant Director Facilities	Sustaining Our Future	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	CCTV System Failure in Prince Charles Hospital	**IF:** Major CCTV security management platform (SMP) headend and camera outage at PCH. Unable to live view live data images at the security control centre. NVR recording function is not available to record data images. The outage is also linked with the PCH site refurbishment scheme. The Capital Major Projects team advise that the new (SMP) headend server is not part of the PCH scheme as there is no funding for it. **THEN:** As a consequence this presents a site security with very limited site surveillance available to identify site incidents and provide evidence of criminal activity and crime. **RESULTING IN:** The ground floor, first floor and external site areas require the roll out of (124) new CCTV cameras as part of the PCH refurbishment scheme and the existing old (SMP) headend server does not have the functionality and capacity to accept these additional cameras therefore the contractor TD are unable to roll out the new cameras on site until a new SMP is installed. Risks to the PCH site, patients and staff safety risk. Site risk of theft, property damage and personal injury/assault.	Incident meeting held by Facilities with Digital ICT, Estates, the system contractor and Capital Major Projects team who are managing the PCH site Major project scheme to review the faults and aim to resolve the issue.	Update August 2024 - The Estate CCTV system contractor attended site and identified the root cause of the system failure and restored the PCH security management system headend and power to the majority of existing site cameras. The outcome and recommendation from the system contractor, Capital Major Projects team and TD s is that there is further CCTV system replacement and upgrade of hardware and software work to be undertaken. The existing Security Management Platform (SMP) which is the headend control system is old and not fit for purpose and requires replacement and upgrading. Until the (SMP) headend is replaced, the GF/FF contractor will also be unable to fully install the (124) new site GF/FF scheme CCTV cameras and a 'moderate' risk of future system failure remains until this work is completed. A specification and estimate of cost of a new (SMP) headend has been completed and funding has been approved. Waiting for a contractor to be allocated the work and an installation date to install the SMP system. Security Systems Risk Assessments A rolling programme of security vulnerability risk assessments is being undertaken out at a number of sites that include the suitability, compliance and provision of current CCTV and control of access systems and where systems may require replacing and upgrading or where site system provision is inadequate. Where there is a requirement for replacement/upgrade or additional systems further work is then required with support from Estates and Digital Services to complete the system technical specifications before a statement of need is provided to the Operational Capital Group for replacement or new works and security hardware/software scheme funding.	Health Safety & Fire Sub Committee Quality & Safety Committee Planning, Performance & Finance Committee	16	C4xL4	C3xL4 12	⟺	31.01.2024	30.08.2024
15	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. Update August 2024 - There has been no update on progressions since the last update reported, therefore, the risk remains the same. CTMUHB continue to liaise with DHCW on seeking a solution.	Quality & Safety Committee Digital & Data Committee	16	C4xL4	8 C4xL2	⟺	26.04.2024	27.08.2024
18	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 August 2024 • Primary care have joined the 642 process to access spare theatre list across 3 hospital sites • 2 regular, additional lists were offered, however, one of the lists in PCH is now not available due to the paediatric ward not having capacity to support list. • The 2nd additional list in POW- the CDS team are shadowing the theatre on 7 October with a view to start running a new list from 1 November at the latest, there is a possibly of a bi weekly Wednesday list that is currently being discussed for us by CDS. • RGH team have been asked if CDS can have access a number of spare theatre lists during September, currently awaiting response. • Service continues to operate with only 2 lists- 876 children are currently waiting for assessment for GA, children can only be assessed within 9-10 weeks of having treatment under GA, otherwise another assessment is required, therefore without confirmed GA list children continue to wait extensively for assessment.	Quality & Safety Committee	16	C4xL4	9 C3xL3	⟺	20.04.2023	02.09.2024

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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
19	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 July 2024 - Operational Management Board updated 15.5.24. Actions will be taken forward by Planned Care Group. Next rv due 18.7.24. Update August 2024 - Following discussion at OMB in May 2024, a meeting has been requested between DTPS with planned care to discuss next steps.	Quality & Safety Committee. People & Culture Committee - Workforce aspect	16	C4xL4	8 (C4xL2)	⟺	19.12.2023	02.08.2024
21	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.	Update August 2024 - Phase 2 commencing in Sept 24, actions complete in relation to updated polices, stakeholder event next week, risk reviewed and remains the same.	Quality & Safety Committee Mental Health Act Monitoring Committee	16	C4xL4	12 (C3XL4)	⟺	08.12.2023	28.08.2024
22	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 August 2024 - Stakeholder engagement continues, leading to a further review of the business case. This requires continued collaboration across DTPS, Children and Family, Public Health and the Growing Well Strategy Group.	Population Health & Partnerships Committee Quality & Safety Committee	16	C4xL4	8 C4xL2	⟺	13.10.2023	02.08.2024
23	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 August 2024 A historic review of all case files has been undertaken. The findings of the review showed a backlog in a number of areas, including Redress and Inquests. To address the backlog, overtime has been agreed and allocated to 1 member of staff within the team. A trajectory of historic cases has been developed to track progress, which is being closely monitored in the Executive Director Led Q&S meeting. From September, the trajectory of historic cases will no longer be reviewed in the Executive Director Led Q&S meeting, however will be monitored within a weekly meeting led by the Executive Nurse Director (along with the Deputy Executive Director of Nursing). As previously updated, and as expected, the implementation of the Duty of Candour has led to a surge in redress cases. Currently, Redress cases remain a high risk, which is due, in part, to capacity and sickness within the team. One member of the Legal Services team has been realigned to assist with redress cases.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	⟺	02.11.2021	28.08.2024
24	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 August 2024 All inquests have now been reviewed and graded as per their risk level. This system utilizes a Red, Amber, and Green (RAG) rating to categorise the level of risk to the Health Board for each inquest. There has been a significant upward trend in the number of inquests over recent years. A dedicated PowerPoint slide has been developed and is instrumental in tracking the progress of inquests, with a particular focus on: 1. Evidence submission requirements for the Coroner 2. Compliance status of completed witness statements This slide has facilitated scrutiny and assurance in the Executive Director Led Quality & Safety (Q&S) meeting. There has been an improvement in the timeliness of receiving witness statements from members of clinical staff across the Health Board: with response rates increasing from 45% to 80%. As noted above, this improvement is being closely monitored and the risk score will be re-reviewed in the next quarter.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	⟺	02.11.2021	28.08.2024
26	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 June 2024 Business case for CT in final draft, to be submitted this week. NOUS vacancies, 3.4 PCH, 1.8 RGH, recruitment issues - offering standard rate overtime and increased capacity with SPRs. Rotate staff to PCH. explore PAAR rates to encourage staff to take overtime. Update August 2024 - Risk reviewed currently still to remain at 16 but with plans in place bringing MR and NOUS waits down by December. CT plan has been agreed to include staff and mobile CT in October, however, this remains as our greatest area of risk. Risk will be revisited at the end of October to review progress and rescore.	Quality & Safety Committee	16	C4 x L4	4	⟺	01.06.2020	02.09.2024
31	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 June 2024 - The first Performance and Escalation Group, & Workforce Framework Group and Medical Workforce Productivity Board meetings have now taken place. Clear Key Performance Indicators have been drawn out and agreed at V&E. Care Groups are engaged and the programme is running to tackle the identified workforce issues. At the stage, risk remains at the same score. Update: Aug 2024 - Deep Dive meetings are in place between the Medical Workforce Productivity Group and the Care groups to enable scrutiny and improvements operationally and financially. Care Groups also having scrutiny meetings with senior Exec team.	Quality & Safety Committee People & Culture Committee	15	C5 x L3	10 (C5xL2)	⟺	01.08.2013	27.08.2024
32	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 July 2024 - Consideration required for further non-recurrent/recurrent investment in service beyond 2024/5 to address backlog of longest waiters. Funding for 2024-2025 from WG confirmed (NDIP) and £313,000 agreed for ND services for CYP. Around £10k to be spent on CPD and assessments and the rest will be spent on locum SLT/CAMHS workforce, existing/overtime hours for A4C workforce and WLI for medical workforce. This investment will stabilise the longest waiting times and start to bring it closer to a maximum wait of 78 weeks by the end of March 2025 (WG target is 26 weeks although historic longest waiting times have been up to 150 weeks). Waiting list likely to rise again (or at best remain stable at 78 weeks without further improvement) after the end of March 2025 once NDIP funding stops without further investment in the service. Update August 2024 - Risk reviewed and currently remains at 15. Additional staff have been recruited as part of the Neurodevelopment improvement plan (WG funded), however, from September onward the capacity will meet the current demand. Backlog clearance plans will help us start reducing to below 104 weeks by end of March 2025. Risk will be reviewed again at end of October to update risk score.	Quality & Safety Committee	15	C3 x L5	9 (C3xL3)	⟺	14.07.2017	02.09.2024

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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
33	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 July 2024 - Extension to the FEN in place until 1st January 2025, with the agreement the Health Board can apply for a further extension if necessary and noting that this will be required. Business case in development for Welsh Government funding, was due to be submitted by October 2024 however this has now slipped and will likely be early 2025. Update August 2024 - in addition to the July update regular meetings are taking place with the fire service to update on progress, last meeting held 24th July 2024.	Quality & Safety Committee Health, Safety & Fire Committee	15	C5xL3	8	⟺	31.01.2020	29.08.2024
36	3337 Linked to RTE Risk 4813 and M&C 4817. Also linked to 4804.	Chief Operating Officer Director of Primary Care and Mental Health Services	Central Support Function: Digital & Data Mental Health Care Group	Lead Infrastructure Architect Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services	Creating Health	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Use of Connecting Care (previously known as 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 August 2024 - The Health Board has continued to work with the National programme for Connecting Care, with an aim to deliver a fully integrated Mental Health solution as a priority for Cwm Taf Morgannwg University Health Board. A Business Case has been submitted to Welsh Government and we are awaiting the outcome. As a contingency measure we are also working with colleagues in another Health Board to accelerate the procurement and implementation of a Mental Health solution should the Connecting Care business case not be approved in the near future. It is expected that we will be ready to procure in the Autumn of 2024. Risk reviewed no change.	Quality & Safety Committee	15	C5xL3	6	⟺	07.11.2018	09.08.2024
37	4691 Linked to RTE Risks 4803, 4799, 3273 and 3019.	Chief Operating Officer	Mental Health Care Group	Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services	Sustaining Our Future	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	New Mental Health Unit	**IF**: Mental health inpatient environments fall short of the expected design and standards. **Then**: Care delivered may be constrained by the environment, which is critical to reducing patient frustration and incidents as well as presenting more direct risk as a result of compromised observations. **Resulting in**: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace and extended lengths of stay.	A Quality Improvement programme in relation to inpatient care has started and a work stream in relation to Safe and Therapeutic Environments has been established with the aim of optimising the patient experience. Inaugural workshop took place on the 26th April. Assistant Director of Strategic Transformation – Mental Health has commenced in post. This new role will lead a range of strategic programmes including recommencing a capital business case for a new Mental Health Unit. Annual revisiting of all patient ligature risks and completion of Statement of Needs via capital process for any ligature risks assessed as needing resolution. All anti ligature works planned for 2022 – 2023 have now been completed. A scoping document case is to be prepared and submitted to WG. Inpatient Improvement Programme established April 2023	Update 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. Update June 2024 - Risk reviewed - no further change as previously reported. Risk ownership will be transferred to the Service Director for MHLD Care Group. Update August 2024 - Risk reviewed no change. Risk will need to be transferred to new Service Director when appointed.	Quality & Safety Committee	15	15 (C3xL5)	6 (C3xL2)	⟺	15.06.2021	29.08.2024
38	5820	Executive Director of Public Health	Public Health - Health Protection	Health Protection Team	Improving Care & Creating Health	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Potential inability to deliver all elements of the Health Protection Strategic priorities as a result of reduced allocation of funding.	**IF** as a result of the reduced allocation of Health Protection resource the Health Protection Team has insufficient resources to deliver a safe and sustainable service. **THEN** there may not be sufficient resources to deliver all elements of vaccination and immunisation (which is the first line of defence against infectious disease) in accordance with the NIF. The health board response to infectious disease or environmental hazards will also be significantly hindered and work to address gaps in equity of access will be limited. **RESULTING in** avoidable harm to patients in vulnerable groups and harm to the public as a result of insufficient health protection interventions delivered. This also poses a reputational risk as a consequence	Governance structure agreed in Health Protection. Health Protection Board established. Recruitment underway to Health Protection structure. A series of planning workshops with partners agreed to review resources available, develop Health Protection strategy and highlight ongoing gaps	A workforce structure has been approved by ELG and work to identify gaps is ongoing which will be reviewed once recruitment is complete. Work with partners is ongoing to reduce inefficiencies and develop A collaborative Health Protection (HP) plan based on all resources available to ensure priorities can be clearly defined and delivered. Work with CTM finance is needed to ensure the HB allocation is maximised to support HP priorities. Welsh Government discussions are ongoing with regards to the reduced allocation N/B - Whilst this risk is not scored at a level of 15 and above - the Executive Lead considers this risk to be of a contentious nature that should be escalated to the Board via the Organisational Risk Register. Update for September 2024: Risk mitigations and scores reviewed with no change at this stage. Next review scheduled for the 30.11.2024.	Population Health & Partnerships Committee Quality & Safety Committee	12 Please see note in column J	C4xL3	8 (C4xL2)	⟺	01.07.2024	12.8.2024

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	Next Review Date
1	
2	30.09.2024
3	30.09.2024
4	30.09.2024
5	16.09.2024
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8	30.09.2024

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	Next Review Date
1	30.09.2024
9	16.09.2024
10	30.09.2024
12	02.10.2024
13	01.10.2024
14	01.10.2024
15	02.10.2024
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	Next Review Date
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19	20.09.2024
21	30.09.2024
22	20.09.2024
23	30.09.2024
24	30.09.2024
26	31.10.2024
31	01.10.2024
32	31.10.2024

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33	31.10.2024
36	30.09.2024
37	30.09.2024
38	30.11.2024

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
4906	Executive Nurse Director / Deputy Chief Executive	Central Support Function - Quality Governance (Concerns & Claims)	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.	Updated May 2024 - LFERs continue to be monitored in: Q&S Team Business meeting, and Weekly Executive Patient Safety Meeting and Quality & Safety Committee. See rationale for de-escalation.	Quality & Safety Committee	12 Decreased from a 16 in June 2024	8 (C4xL2)	The Health Board has successfully implemented and maintained new systems and processes for managing Learning from Events Reports. These improvements have resulted in timely submission of LFERs to the Welsh Risk Pool panels on a consistent basis. As a consequence, the Health Board is now able to recover costs associated with personal injury and clinical negligence claims filed against it. The punctual submission of LFERs has not only ensured cost recovery but has also helped the Health Board avoid penalties. At the most recent Welsh Risk Pool Committee (LFER Panel) meeting, no penalties were imposed due to the Health Board's compliance with submission deadlines. Ongoing collaboration and review with the Heads of Quality & Patient Safety continue. The Health Board links with the WRP Safety Learning Advisor for complex and challenging LFERs.The proactive approach to LFER management has shown positive results. This strategy of active oversight and monitoring will be maintained going forward.Risk will continue to be monitored via the Patient Care and Safety Directorate. Further update requested at the Audit & Risk Committee in August 2024 ahead of decreasing this risk. Updated rationale as follows to support de-escalation from the Organisational Risk Register: Risk reviewed both narrative and risk rating following a query raised by the Committee on receipt of the losses paper which informed members of recent LFER penalties.The update was approved and the risk rating remains at 12 due to the revised and improved processes in place, which despite the Health Board receiving 3 penalties in July 2024, these were the first penalties received since May 2023. These penalties are felt to be one-off penalties, as the current processes for LFERs are resulting in an improved trend. Therefore, the risk should remain at a score of 12 and be re-reviewed and re-scored, if necessary, at the next risk review. 29/08/24. Risk, rating and rationale reviewed by the Executive Director of Nursing/Deputy CEO and was approved for reporting to September QSC.
3133	Executive Director of Nursing / Deputy Chief Executive	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.	A notable improvement has been made with over 1000 CTMUHB staff having completed the course in the past 3 months, as opposed to the 180 staff from across the entire CTMUHB in 2023, for the face to face training.	Quality & Safety Committee. People & Culture Committee.	12 Decreased from a 16 in September 2024	8 (C4xL2)	Likelihood score reduced from a 4 to a 3 in August 2023 as a result of a notable improvement in compliance. Over 1000 CTMUHB staff having completed the course in the past 3 months, as opposed to the 180 staff from across the entire CTMUHB in 2023, for the face to face training. Medical Gases training also changed from a classroom based session to an ESR E-Learning course which is being advertised via flyer and other mechanisms to raise awareness.
1133 Linked to risk 3826	Chief Operating Officer	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Sustainability of the Emergency Department at the Royal Glamorgan Hospital	**If:** the Clinical Service Group (CSG) is unable to deliver a sustainable staffing model for the Emergency Department at the RGH in line with other units within the area; **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.	SMT risk reviewed, nurse establishment invest to save paper completed unitising the RCN BEST tool (same tool used to review the PCH nursing workforce 2021). To substantiate 2 additional registered nurse. Invest to save paper approved and recruitment tracker in place and interviews are due the 1st week of September. Risk is currently mitigated by staffing to the agreed level by using bank and agency staff.	Quality & Safety Committee. People & Culture Committee - Workforce aspect	12 Decreased from a 15 in September 2024	9 (C3xL3)	SMT risk reviewed, nurse establishment invest to save paper completed unitising the RCN BEST tool (same tool used to review the PCH nursing workforce 2021). To substantiate 2 additional registered nurse. Invest to save paper approved and recruitment tracker in place and interviews are due the 1st week of September. Risk is currently mitigated by staffing to the agreed level by using bank and agency staff. This Risk can now be de- escalated.

	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	5254	Executive Nurse Director / Deputy Chief Executive	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 August 2024: A historic review of all case files has been undertaken. The findings of the review showed a backlog in a number of areas, including Redress and Inquests. To address the backlog, overtime has been agreed and allocated to 1 member of staff within the team. A trajectory of historic cases has been developed to track progress, which is being closely monitored in the Executive Director Led Q&S meeting. From September, the trajectory of historic cases will no longer be reviewed in the Executive Director Led Q&S meeting, however will be monitored within a weekly meeting led by the Executive Nurse Director (along with the Deputy Executive Director of Nursing). As previously updated, and expected, the implementation of the Duty of Candour has led to a surge in redress cases. Currently, Redress cases remain a high risk, which is due, in part, to capacity and sickness within the team. One member of the Legal Services team has been realigned to assist with redress cases.	Quality & Safety Committee	aug-24	Risk reviewed with the Assistant Director of Quality & Safety following discussion with the Executive Director of Nursing/Deputy CEO. I t was agreed to close this risk and amalgamate it with risk 4907 and the Duty of Candour element has been added as a new risk with a rating of 12 (ID 5895). Executive Director of Nursing/Deputy CEO approved for submission to September QSC.

Agenda Item
6.2

Quality & Safety Committee

HMP Parc and Young Persons Unit
A Year on

Dyddiad y Cyfarfod / Date of Meeting	05/09/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Steffan Gwynne, Directorate Manger, Prison Healthcare
Cyflwynydd yr Adroddiad / Report Presenter	Lucie Williams, Nurse Director, Primary Care & Community Services Care Group
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director
Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Prison Healthcare SMT Meeting	02/09/2024	Approved

Acronyms / Glossary of Terms	
ACCT	Assessment, Care in Custody and Teamwork
AMAT	Audit Management and Tracking
BBV	Blood Borne Virus
BCBC	Bridgend County Borough Council
CAMHS	Child and adolescent mental health services
DIC	Death in Custody
ESR	Electronic Staff Record
HCSW	Healthcare Support Worker
HIW	Healthcare Inspectorate Wales

HMP	His Majesty's Prison
HMPPS	His Majesty's Prison and Probation Service
HSCNA	Health and Social Care Needs Assessment
IPC	Infection Prevention and Control
PDR	Personal Development Review
PPO	Prison and Probation Ombudsman
SWP	South Wales Police
TUPE	Transfer of Undertakings (Protection of Employment)
VP	Vulnerable prisoner
YPU	Young Persons Unit

1. Situation /Background

1.1 This report outlines the progress made with providing health care services within the prison since the 15th December 2022. It evaluates service delivery, key achievements to date and future recommendations aimed at enhancing the quality of care for prisoners.

1.2 Located in Bridgend, Parc was the first prison to be built in the UK under the private finance initiative and opened in November 1997. Parc is a Category B prison that holds a complex population including children aged 15–17 years, young adults, life-sentenced prisoners and those who have committed sexual offences.

1.3 The prison has an operational capacity of circa 1,810 prisoners, this represents a 6% increase in the prison population over the last 12 months. A comparison in the turnover of prisoners being admitted to Parc for April 2023 and April 2024 shows an increase in activity of 50%.

1.4 The prison population is split into three main areas:

- Main Prison;
- YPU Unit – 60 spaces dedicated to children and young people;
- VP Unit – for those on remand or convicted of sexual offences;

1.5 G4S was awarded a 10 year manage and maintain contract for Parc in June 2022, which includes the day-to-day operational management of the prison. CTMUHB have been the providers of primary healthcare since the 15th December 2022 following a change from G4S Health as the existing health care providers.

2. Specific Matters for Consideration

2.1 CTMUHB will aim to deliver high quality, safe, effective and patient centred care, offering broadly equivalent service access to that which is available to our patients in the community, whilst operating within the constraints and restrictions associated within a secure establishment.

2.2 Service Delivery

2.3 Since the initiation of CTMUHB led health care services within the prison, the focus has been on developing a comprehensive health care program designed to meet the physical and mental health needs of the prisoner population. Key services implemented include:

2.4 General medical services that provide all aspects of care including referral, assessment, diagnosis and treatment. The primary care nursing and pharmacy services also support the delivery of general medical services within the prison;

2.5 Nurse led community based clinics providing ongoing services for those prisoners with chronic illnesses. In addition to local services, the prisoners have access to local specialist community services e.g. palliative care services;

2.6 Pharmacy services are provided from the onsite pharmacy dispensary, on the wings, and within the healthcare setting. All prescriptions are clinically screened by a pharmacist

and medications are dispensed both in possession and not in possession, as appropriate, for the prisoners. The pharmacy team also process and supply stock medication;

2.7 The pharmacy team provide advice and support regarding medication management to prisoners and the wider multi-disciplinary team as well as providing support to the drug testing team, processing prescription requests from prisoners, managing the pharmacy shop, and communicating with community teams and/or other prison estates to support transfers and releases;

2.8 Psychological assessments, crisis intervention, and ongoing therapy for the prisoners with mental health and learning disability issues are provided jointly via the primary care nursing team and by the mental health in-reach services;

2.9 CAMHS support is provided to meet the emotional and mental health needs of all the children accommodated on the YPU Unit, it is delivered via the main CAMHS service within secondary care;

2.10 The health care team provide integrated clinical and psychosocial services, in conjunction with Dyfodol (a specialist substance misuse service); to support the rehabilitation of drug and alcohol users.

2.11 An onsite general dental and optometric service provides all aspects of care including assessment, advice, treatment, referral, and discharge;

2.12 Working with the main prison operator, the health care team will advise on operational risk assessments (e.g. cell sharing) and undertake a medical screening to assess the prisoners fitness to transfer;

2.13 The health care team will attend all new ACCT reviews for all prisoners who are identified as being at risk of suicide or self-harm.

2.14 In addition, the healthcare team will advise on the suitability of prisoners transfer into the Care and Support Unit (Segregation) and complete an appropriate clinical review within two hours of the prisoner's transfer (when the health team are on duty). An appropriate clinician will have daily contact with a prisoner to continually assess their health and wellbeing;

2.15 An unscheduled care service is also provided with a response nurse available at all times. The health care team will respond to emergency requests for clinical assistance and assess whether the prisoner needs an emergency transfer to hospital;

2.16 The health care team will undergo a medical assessment of all admissions to the prison (including those returning from court, hospital visits and transfers) to assess their physical and mental health needs at the time and to determine whether there are any clinical needs that require review;

2.17 Discharge planning is undertaken by the healthcare team for all prisoners released from the prison, including those attending court or being transferred to another establishment;

2.18 The healthcare team work in partnership with Public Health Wales and the Health Promotion team in relation to prevention, education opportunities are explored to raise awareness about personal health, hygiene and chronic disease management.

2.19 Key achievements

2.20 In order to provide the services within the prison, the following achievements have been accomplished since CTMUHB have provided the health care provision:

2.21 Workforce Improvements

2.22 An extensive TUPE programme, working alongside People Services colleagues, to ensure that all G4S Health staff were provided with suitable CTMUHB job descriptions and terms and conditions. In addition, the All Wales nursing uniforms were provided across the clinical teams;

2.23 The identification of the need to further improve the services provided within the prison with the appointment of key leadership roles, namely the Principal Pharmacist and Clinical Lead Nurse Manager. In addition to this, following completion of PDRs, the roles and responsibilities for the four Nurse Team Leaders were agreed and put in place;

2.24 A review of all staffing rosters across nursing and pharmacy (and the introduction of HealthRoster) was undertaken to ensure safe staffing levels are delivered where possible and compliance with the roster policy;

2.25 A HCSW competencies framework has been introduced, which has enabled additional HCSW services which were previously undertaken by the registered nurses;

2.26 As of 1st July 2024, a Prison Healthcare Directorate has been established within the Primary Care and Community Services Care Group. The new directorate, structure at ***Appendix A***, with a dedicated Directorate Manager and Lead Nurse, will provide appropriate management support for the clinical team (in line with other prison establishments) and strengthen the partnership working with HMPPS and G4S to improve the services provided within the prison.

2.27 A dedicated governance manager has been employed to support the team and provide oversight to the senior leadership team of all governance risk and issues.

2.28 All staff added to ESR and provided access to all mandatory and statutory training opportunities in line with all CTMUHB staff;

2.29 Improved Governance Arrangements

2.30 As part of the change in health provision, CTMUHB has introduced the Quality framework into the prison including the Duty of Candour, rapid review meeting, Putting Things Right guidelines for concerns and incident reporting using the All-Wales Datix reporting system. As part of the ongoing continuous improvement work, a weekly Datix incident scrutiny panel has been introduced so that themes and trends are understood and actions are agreed for further improvement.

2.31 In line with CTMUHB processes, documentation, IPC and standards of care audits are now being reported via AMAT.

2.32 In the event of a Death in Custody (DIC), the health care team take appropriate action following the incident, which includes a rapid review and action plan, if appropriate. The health care team support and provide evidence for all HIW and PPO reports following the DIC. This process has been reviewed and each action plan is shared and adopted by the Health Board.

2.33 Monthly multi agency safeguarding meetings have been established with representation from Health, G4S, BCBC and other interested parties (e.g. SWP) to ensure that safeguarding processes are reviewed and improved.

2.34 An ongoing review of the governance arrangements are in place including the introduction of new terms of references and attendance for key meetings such as the Prison Healthcare Operational Group, the Prison Healthcare Assurance Board and the HMP/YPU Parc Partnership Boards.

2.35 Due to the fact the pharmacy dispensary holds stock controlled drugs, a review of all controlled drug processes was required to ensure that the Home Office licence was granted in order that stock controlled drugs could be held and processed onsite. The first licence under CTMUHB was secured in February 2023 and the licence was successfully renewed in early 2024.

2.36 There are weekly governance meetings with the senior leadership team and quality and safety leads to ensure all aspects of governance are monitored.

2.37 Improved Service Provision

2.38 As part of the ongoing work to reduce unnecessary officer escorts or time outside of the prison, the health care team have agreed pathways with secondary care services to utilise in-reach services and provide onsite clinics where possible. To date, sexual health now provide services on site alongside existing services such as physiotherapy and podiatry. In addition to this, the diabetes team undertook clinics on site whilst providing training to the practice nurses who now provide an in-house service.

2.39 The health care team have also invited services into the prison to review services so that new pathways can be developed. At present, the team are working through action plans following visits from the tissue viability nurse and resuscitation teams. In addition to

this, the health care team are working with the BBV Project team as part of the WHO target to eliminate hepatitis B and C as a public health threat by 2030, with the aim to offer all prisoners testing and treatment where appropriate.

2.40 In addition to links with clinical services, the ability to link in with corporate services have identified and improved services for both staff and prisoners at Parc. Recent visits and inspections by the Health & Safety Coordinator has enabled improvements such as the action cards to be used when prisoners attend the Princess of Wales Hospital.

2.41 In addition to improvement in service provision, within the constraints of the prison regime health promotion events are held. A recent example was the over 55 year old event that brought together health professionals, community organisations, and prisoners aged 55 and above to foster an environment of health awareness and education. The event had various interactive sessions that focused on vital health topics such as nutrition, chronic disease management, mental health resources, and physical activity tailored for older adults.

2.42 As part of the health service model review, a Health and Social Care Needs Assessment (HSCNA) has been commissioned to better understand the health needs of the resident population in Parc and to assess the extent to which the current need and demand for health and social care in the prison establishment were being met. The HSCNA is due to be published in October 2024 and an action plan for improvements required will be developed as a result.

3. Key Risks / Matters for Escalation

3.1 Following the progress made, there remains challenges:

3.2 **Staffing Shortages:** difficulty in recruiting and retaining qualified personnel has constrained our ability to meet the increasing healthcare demands and increased the use of bank and agency staff to maintain safety within the prison;

3.3 **Prison operational staffing challenges:** any fluctuations in operational staffing levels and resulting regime changes, can pose challenges to health care resource allocation and service delivery;

3.4 **Integration of health services:** whilst various services have been established, efforts to integrate them into a cohesive health care strategy continue to require attention.

3.5 **Prison estate issues:** navigating the physical environment of the facility can pose barriers for staff to provide health care. The need for appropriate and increased space requirements with suitable IT and network capabilities can restrict service expansion and improvement.

3.6 **Changes to prison demographics/provision:** currently the health care team are reviewing service provision to adapt to legislation changes (reduction of standard determinate sentences from 50% of their sentence to 40%) and requests from HMPPS to change the proportion of the prisoners who are housed in Parc. These imposed changes have a huge effect on the staffing models and service provision.

All of the above challenges are monitored and managed through the appropriate governance/assurance meetings.

3.7 Future Developments:

3.8 To continue enhancing healthcare services in Parc, the following developments are proposed:

3.9 **Staff Recruitment and Training:** increase efforts to recruit additional health care staff and provide ongoing training to current staff focused on the different elements of prison health care. Discussions have commenced with the Clinical Director for ED regarding the possibility of developing a bespoke training programme to enable staff to treat more prisoners on site and reduce the need to transfer to an emergency department;

3.10 **Staffing Model:** as part of the HSCNA and in response to the DIC action plans, a review of the current staffing model is underway to review the nursing and pharmacy staffing model provided at the prison;

3.11 **Integrated Services:** to develop a coordinated care model that integrates mental health, neurodiversity and substance misuse programs to provide holistic treatment for prisoners. A review of how secondary care services are provided within the prison is underway to understand the use of remote clinics and assess potential for further in-reach services.

3.12 **Continuous Improvement Plans:** regularly evaluate healthcare outcomes and processes to identify opportunities for further enhancements and ensure compliance with health care standards. The pharmacy team are in process of working with iCTM to review current practices and to identify possible changes that will improve the staff experience whilst reducing errors and incidents as part of the medication hatch review;

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: A More Equal Wales A healthier Wales
Dolen i Hwyluswyr Ansawdd	Learning, Improvement & Research

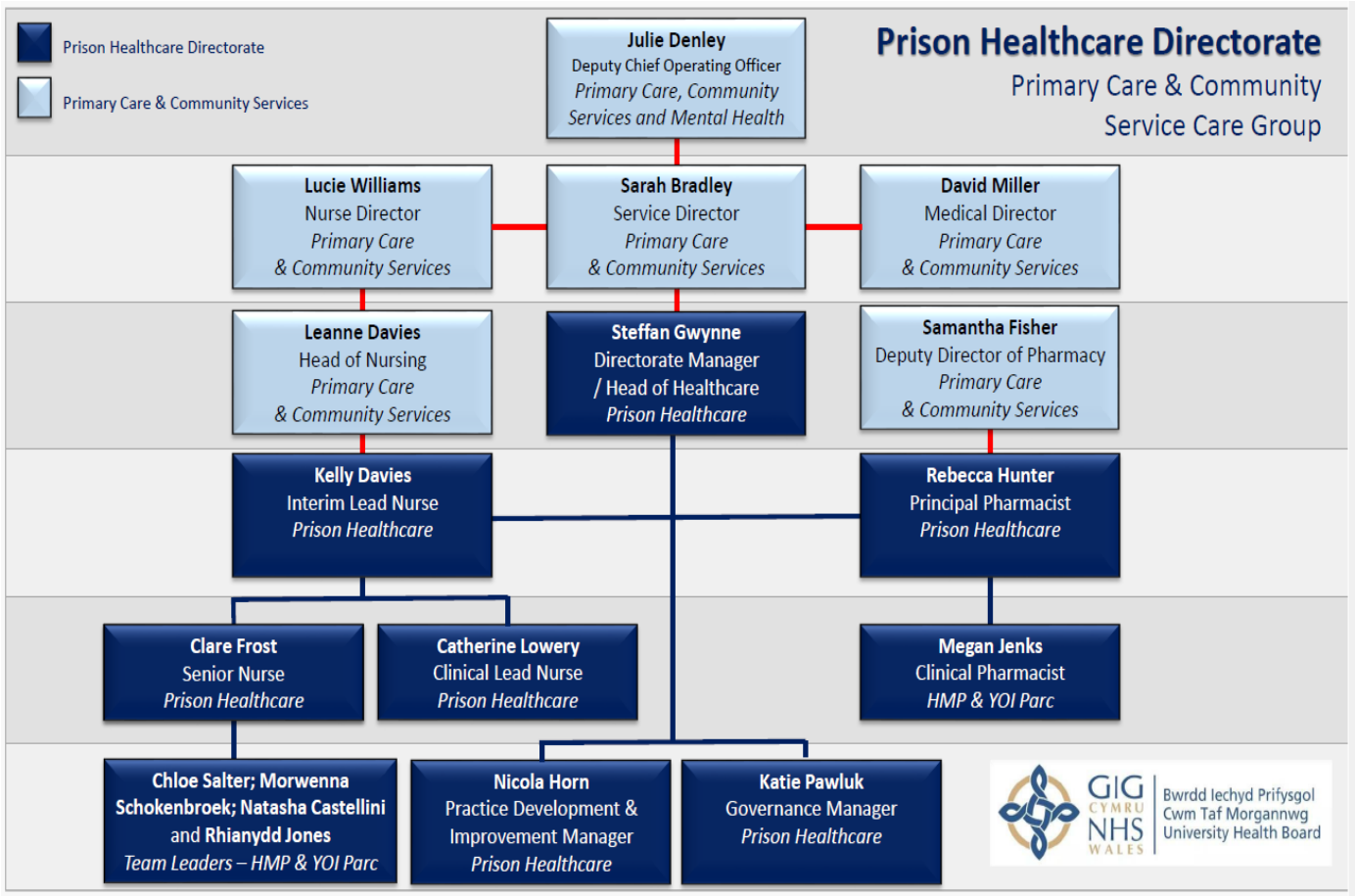
(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	If more than one applies please list below: Culture and valuing people Data to knowledge
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Equitable
	If more than one applies please list below: Safe, Timely, Person Centred, 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: *Position paper – no changes suggested at present*
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: *Position paper – no changes suggested at present*
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 report.

Appendix A

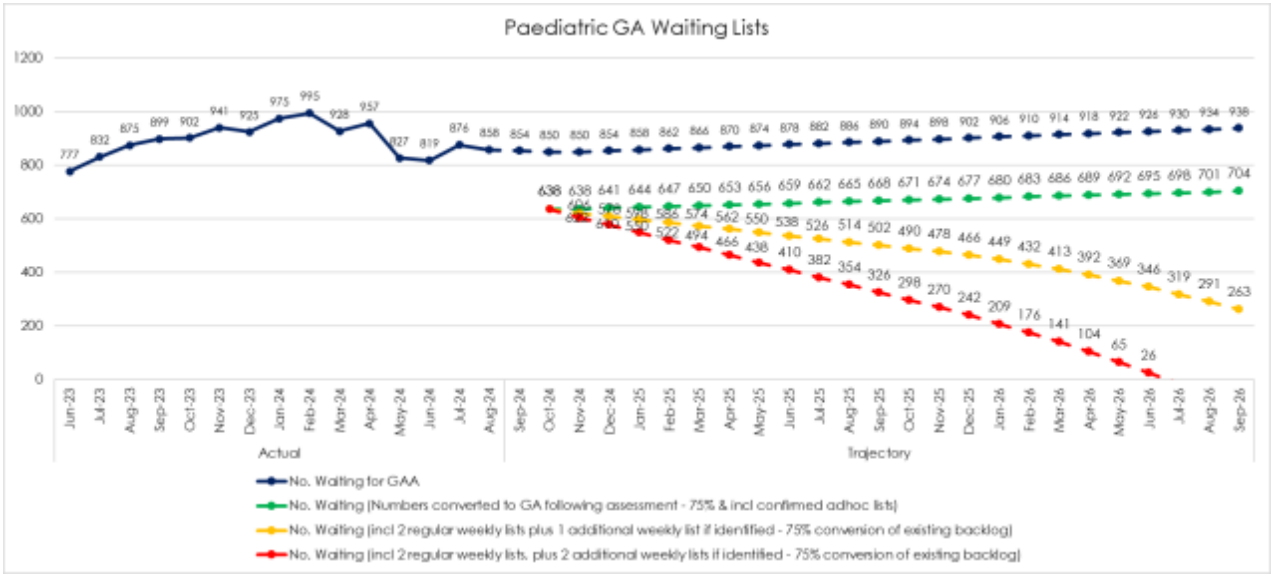

Prison Healthcare Directorate
Primary Care & Community Services
Julie Denley
Deputy Chief Operating Officer
Primary Care, Community Services and Mental Health
Prison Healthcare Directorate
Primary Care & Community
Service Care Group
Lucie Williams
Nurse Director
Primary Care & Community Services
Sarah Bradley
Service Director
Primary Care & Community Services
David Miller
Medical Director
Primary Care & Community Services
Leanne Davies
Head of Nursing
Primary Care & Community Services
Steffan Gwynne
Directorate Manager / Head of Healthcare
Prison Healthcare
Samantha Fisher
Deputy Director of Pharmacy
Primary Care & Community Services
Kelly Davies
Interim Lead Nurse
Prison Healthcare
Rebecca Hunter
Principal Pharmacist
Prison Healthcare
Clare Frost
Senior Nurse
Prison Healthcare
Catherine Lowery
Clinical Lead Nurse
Prison Healthcare
Megan Jenks
Clinical Pharmacist
HMP & YOI Parc
Chloe Salter; Morwenna Schokenbroek; Natasha Castellini and Rhianydd Jones
Team Leaders – HMP & YOI Parc
Nicola Horn
Practice Development & Improvement Manager
Prison Healthcare
Katie Pawluk
Governance Manager
Prison Healthcare
GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

(AGENDA ITEM)	(18.09.24)	(Name of Meeting)	Paediatric Dental GA

Report Details:	
FOI Status:	Please select: Open (Public)
If closed please indicate reason:	Not applicable
Prepared By:	Kim Dunn- DM Primary Care
Presented By:	Tarek Allouni [Director Planned Care]
Approving Executive Sponsor:	Gethin Hughes
Report Purpose	For Noting
Engagement undertaken to date:	Dental Q and S Primary Care Q and S Operation Management Board Primary Care Board

Impact Assessment:	
Indicate the Quality / Safety / Patient Experience Implications:	Patient Experience
Related Health and Care Standard	Timely Care
Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	No
Are there any Legal Implications /Impact.	No
Are there any resource (capital/Revenue/Workforce Implications / Impact?	Yes: Revenue Funding/Additional clinical and administrative workforce needed to operate additional GA lists
Link to Strategic Goals	Improving Care

PERFORMANCE
SALARIED DENTAL SERVICE- PAEDIATRIC GA SERVICE



Trajectory Assumptions & Caveats:

1. **Demand & capacity**: trajectories based on averages calculated using the previous 12 months' data. However, confirmed ad hoc lists which have been obtained by the service have been factored in.
2. **Trajectories**: calculated on the basis the service can maintain a sufficient workforce to carry out additional theatre activity.
3. ***List capacity**: Although up to 6 children can be seen per list, calculations are based on average of 4 patients completing GA per list, taking into account double slots for multiple/full clearance extractions, DNAs and list cancellations i.e. lists that fall on BH and not replaced/hospital audits/ hospital prioritisation of lists during high demand.

- **Current Service Risk Score 16.**
- **Background Pre-COVID** : 2 X GA lists in RGH were sufficient to meet demand prior to COVID pandemic where up to 11 patients treated per week* [refer to point 3]
- **In Aug'24**: there are now approx. **858** children waiting for GA assessment in the community dental service including those on the waiting list and those who have an appointment booked for assessment. Following assessment, **644** children will require dental treatment under GA.
- **Conversion rate:** currently 75% of children require GA once assessed, compared to 48% pre-covid. Reasons for the increase are due to prolonged & restricted access to dentistry during COVID [national IPC guidelines] / longer waiting times for GA / children with higher treatment need i.e. multiple extractions required.

Current Mitigations/Actions:

- There are currently no regular additional lists identified for the service. Originally, 2 additional weekly lists were identified (1 in PCH & 1 in POW) but the PCH list cannot go ahead due to capacity issues on the paediatric ward and the POW list cannot go ahead due to hospital staffing levels.
- Primary Care will continue to source additional lists via the 642 process. Currently, 5 ad hoc lists have been picked up by the service across September, October & November in PCH and the possibility of backfill lists in RGH identified through 642 is being explored.
- Dotted green line on table shows how 2 regular lists running per week from Nov'24 will impact on waiting time for assessment.
- Dotted orange line shows impact on service if 3 regular lists were available p/w, which would help to reduce the current backlog, but the service would still have a sizeable waiting list by Sept 2026.
- Dotted red line shows impact on service if 4 lists were available p/w, which would generate a bigger impact to reduce waiting times. By Aug 2026, the number of GA lists required could revert back to the original 2 p/w.
- NB. The backlog for this service is assessment waiting time, not waiting times for treatment. Children are only assessed for GA within 9-10 weeks of having treatment, any longer requires a second assessment prior to treatment.

- Despite the opportunity for regular lists on the POW & PCH sites not currently being feasible, the service is continuing preparations to be able to carry out ad hoc GA activity on these sites.
- The service has been invited to the weekly 642 meeting for Ophthalmology on the POW site to pick up any suitable backfill lists.
- Admin support is required for both secondary/primary care. 1.00 WTE B4 post currently being advertised [funded by Primary Care] to support regular & ad hoc GA activity]. Post holder will work across both care groups. The service will require support from secondary care administrators for any ad hoc lists picked up through 642 until an appointment is made.
- Additional clinical workforce required in primary care to undertake GA assessments / treatment under GA. Interim solution: non-urgent community dental clinics will be cancelled to release workforce to support any ad hoc lists identified through the 642 process. Medium Term: Recruitment of 1 WTE dentist and dental nurse.
- To support utilisation: Meeting arranged with consultant anaesthetist to identify best approach to managing patient distribution on lists, to avoid delays / discussions ongoing to identify charitable funds for sensory room and identify patients at high risk for failure to provide increased nursing support.

Dependencies:

- Additional lists to be available and suitable for paeds GA services through 6:4:2
- Available workforce to operate lists in primary care
- Paediatric ward capacity to enable list to run
- Temporary administration support from secondary care to support adhoc lists

Issues:

- Cardiff and Vale UHB has requested that CTM transfer the paediatric comprehensive care GA list to CTM [this GA list is for treatment of complex paediatric patients or those needing restorative treatment].
- If this service was to be repatriated, this would add to the current risk in the service. Discussions are required with Cardiff to discuss this list and to ensure referrals are not being refused and bounced between HBs

Recommendation:	**The Committee are asked to:**
	• *Acknowledge the work being undertaken across primary/secondary care to mitigate the risk and reduce patient backlog, accepting this cohort of patients need access to regular theatre lists to reduce backlog and prioritise care* • *Recognise additional workforce is required to provide administrative and clinical support to operate the additional lists, with no additional funds available* • *Trajectories could be improved if list utilisation increases [slide 2, point 3] and further additional suitable lists can be identified via the 642 process* • *Acknowledge further discussion is required with CAV UHB regarding their request to transfer the comprehensive care GA list to CTM UHB and the impact this will on theatre list requirement in CTM*

Agenda Item
6.4

Quality & Safety Committee

Highlight Report from the Health, Safety & Fire Sub Committee

Dyddiad y Cyfarfod / Date of Meeting	18/09/2024
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	Geraint Hopkins, Independent Member/Chair of the Health Safety & Fire Sub Committee
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Hywel Daniel, Executive Director for People

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	

1. Introduction

1.1 This report had been prepared to provide the Quality & Safety Committee with details of the key issues considered by the Health, Safety & Fire Sub Committee at its meeting on 5 September 2024.

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

2. Purpose of this Meeting

2.1 The purpose of this Sub-Committee is to:

Advise and assure the Board and the accountable officer on whether effective arrangements are in place to ensure organisational wide compliance of the health Board's health and safety policy, approve and monitor delivery against the health and Safety priority action plan and ensure compliance with the relevant standards for Health Services in Wales.

This will be achieved by encouraging strong leadership in health and safety, championing the importance of a common sense approach to motivate focus on core aims distinguishing between real and trivial issues.

Where appropriate, the committee will advise the Board (through the Quality & Safety Committee) and the accountable officer on where and how, its health and safety management may be strengthened and developed further.

Highlight Report

Alert / Escalate	• The **Fire Safety Report** was received. Members remained concerned in relation to the issues being experienced with items obstructing all centre core landings within the main H block at Prince Charles Hospital, with particular concern raised regarding the continual blocking of the evacuation routes to the evacuation lifts. The Executive Director for People committed to escalating this further to the Executive Team and Operational Management Board to ensure this matter was resolved. **<u>Positive Escalation</u>** • The **Health, Safety & Fire Performance Report** was received. The Committee noted the improvements that had been made in statutory and mandatory training compliance.

Advise	• The **Organisational Risk Register report** was received and Members noted that the risk register was in the process of being updated for submission to the September Executive Leadership Group and subsequent Committees. • The **overarching Care Group Highlight Report** was received. Members welcomed the work being undertaken to develop an overarching CTM Escalation Policy which should help to address the issues experienced in relation to Boarding of patients. • The **Children and Families Care Group Highlight Report** was received. Members noted that the risk relating to the Electrical and air handling unit resilience in Princess of Wales Labour ward and Neonatal Unit had now been reduced from 20 to 16 • The **Diagnostic, Therapies, Pharmacy and Sciences Care Group Highlight Report** was received. The Executive Director for People welcomed the progress that had been made in Care Group reporting at this meeting.
Assure	• The Committee received the **Assistant Director of Health, Safety & Fire report** and noted that following concerns raised by Members at the last meeting in regards to funding for replacement batteries for core equipment, funding had now been sourced by the Chief Operating Officer which was welcomed by Members. • The **Estates High Voltage Electrical System Compliance Report** was received. Members welcomed the Substantial Assurance rating that had been allocated
Inform	The following items were approved/noted via the consent agenda: • Unconfirmed Minutes of the meeting held on 19 June 2024 – **Approved**; • Health, Safety & Fire Sub Committee Forward Work Programme for 2024/2025 – **Noted.** • The Committee **NOTED** the action log and requested a review of completion dates was undertaken against the actions identified
Appendices	

3. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM /	Improving Care
	If more than one applies please list below:

Link to CTMUHB Strategic Goal(s)	
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	Not Applicable If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Not Applicable If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Safe If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable If more than one applies please list below:

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

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

4. Recommendation

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

Agenda Item
6.5

Quality & Safety Committee

Human Tissue Authority Reportable Incident (HTARI) Reporting

Dyddiad y Cyfarfod / Date of Meeting	18/09/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Dr Paul D Davies, Designated Individual
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**
Dr Dom Hurford, Executive Medical Director	14/08/2024	Noted
Mr Carl Verrecchia, Director of Operations Diagnostics, Therapies, Pharmacy & Specialties	14/08/2024	Noted

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf Morgannwg University Health Board
CLH	Corporate Licence Holder
DI	Designated Individual
HTA	Human Tissue Act
HTAuth	Human Tissue Authority
HTARI	Human Tissue Authority Reportable Incident

1. Situation /Background

1.1 CTMUHB has a Post Mortem sector HTA Licence, covering all three District General Hospital sites.

1.2 The CLH is the Executive Medical Director and the DI has the primary legal responsibility for ensuring all relevant standards are upheld.

1.3 The DI also has the responsibility for ensuring that the incidents which meet the threshold for a HTARI are reported following HTAuth guidelines.

1.4 The HTARI guidance describes the following classifications;

1.4.1 HTARIs are serious incidents that may affect the dignity of the deceased and damage public confidence. HTARIs can be defined as largely preventable incidents that should not occur if establishments and their staff are compliant with HTA standards and guidance where applicable and available preventative measures are in place to mitigate risk of incidents

1.4.2 A near-miss HTARI is an incident that was prevented from happening by chance or a factor external to the establishment's own procedures; or an incident that occurred but there was no adverse outcome.

1.4.3 An incident prevented from occurring by the establishment's own procedures is not considered a near-miss HTARI and does not need to be reported to the HTA.

1.5 This report sets out the process of HTARI reporting and the governance of the learning and outcomes in practice.

2. Specific Matters for Consideration

2.1 For CTMUHB the following table presents HTARI and Near-Miss HTARIs outcomes since April 2023;

		HTARI	Near-Miss HTARI	Non-HTARI
2023/24	**Q1**			
	Q2			1. Security
	Q3	1. Loss of Tissue		
	Q4		1. PM Consent	
			2. PLR Traceability	
2024/25	**Q1**		3. Loss of Tissue	

2.2 There was no significant harm identified relating to the HTARI reported in 2023/24 Quarter 3 'Loss of Tissue'.

2.3 Within the Health Board the reporting of HTA related incidents is initiated through the DATIX system.

2.4 The DI has early notification of such incidents via an automatic copy to reports with reference to key words (e.g Mortuary, Deceased) and through a network of HTA Persons Designated who are usually line managers of the areas where the incident has occurred.

2.5 Most incidents relate to non-conformity with agreed Standard Operating Procedures attributable to human error.

2.6 Each incident is managed as per the Incident Management Framework and where they are HTA related the DI is involved.

2.7 The process for HTARI reporting and subsequent management is as follows;

STEP 1 - The DI receives a DATIX by email and/or a verbal report from a Persons Designated setting out an incident which is HTA related.

STEP 2 - Within 5 working days the DI will determine if the incident is reportable to the HTA following the HTARI guidance. This enables time for an initial fact finding investigation, discussion with relevant clinicians/managers, taking advice from the HTA if necessary and a determination of the level of harm in line with the Incident Management Framework.

The CLH is also informed. Clinical leads may also organise a Rapid Review meeting dependant on the level of harm initially reported.

STEP 3 - If the incident is reportable, the DI uploads the necessary information to a secure HTAuth portal following a set template.

STEP 4 - The HTA will reply by email within a few days and commission a Follow-Up report with a date for submission. This is usually 8 weeks from the date of the HTARI report.

STEP 5 - The DI will request from clinical leads / managers a Follow-Up report offering advice as needed. This Follow-Up report is quality assured by the relevant Directorate before submitting to the DI. This report, including an action plan, is uploaded to the HTAuth secure portal.

STEP 6 - Within a week the HTAuth will contact both the CLH and DI with their assessment of the investigation report and action plan. There are a number of potential assessment outcomes;

a. Non-HTARI
b. Near-Miss HTARI
c. HTARI

2.8 If the feedback determines that the incident was a HTARI, at some point later in that year the HTAuth will contact the Health Board with the information which will be published on the HTA website.

2.9 This is a quarterly analysis and contains a high level information table of names of Licenced Establishments and what type of HTARI was reported. For example, "Loss of Tissue / Procedural Error led to Loss of Tissue".

2.9 The DI works closely with clinical and management leads to ensure all actions set out in the Follow-Up report is met as per each target date specified.

2.10 This work ensures improvements in the specific areas involved and also wider learning within the Health Board. For example, a recent Near-Miss HTARI regarding the loss of tissue traceability for Pregnancy Loss Remains has resulted in a revision of the established Histology Checklist in Gynaecology to include a counter-signature by the woman and a copy provided for future reference.

2.11 This has improved the informed consent for Histology testing following ectopic pregnancy loss.

2.12 Further improvements to the overall literature provided to women is planned by Bereavement Services.

2.13 Overall monitoring of HTA incidents, including HTARI reports, is summarised and reported quarterly to the HTA Board chaired by the Group Service Director and every 6 months an update report is submitted to the Health Board Quality & Safety Committee.

2.14 This ensures oversight of any trends in reporting and provides a review of the work undertaken to meet the standards of the HTA.

2.15 The governance systems for maintaining the conditions of the Licence was commended by the HTA when last inspected in early 2023.

3. Key Risks / Matters for Escalation

3.1 There is a continual requirement for staff to be both trained and competent in the wide range of Standard Operating Procedures applicable to the Mortuary Department including clinical services who care for the deceased and pregnancy loss at ward and department level.

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))*	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: 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: The report is for noting
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: The report is for noting
Cyfreithiol / Legal	Yes (Include further detail below)	

	The HTA (2014) and related standards are legally applicable in CTMUHB for the Post Mortem Sector Licence.
Enw da / Reputational	Yes (Include further detail below)
	Adherence to the process is essential to maintain the HTA Licence
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 requested to **NOTE** the process for HTARI reporting and follow-up of actions within a governance framework for CTMUHB.

6. Next Steps

6.1 No further steps identified.

Agenda Item
6.6

Quality & Safety Committee

Impact and Governance around the Management of Medication Shortages

Dyddiad y Cyfarfod / Date of Meeting	18 September 2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Carol Hudson Advanced Pharmacist, Formulary and Interface
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	
MSN	Medication Shortage Notification
CPhO	Chief Pharmaceutical Officer
DHSC	Department of Health and Social Care

1. Situation /Background

1.1 Medication shortages are becoming increasingly frequent across the UK and globally, for a variety of reasons. They present significant and ongoing challenges to the NHS. Some can easily be resolved, whilst others have the potential to pose a significant risk to patients.

1.2 Medicine Shortages are identified through a variety of sources. The Department of Health and Social Care (DHSC) are responsible for the continuity of supply, and manufacturers have a legal requirement to inform the DHSC of any supply problems. The DHSC work closely with NHS, the Medicines and Healthcare products Regulatory Agency (MHRA), Specialist Pharmacy Services (SPS), and others (including wholesalers, national pharmacy representatives) to help prevent shortages and to ensure that the risks to patients are minimised when they do arise. After assessment of notifications, the DHSC will issue a Medicine Supply Notification (MSN). Welsh Government, via the Chief Pharmaceutical Officer (CPhO) may also issue a CPhO notification letter if this shortage is likely to have an impact in Wales.

1.3 The number of medication shortages has increased over the last few years, from 71 MSNs (and 41 CPhO letters) in 2021 to 121 MSNs (89 CPhO letters) in 2023. By August 2024, there have already been 83 MSNs (79 CPhO letters) issued.

1.4 The potential impact of each medication shortage is assessed by the DHSC, and assigned into a Tier.

- Tier 1: low impact (eg minimal risk; short duration),
- Tier 2: medium impact (eg therapeutic alternatives available, including unlicensed imports; require some clinical management),
- Tier 3: high impact (eg no or limited clinical alternatives, significant issues with switching products; live-saving medication)
- Tier 4: critical impact (eg life-threatening impact; no viable therapeutic alternative).

There has been an increase in Tier 2 and Tier 3, both of which require more monitoring and/or management.

2. Specific Matters for Consideration

2.1 Medication shortages have the potential to impact on the care available to patients and also on clinician choice of medication.

2.2 Management of shortages, from dissemination of information to stock procurement, is taking an increasing amount of time.

2.3 The most effective way for dissemination of information regarding the shortage and the options available to mitigate the shortage needs to be considered.

2.4 Governance and accountability regarding the management of shortages, particularly as shortages are having an increasing impact on patient care and associated FOI requests are increasing.

2.5 Increasing numbers of people need to be involved in managing shortages, particularly Tiers 2 and 3, and the time involved in trying to mitigate the impact is escalating. A Tier 2 shortage that has licensed therapeutically

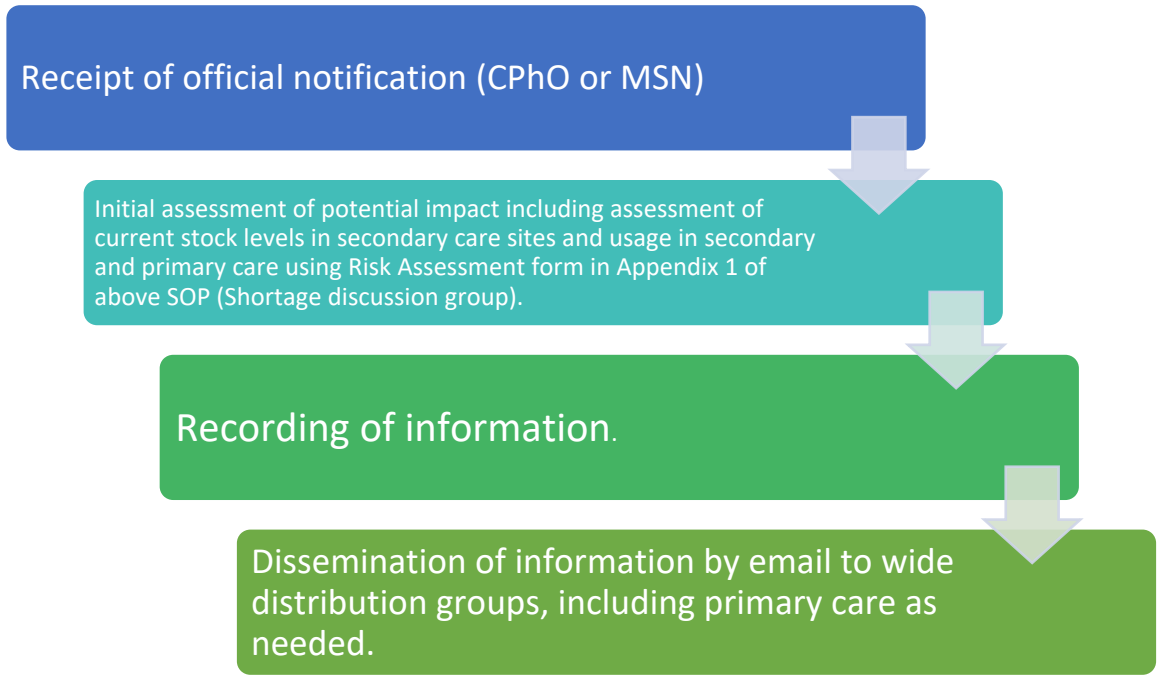
equivalent products will still require assessment for local impact, dissemination of information, reviewing of stock levels and usage, completion of initial risk assessments, recording of information for 'audit trail', ordering of stock, possible referrals back to prescribers, thus involving MMPU, pharmacy logistics, clinical pharmacists, prescribers/clinicians. A more complex shortage will require extra input potentially involving time to source unlicensed products, completion of risk assessment and quality assurance on product, drafting and approval of communication about the alternative products, potential amendments to pathways/PGDs and so on.

2.6 Procedure developed to reduce the triplication of work across the sites in CTM, and give a unified response across the Health Board.

2.7 Process undertaken in Medicines Management has been formalised into an SOP: 'Procedure for the management of medicines shortages'[1] that was taken to the Access to Medicines group in July 2024 for approval.

2.8 Summary of Process (for full details see document[1]):

Initial actions



Subsequent actions as needed



2.9 Supporting groups/meetings involving CTMUHB:

- All Wales Medicines Shortage Advisory Group
  - Fortnightly – chaired by National Contingency Planning Pharmacist for Wales
- CTMUHB logistics meeting
  - Weekly – involves pharmacy logistics lead pharmacist and technicians
- Shortage discussion group
  - As needed – minimum two, preferably three individuals. Usually Lead Pharmacist for Operational Services, Medicines Safety Officer (MSO) and Formulary Pharmacist – to complete initial assessment.
- Shortage Action Working Group
  - As needed, and frequency to be decided by group. Composition of group dependent on specific shortage. To include pharmacy logistics, clinical pharmacist, clinicians, primary care etc as appropriate.
- Weekly CTMUHB 'touch point'
  - Assistant Director of Medicine, Chief Pharmacist and/or Deputy director of Medicines Management, MSO and Formulary Pharmacist. To brief any significant issues, highlight any cost pressures and ensure correct people involved in Discussion or Action groups.

3. Key Risks / Matters for Escalation

3.1 Potential for negative impact on quality of treatment.

3.2 Significant cost pressures may be associated with the alternative products recommended, particularly if these are unlicensed or imported.

3.3 Increasing use of unlicensed and/or imported medication as the only options available to replace the medication in short supply.

3.4 Increasing time taken to try to manage medication shortages by multiple teams is impacting on ability to complete other tasks.

3.5 Impact of severe/critical shortages in community can also impact on secondary care. This can range from additional requests for hospital prescriptions and supply, to demand on clinics/specialities to recommend or even monitor switches to available alternatives.

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))*	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: This is an update of an existing procedure
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:
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. Recommendations

5.1 For awareness of process to manage shortages.

6. Next Steps

6.1 Ratification of SOP by OMB
6.2 Communication of Process to team members who are involved or may need to be to cover absences and any required training.
6.3 Access to necessary reports obtained for additional team members.
6.4 On-going review.

Reference/Attachment
Management of Medicines Shortages Procedure v 3.0 (see point 6.1 above)

Management of Medicines Shortages Procedure

Document Type:	Non Clinical Procedure
Ref:	CTM-MM17
Author:	Carol Hudson, Advanced Pharmacist, Formulary and Interface Huw Carson, Medication Safety Officer
Executive Sponsor:	Executive Medical Director
Approved By:	Choose an item.
Approval / Effective Date:	(00/00/0000)
Review Date:	(00/00/0000)
Version:	3.0

Target Audience:

People who need to know about this document in detail	Medicines Management Staff
People who need to have a broad understanding of this document	Medicines Management Senior Team
People who need to know that this document exists	Health Board Senior Clinical and Executive Staff

Integrated Impact Assessment:

Equality Impact Assessment Date & Outcome	**Date:** **Outcome: An Equality Impact Assessment has been undertaken and no equality impact has been identified**
Welsh Language Standard	Choose an item.
Date of approval by Equality Team:	(00/00/0000)
Aligns to the following Wellbeing of Future Generation Act Objective	Choose an item.



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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Amendment Record

If a change has been made to the document, the changes must be noted and circulated to the appropriate colleagues.

Detail of change	Why change made?	Page number	Date of change	Version	Name of Policy Author
Changed hyperlinks to reflect new shortages folder location	update	4 and 6	18.01.21	1.1	Kathryn Howard
Added information on how to access stock data on WellSky	update	6	15.04.21	1.2	Kathryn Howard
References to Pharmacy EDS system removed	Has not been live since March 2021 so Wellsky system can now provide >1 years data	6	19.04.22	2.0	Rowena Havard
SPS medicines Supply tool	Link added	4	05.05.22	2.0	Rowena Havard
PGD wording added	Make clear unlicensed medication cannot be used on PGD	4	08.06.22	2.1	Huw Carson
Formatting change	Procedure review	all	21.03.23	2.3	Huw Carson
Full review of process	Review	all	04.07.24	3	Carol Hudson

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1. Introduction

This guidance is to ensure that all shortages of medicines and other prescribable products are managed as efficiently as possible and the impact on both CTMUHB and patients is minimised.

1.1 Scope

This guidance applies to the shortages of all medicines and prescribable products, with the exception of blood products, that have the potential to impact upon patients and services.

1.2 Objectives

There are a number of objectives, which include:

- Detailing how medicines Shortage notifications are actioned and disseminated within Cwm Taf Morgannwg University Health Board (CTMUHB).
- Outline the roles and responsibilities for the reporting, actioning and escalating of shortages
- Defining the impact of shortages and the roles of different groups to assess and respond to individual shortages
- Provide assurance and documentation on the monitoring and management of shortages within CTMUHB

1.3 Definition

Shortage is defined as: where the supply of a product is inadequate to meet the current or expected demand. This may be a total shortage, where no supply is available; or a partial shortage where some demand can still be met.

1.4 Background

Medication shortages are becoming increasingly frequent across the UK and globally, for a variety of reasons. They present significant and ongoing challenges to the NHS. Some can easily be resolved, whilst others have the potential to pose a significant risk to patients. This guidance aims to provide a mechanism for evaluating the potential impact; to clarify how the information is disseminated across the Health Board; and to outline a process to proactively manage shortages across the Health Board.

1.5 Identification and communication of a Medicine Shortage

Medicine Shortages are identified through a variety of sources. The Department of Health and Social Care (DHSC) are responsible for the continuity of supply, and manufacturers have a legal requirement to inform the DHSC of any supply problems. The DHSC work closely with NHS, the Medicines and Healthcare products Regulatory Agency (MHRA), Specialist Pharmacy Services (SPS), and others (including wholesalers, national pharmacy representatives) to help prevent shortages and to ensure that the risks to patients are minimised when they do arise.

After assessment of notifications, the DHSC will issue a Medicine Supply Notification (MSN). Welsh Government, via the Chief Pharmaceutical Officer (CPhO) may also issue a CPhO notification letter if this shortage is likely to have an impact in Wales. In these the supply issue will be categorised into one of four tiers depending on the severity of the issue:

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Tier	Example of Situation
Tier 1 – low impact ***'Business as usual'*** Likely to carry minimal risk. Management options should result in patients being maintained on the same licensed medicine.	Supply problems with a short-expected duration (up to four weeks), and where temporary supply controls are expected to manage available stock. Other suppliers of the same medicine are likely to be able to pick up the demand and meet the full supply gap
Tier 2- medium impact **'Most frequent level of alert & usually triggers a MSN'** Require more intense management options, which may carry a greater risk to patients/health providers than tier 1 issues, but which is considered safe to be implemented sub-regionally without further escalation.	Therapeutic alternatives are available. Limited clinical risks associated with switching. Issue can be fully resolved following further engagement with suppliers or where MHRA are able to resolve and issue through regulatory assistance. Unlicensed imports of the same medicine are available in sufficient gaps to meet a supply gap. An alternative strength/ formulation of the same medicine is sufficient to meet the supply gaps but further clinical advice is required to help manage.
Tier 3- high impact **'More critical than Tier 2. Usually triggers a SDA'** These may include invoking a Serious Shortage Protocol. CPhO letter usually generated	Medicine is used in life saving conditions such as anaphylaxis (these circumstances may warrant escalation to Tier 4) No or limited clinical alternatives Product designated by MHRA where a patient should be maintained on the same brand or where switching between preparations is particularly difficult. The process of switching a patient over to a therapeutic alternative requires monitoring. Patient group affected is classed as a 'vulnerable' patient group. Supply Disruption Alert (SDA) triggered.
Tier 4 – critical **'Critical Shortage'** Cannot be resolved as a 'tier 3 shortage' requires additional support from outside the health system.	Likely to have life threatening impact on patients. A supply gap remains (and no viable therapeutic alternatives exist) following exhaustion of supply and clinical management plans at previous tiers of escalation. Requires the support of agencies outside of the health system (e.g. Department for Transport, police services) to support its management.

Following receipt of such notifications, the procedure outlined in Section 2 will be followed and a communication sent out via email as appropriate.

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2. Procedure

2.1 Initial actions- receipt of shortage notice

MMPU team will:

- Read through the CPhO letter and ascertain scale and clinical areas affected by shortage
- Add shortage details to CTM Medicines Management 'Medicines Shortages Spreadsheet'
- Create specific sub-folder in the 'Stock Shortages' folder for the specific shortage under year and drug name and save MSN/SDA and/or CPhO letter
- Place MSN/ SDA/ CPhO letter on Stock Shortages section of Medicines Management page on Share Point
- Draft shortage email for distribution

2.2 Assessing Stock Levels and Usage Data

MMPU team (in conjunction with logistics team if required) to start initial risk assessment of the implications of the shortage. This risk assessment will be documented on the proforma in appendix 1, and the spreadsheet as appropriate.

This will include the need to:

- Establish current Health Board stock levels by looking on 'KLENQ' (for stock holding on each site) and/or 'KANAL' function on WellSky, or if unable to do this, by emailing the CTM logistics group.
- If the shortage could impact Primary Care, access CASPA data to establish the use within the Health Board
- Use the information above, and taking into consideration factors such as:
    - Anticipated length of shortage
    - Clinical significance of the medicine
    - Availability/suitability of alternative(s)

The risk assessment will decide on the level of actions required according to the potential impact. The risk should be categorised as one of the following:

Category	Possible descriptors	Actions
Green (anticipated to have little impact)	Can be managed locally by e.g. readily available, clinical equivalent, alternatives Short term and sufficient stock available (NB this can only be checked in secondary care)	Disseminate information via generalised email
Amber (anticipated to have medium impact)	Alternatives may be available, stock levels may be lower/unable to support for duration of shortage,	Initial meeting of Shortage Discussion Group (formed of lead Procurement Pharmacist, MMPU pharmacist and others as appropriate) to confirm 'Amber status'
Red (anticipated to have significant impact)	Alternatives not available/suitable Long term Significant cost pressures	Shortage Working group formed for each 'Red status' shortage (i.e. there may be multiple working groups at a particular time)

The risk assessment should be agreed with at least two of the following: Formulary/Interface Pharmacist, Medication Safety Officer, Deputy Head of Pharmacy- Procurement, Head of Pharmacy POW (with responsibility for logistics), and another member of MMPU team.

- Use spreadsheet to log ongoing issues, comments etc. while shortage is being dealt with to allow other users to access up to date information.

2.3 Actions following risk assessment

Actions appropriate to level of impact (note this may change as the shortage progresses, or further discussions take place)

Category	Actions
Green (anticipated to have little impact)	• Send shortage email (see section 2.4 below) • Ensure all information/relevant correspondence stored in drug file with MSN/CPhO letter
Amber (anticipated to have medium impact)	• Send shortage email (see section 2.4 below) • Meeting of Shortage Discussion Group held as soon as possible. This will confirm status as Amber and also note any particular actions required • Any further actions to be documented on spreadsheet

Red (anticipated to have significant impact)	• Send initial shortage email (as per 'green'). Include the following statement 'Due to the potential impact of this shortage, a HB wide working group will be formed and any additional information/action will be communicated as appropriate'
	• Meeting of Shortage Working Group for the specific shortage to be held as soon as possible. This meeting to be chaired by the Head of Pharmacy POW (with responsibility for logistics) or appointed deputy.
	• This group to nominate a 'Designated clinical pharmacist(s)' (DCP) to lead and support from a clinical point of view. This may be the clinical pharmacist in the specific area, but in the absence of a specific pharmacist the Deputy heads of Pharmacy- Clinical Services will nominate a DCP
	• The group meeting should include:
	  ○ the Head of Pharmacy POW (with responsibility for logistics) or their appointed deputy [Chair]
	  ○ 'Designated clinical pharmacist(s)' (DCP)
	  ○ MMPU pharmacist
	  ○ Where appropriate: Prescribing Advisor (team leader), Principal Pharmacist for Community Services; Principal Pharmacist Primary Care; MSO; QA Pharmacist.
	• Where there is likely to be a significant cost or clinical impact the Chief Pharmacist, Deputy Director of Medicines Management (Medicines Governance Lead) and assistant Medical Director should be informed [as part of the regular 'Shortages touch point'
	• The frequency of the meetings of this group should be established according to the urgency/severity of the shortage, and take into account any action that may be a UK or an 'All Wales' recommendation. Any significant decisions should be communicated via email to wider groups as appropriate.
	• The date of cessation of the group should be recorded on the spreadsheet for each specific shortage
	• All documentation relevant to decisions made by this group must be stored in the file for the individual drug in the shortages folder.

See appendix 2 for flowchart

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2.4 Email dissemination

Once the information on current stock levels, primary and secondary care usage is pulled together and an initial decision on potential impact has been made and all information is recorded on the spreadsheet, an email will then be distributed with a summary of the information and relevant copies of CPhO letter (or occasionally the MSN if urgent notification is required) attached. The distribution lists should include the following:

Secondary care

- To the Care Group triumvirate directors
- Heads of Nursing.
- For Pharmacy – to the secondary care pharmacy teams using: CTM.Pharmacy.PCH@wales.nhs.uk, CTM.Pharmacy.POW@wales.nhs.uk, CTM.Pharmacy.RGH@wales.nhs.uk, CTM.Pharmacy.YCR.YCC@wales.nhs.uk

Primary care and HMP/YOI Parc

- For CTMUHB GP practices- to the primary care development manager for circulation to all GP practices
- For primary care, cluster and practice based pharmacists and HMP Parc – use distribution list: CTM.Pharmacy.PrimaryCare@wales.nhs.uk (which includes the Chief Pharmacist Primary Care, Principal Pharmacists for Primary Care)
- Medicines Management Support Officer, Principal Pharmacist for Community Services and Community Pharmacy Facilitator

3. Roles and Responsibilities

3.1 All Pharmacy staff

It is expected that all pharmacy staff will read the shortage notifications as they are distributed by email and will ensure that relevant information is passed on to clinical staff on wards, in clinics, surgeries etc.

Any pharmacy staff that are made aware of difficulties in obtaining prescribable medicines should ensure that information is fed back to the logistics teams on the secondary care sites so that the situation can be monitored.

3.2 Clinical Pharmacists

Where shortages affect specific areas, it is expected that the specialist clinical pharmacists, or the pharmacists working in a specific clinical area, will ensure that consultants/specialist teams/clinicians are aware of the shortage and support the teams to prescribe alternatives and complete any actions as required by the shortage notification.

If the shortage is likely to have a moderate/ significant impact, then the specialist clinical pharmacist (or pharmacist working in that area) should discuss actions and response to the shortage with MMPU.

3.3 MMPU

A member of the MMPU team (normally the Formulary and Interface Pharmacist) will be responsible for:

- the initial assessment of stock levels and usage [in conjunction with the MSO and Lead Pharmacist for Procurement and an initial impact assessment (RAG) will made.
- the initial shortage email dissemination.

MMPU will be responsible for maintaining the spreadsheet and ensuring that decisions are clearly documented, although other individuals in the process may have access to add relevant information to the spreadsheet as appropriate.

The Principal Pharmacist-Quality and Safety is responsible for ensuring that these actions are undertaken in order to provide assurance to the Director of Medicines Management that medicine shortages have been actioned appropriately.

3.4 Pharmacy Logistics

The lead pharmacist for procurement will have responsibility for managing the shortage where there are anticipated to be ongoing stock supply issues. This may be designated to another senior member of the team. They will be supported by MMPU and where appropriate a DCP, MSO and/or QA Pharmacist.

If there is likely to be a cost pressure involved, e.g. obtaining unlicensed stock or the alternative licensed preparation is more expensive, then they will notify the appropriate individuals as detailed above.

Procurement teams are responsible for sourcing the alternative(s) and ensuring that this is done in a timely manner according to stock levels and usage. Any issues sourcing this should be escalated immediately to the lead pharmacist for procurement. If it is not possible to source an alternative product, this should be communicated appropriately

If an unlicensed product needs to be procured, the Lead Pharmacist for procurement is responsible for starting the risk assessment form and sent via the appropriate route to the appropriate clinician for completion. For shortages affecting all care groups, the assistant medical Director and Clinical director of Medicines Management will be the signatories.

3.5 Deputy heads of Pharmacy/ Heads of Pharmacy

The Deputy heads of pharmacy (or heads of pharmacy) are responsible for maintaining and updating the list of pharmacists and their clinical specialties on the MMQSG Teams Channel

DHOP/Principal Pharmacists to facilitate their clinical specialist pharmacists to support shortage management when necessary, and to help with setting the expectation that this is prioritised.

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4. Summary of Meetings which support shortage management

The following meetings are held involving CTMUHB colleagues with the purposes as outlined. This list is not exclusive, and meetings may be changed (frequency, function etc.) as appropriate.

All Wales Medicines Shortage Advisory Group (AWMSAG)

Chaired by the National Contingency Planning Pharmacist for Wales, normally held fortnightly.

Purpose: to share advanced information regarding potential shortages from information received by the DHSC; share information regarding shortage management across Wales; discuss any potential for 'All Wales' actions; discuss issues regarding procurement and purchasing contracts; and any issues regarding availability of medicines in practice can be fed back and escalated to DHSC if needed.

CTMUHB logistics meeting

Chaired by Deputy Head of Pharmacy- Operational Services (POW) and involving logistics team leaders and senior technicians from all sites and Formulary Pharmacist

Purpose is to discuss any shortages and potential actions; to delegate these actions to individuals to enable a CTMUHB approach across secondary care without duplication of effort on each site; to manage stock levels and enable the movement of stock across sites where needed; discuss impact of shortages and identify any that may need additional action/change impact RAG on spreadsheet; highlight any issues with stock not being available that are not 'official' shortages and can then be fed back to AWMSAG

Shortage discussion group

Chaired by Head of Pharmacy- Operational Services (POW) (or deputy) and involving MSO and Formulary Pharmacist. Where required can also include Deputy Director of Pharmacy (Governance), Operational Services Lead Pharmacists. Held as needed. (Where the purpose is purely to assess the RAG risk, this can be a minimum of two individuals as described in section 2.2.)

Purpose: discuss categorisation of potential impact of shortage; assess if further action is needed and if so, identify DCP and other colleagues that need to be involved.

Shortage Action Working group

Chaired by Head of Pharmacy- Operational Services (POW) (or deputy) and/or DCP. Membership as appropriate to need as detailed above. Frequency of meetings to be established according to need.

Purpose: to formulate CTMUHB wide approach to the shortage; assess likely impact including patient affect; assess any potential cost pressure and escalate where appropriate; formulate any local guidelines/policy that may be required (clinical, procedural etc); involve clinicians where necessary; communicate any decisions, policies, guidelines to wider team(s); ensure proactive rather than reactive approach eg paperwork required for unlicensed medicines; document meetings and decisions on spreadsheet so that actions can be logged;

Weekly CTMUHB 'touch point'

Involving Assistant Director of Medicine (Chair ATMG), Chief Pharmacist and/or Deputy Director of Medicines Management (Governance), MSO and Formulary Pharmacist

Purpose: to highlight any new shortages; discuss any that may have significant impact; ensure that support from the different Care Groups is obtained as needed in a timely manner; monitor progress of significant shortages and any associated cost pressures.

5. Training Implications

Team members involved with risk assessing the shortages will require training on the use of WellSky, CASPA, and Share Point. All Team members will also require the appropriate access.

Expectations to be outlined to pharmacy teams e.g. specialist pharmacists and all staff working on ward/dispensary

6. Review, Monitoring and Audit Arrangements

This procedure will be reviewed annually or when there is a change in practice that requires any amendments to be made to the procedure.

7. Retention/ Archiving

This procedure will be retained and archived in line with CTMUHB Policy

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Appendix 1- Shortage Risk Assessment

Medication affected (inc. strength, form etc.)	
CPhO Number	
CPhO letter/MSN issued on	

Anticipated resupply date								
Stock in secondary care sites	PCH:		POW:		RGH:		YCR:	
	Total CTMUHB:							
Average secondary care usage (state if weekly/monthly/pa)	PCH:		POW:		RGH:		YCR:	
	Total CTMUHB:							
Average usage Primary care (weekly/monthly/pa?)								
Is there enough stock to potentially maintain supply?	YES- (mark as **Green** below) ☐				NO – continue assessment ☐			

Are there suitable alternatives recommended? (detail)	
Are these alternatives readily available? (detail eg if unlicensed etc)	

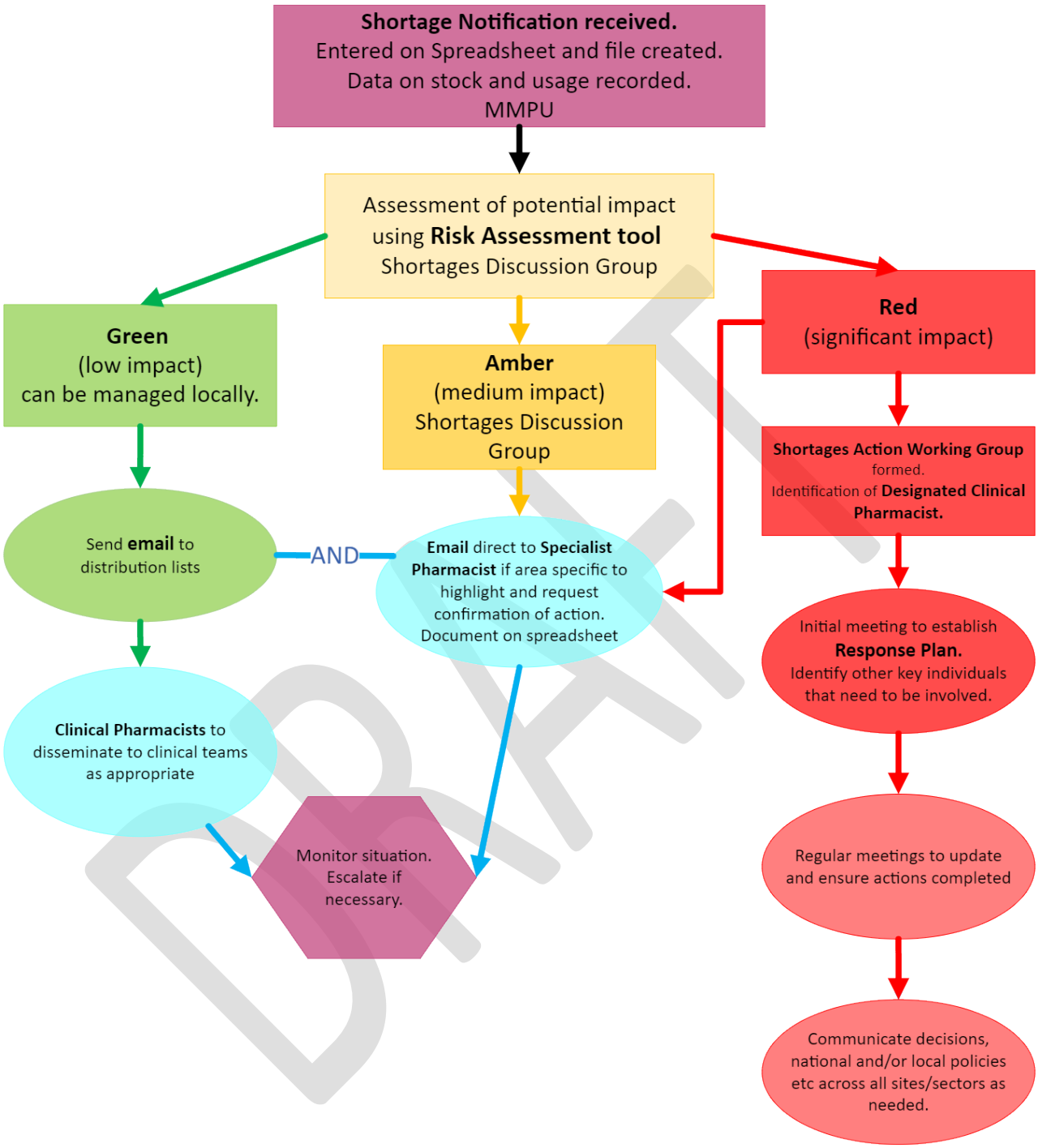
Will the non-availability of this medication have serious clinical consequences?	
Do the available alternatives have any significant differences eg excipients, side effects etc?	
Are there any cost implications?	

Risk Assessment Rating	**Green (anticipated to have little impact)** ☐	**Amber (anticipated to have medium impact)** ☐	**Red (anticipated to have significant impact)** ☐

Completed by:	
Date Completed	

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Appendix 2- Flowchart



Agenda Item
6.7

Quality & Safety Committee

Accreditation Phase 2 update

Dyddiad y Cyfarfod / Date of Meeting	18/09/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Becky Gammon – Assistant Director of Nursing
Cyflwynydd yr Adroddiad / Report Presenter	Becky Gammon – Assistant Director of Nursing
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	
iCTM	Improvement Connect Transform Motivated
AMaT	Audit Management and Tracking
KPI	Key performance Indicators

1. Situation /Background

1.1 To enhance the delivery, recognition, and assurance of care, a robust accreditation framework has been developed, tested, and is set to be implemented across all clinical areas across in patient wards and departments in the acute hospital and community hospitals, across CTUHB. This framework covers key domains such as patient safety, care quality, staff education and training, regulatory compliance, providing a comprehensive blueprint for achieving and surpassing healthcare excellence. Phase 1 is now completed which has a robust framework developed and all data sets, and audit suites agreed and a pilot carried out.

1.2 This briefing paper gives a high-level overview of phase 2 of the rollout and the themes for improvement identified to date.

1.3 To date 10 wards have been visited as part of the formal program including a cross-section of wards from planned care, Unscheduled care and community hospitals (Prince Charles Hospital wards 11, 2, Royal Glamorgan Hospital wards 5,15,10&11, Princess of Wales Hospital wards 18, 3,20, Ysbyty Cwm Cynon ward 3, and Ysbyty Cwm Rhondda ward B2.)

1.4 Each area assessed is awarded an accreditation rating from Red to Gold. Red requiring significant improvement and enhanced monitoring through to gold status, exceeds standards of expectation

Awarded Status	Definition	Data Pack Scrutiny (Reassessment/review)	How to achieve a higher Award
Gold *(Outstanding)*	Significantly exceeds CTMUHB standard expectation of what a ward should achieve	No Red or White scores 39% or more of the standards are Silver Must have evidence to show collaboration with the iCTM team. Must have evidence of action planning and quality improvement projects.	
Silver *(Excellent)*	Greatly exceeds CTMUHB standard expectation of what a ward should achieve Some measures may require improvement	No Red or White scores AND no Red scores at the unannounced visit. 50% or more of the standards are Bronze Must have evidence of action planning and reassessment	Gold accreditation can only be achieved by presenting to a formal panel, Simply Do from iCTM will be utilised for this. Submit a "Striving for Excellence" application and present to the validation panel/board.
Bronze *(Good)*	Satisfactory expected standards Some measures require improvement	Greater that 65% Bronze/Silvers Less Than 25% White Less than 10% Red	Improvement plan required for "White" measures as appropriate
White *(Not Achieved)*	Below standards expected from a ward to achieve accreditation Some measures require improvement	If ≥ 50% in a single RED category OR (Bronze <= 75% AND Red <= 30%)	Improvement plan required for "White" measures as appropriate A second revisit should be scheduled within the next 6 months, and the Executive Director of Nursing and Midwifery/Deputy and Care Group Nurse Directors will be informed
Red *(Poor)*	Immediate Actions required Enhanced Monitoring to begin	If ≥ 90% in a single RED category or if none of the above conditions are met	Support required by Senior Nurse Improvement plan required for "White" & "Red" measures as appropriate A second revisit should be scheduled within the next 3 months, and the Executive Director of Nursing and Midwifery/Deputy and Care Group Nurse Directors will be informed

1.5 In preparation for the assessment, all wards under review receive a comprehensive data pack one week prior to their scheduled visit. This data pack provides a detailed overview of key performance indicators (KPIs) extracted from various digital systems, including Datix, Safecare, and AMaT. These KPIs are carefully aligned with the six dimensions of healthcare quality Safe, Timely, Effective, Efficient, Equitable, and Person-Centred care. By presenting this information in advance, ward staff are given the opportunity to familiarise themselves with their performance metrics, identify areas of strength and potential improvement, and prepare for a more informed and productive assurance process.

1.6 The visiting team is multi-disciplinary team that consists of colleagues from Pharmacy, Nursing, Central nursing and administration team, Allied Health Professionals, Patient Advisory Liaison Service, and the iCTM Improvement team.

1.7 Any immediate risks identified are highlighted at the time of the visit with the Ward manager for attention.

2. Specific Matters for Consideration

2.1 There was some confusion during the analysis of the data as there were some repeated questions. This was clarified as the questions were targeted at different respondents (e.g. manager vs. staff). The questionnaire has been revised and will be consolidated into a single form for future visits.

2.2 Two wards scored at the White level. Immediate focus is required to ensure these wards develop and implement robust action plans. Continuous support from iCTM should be emphasised to help them improve, supported by the senior nursing teams.

2.3 Feedback on the report indicating a lack of clarity between the identified strengths and areas for improvement in the reports. This has been addressed and changes will be implemented to rectify and ensure future reports are clearer.

3. Key Risks / Matters for Escalation

3.1 Wards, particularly those scoring White, are encouraged to engage with iCTM for guidance throughout the improvement process. This will help ensure they have the support needed to progress in the accreditation programme.

3.2 Timeliness in rolling the accreditation framework across all clinical areas given the time required to pull together the data packs and commitment for the visits.

3.3 The data is held on various digital systems leading to a risk of a gap in data if one of these systems goes down and therefore invalidating the data set if not all the data can be inputted.

3.4 Availability of a Multidisciplinary team available for all visits.

3.5 Time required to write up reports for all areas.

4. Assessment

4.1 Each ward is provided with a file containing, their personalised report, data pack, an award/certificate, and an overview of the accreditation guidance. This ensures that all wards have the necessary resources to understand their status and have oversight and responsibility for the actions required to move through to the next award stage.

4.2 Nurse Directors are provided a copy of the formal report and will work with their teams to develop an action plan outlining the necessary improvements.

4.3 Each area has had a formal certificate signed by the Executive Nurse Director and will be formally presented with these at a future celebration event.

4.4 The table below gives an overview of the 10 wards to date and some of the strengths and improvements identified.

4.5 The table below shows the accreditation level of each of the wards assessed and an example of the Strength and improvement against one area of the quality standard.

Site	Ward	Specialty	Accreditation Level	Strength	Areas for improvement
PCH	2	Cardiology/ General medicine	Bronze	Good practice around medicine management	Risk assessments and roster compliance
PCH	11	Endocrinology / General medicine	Bronze	Good incident reporting and investigation knowledge	Information Governance Standards/policy not always followed. Limited evidence of MDT working to support discharge

PoW H	18	Care of the Elderly/ Gen medicine	Bronze	Team meetings held regularly with a formal agenda set and minutes recorded	Medication fridges not locked (when not in use) as per CTM UHB Policy
PoW H	20	Care of the Elderly/ General Medicine	Bronze	Managers/leaders are visible and approachable; they feel supported in their role and appreciated	Medication administration gaps. Not all Nursing staff aware of patients who have a DNACPR
PoW H	11	Surgical-Gynaecology	White	The ward/unit enables patients to retain dignity and privacy	Storage of Substances Hazardous and stores
RGH	10	Surgery-Elective green pathway	Bronze	Patients encouraged to ask questions and / be involved in decisions about their care and treatment	Patient Above Bed Boards not up to date or not visible
RGH	5	Gastrology	Bronze	Compliance with Substances Hazardous to Health (COSHH) products are storage	Not all Staff have knowledge of Quality Improvement Methodology
RGH	15	Surgery-Elective Orthopaedic	White	Controlled Drugs are checked weekly as per CTM UHB policy.	Patient Above Bed Boards are either not up to date or not there. Not all patients are offered Hand Hygiene at meal times
YCR	B2	Rehabilitation	Bronze	Staff verifies patient's identification before providing care to ensure patient safety	Medication fridges were not locked on the day of the visit
YCC	3	Rehabilitation	Bronze	Ward / Team information is displayed to inform staff, visitors & patients who is on duty and who are who	Gaps on medication charts

5. 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))*	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))*	Efficient
	Safe, Timely, Efficient, Equitable and 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: scoring less than 12 which results in full impact assessment not being required.	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg	Yes: ☐	No: ☐

Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? / **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Outcome for Equality (delete as appropriate): POSITIVE Outcome for Welsh Language (delete as appropriate): NEUTRAL	If no, please include rationale below: There is no potential impact
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.	

6. Recommendation

The Quality and Safety Committee are asked to **Note** the update on the progress of the Ward Accreditation Programme.

7. Next Steps for Phase 2

7.1 Enhance Leadership Visibility: Improve managerial visibility and support across all wards.
7.2 Strengthen Safety Practices: Ensure daily safety huddles and accurate patient information on above-bed boards.
7.3 Improve Documentation: Focus on accurate and consistent documentation practices, particularly for NEWS scores and patient discharge planning.
7.4 Implement systems to use patient feedback in quality improvement initiatives actively.
7.5 The next 15 ward visits are planned for September 2024, with data packs currently being prepared.

Agenda Item
6.8

Quality & Safety Committee

Annual Letter 2023/2024
Public Services Ombudsman for Wales

Dyddiad y Cyfarfod / Date of Meeting	18/09/2024
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	Richard Hughes, Deputy Director of Nursing
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

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

1. Situation /Background

The role of the Public Services Ombudsman for Wales (PSOW) is to consider complaints about public services, to investigate alleged breaches of the councillor Code of Conduct, to set standards for complaints handling by public bodies and to drive improvement in complaints handling and learning from complaints. The PSOW also undertakes investigations into public services under their own initiative.

As part of their role, the PSOW provides an annual letter to Health Boards in Wales updating on the work of their office, share key issues for Health Boards and to highlight any particular issue for organisations, together with actions Health Boards are required to undertake.

The PSOW's letter always coincides with their Annual Report, this year it is titled: "A New Chapter Unfolds". It is noted in the letter that public services continue to be in the spotlight, and under considerable pressures.

Overall, from across Wales, the PSOW office has received:

- 17% increase in number of people requesting help of the PSOW
- Almost 10,000 enquiries and complaints
- PSOW caseload increase by 37% since 2019

2. Specific Matters for Consideration

2.1 Cwm Taf Morgannwg University Health Board (CTMUHB) data 2023/24:

Over the year 2023/24, it was reported that the PSOW received the following for CTMUHB:

- 109 complaints (down from 134 complaints in 2022/23)
- 0.25 per 1000 residents (down from 0.30 per 1000 residents in 2022/23)
- 58% of complaints received by the PSOW were in relation to clinical treatment in hospital
- 14% of complaints received by the PSOW related to complaints handling
- 6% of complaints received by the PSOW were in relation to clinical treatment outside hospital
- 123 recommendations were made during the year to CTMUHB
- 121 recommendations due during the year, and 60% were complied with in the timescale agreed (remainder complied with outside of agreed timescale)

Health Board	Complaints Received	Received per 1,000 residents
Aneurin Bevan University Health Board	175	0.30
Betsi Cadwaladr University Health Board	214	0.31
Cardiff and Vale University Health Board	150	0.30
Cwm Taf Morgannwg University Health Board	109	0.25
Hywel Dda University Health Board	138	0.36
Powys Teaching Health Board	21	0.16
Swansea Bay University Health Board	132	0.35
Total	939	0.30

2.2 Public Interest Report

The PSOW published one Public Report in the Public Interest relating to CTMUHB – in October 2023. The case concerned treatment delivered at the Emergency Department of Princess of Wales Hospital, Bridgend. The PSOW noted they were pleased that compliance with all recommendations is complete.

2.3 Handling of PSOW Complaints and Responses

The letter notes that the PSOW has raised serious concerns about CTMUHB's handling of complaints and responses to the PSOW office. As outlined in the PSOW letter, CTMUHB's performance is affecting the PSOW's office's ability to handle complaints in a timely manner, undermining the trust and confidence of service users who have complained about the Health Board. The PSOW is continuing to engage closely with the Chief Executive on this and request the Board considers this matter to scrutinise the Health Board's performance on complaint handling.

Actions being taken to address the handling of complaints from PSOW office:

To address the issues in relation to the management of PSOW cases, the following improvement actions are being implemented. A comprehensive review of the PSOW case management processes has been undertaken, along with the following:

Ombudsman Huddles

- The CTMUHB Team have instituted three-times per week Ombudsman Huddles to:
  - Review new and ongoing cases
  - Assign action items

- Identify escalation needs
- Update on upcoming deadlines

Executive Oversight

- A weekly meeting, led by the Executive Director of Nursing, has been established to monitor Ombudsman Case Management progress

Digital

- Digital platform for real-time updates, fostering improved collaboration and transparency

Regular Reporting

- Every Week, an updated Ombudsman Case overview tracker will be distributed to all PSOW handlers, ensuring consistent information dissemination
- These initiatives aim to streamline CTMUHB's PSOW case management, improve communication, and enhance overall efficiency in handling PSOW cases

It is also noted within the letter that the PSOW Improvement Team are continuing to meet regularly with CTMUHB to discuss compliance with PSOW recommendations and complaints standards. The PSOW notes they have seen real benefit coming from these conversations, as well as improved working relationships. The PSOW noted that they wanted to pass on thanks to Kellie Jenkins-Forrester and the Concerns' team for their work with the PSOW Improvement Team/Officers.

2.4 Action to be taken by CTMUHB:

- Present the PSOW's Annual Letter (Appendix A) to the Board at the next available opportunity and notify the PSOW of when these meetings will take/have taken place

- Consider the data in the PSOW letter, alongside CTMUHB's own data, to understand more about CTMUHB's performance on complaints. This should include any patterns or trends and CTMUHB's compliance with PSOW recommendations

- Ensure that Board members consider CTMUHB's performance on complaint handling and considers whether any further action needs to be taken to improve its performance

- Provide the PSOW with a copy of the Health Board's Annual Report for 2023/24 on the Duty of Candour and Quality

- Inform the PSOW of the outcome of the Board's considerations and proposed actions on the above matters at your earliest opportunity.

3. Assessment:

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	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 *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☒	No: ☐
	Outcome: This report outlines key areas of quality across the Health Board.	If no, please include rationale below:

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

4. Recommendation

Members of the Quality & Safety Committee are asked to:

- **NOTE** the content of the report and PSOW letter (Appendix A)
- **DISCUSS** the content of the report and flag areas (if not already identified) where further assurance is required
- **SUPPORT** the direction in developing a wider reach of quality reporting and locality based assurance reports

5. Next Steps

- Continue to monitor PSOW activity via the quality & safety dashboard, with key areas escalated to the weekly Quality & Safety Executive Meeting as required.

- Inform the PSOW of the outcome of the Health Board's considerations and proposed actions on the matters/actions identified above by 31 October 2024.

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Ask for: Communications

01656 641150

Date: 9 September 2024

Caseinfo@ombudsman.wales

Jonathan Morgan
Cwm Taf Morgannwg University Health Board

By email only
CTM_BoardMember@wales.nhs.uk
paul.mears@wales.nhs.uk

Annual Letter 2023/24

Dear Jonathan

Role of PSOW

As you know, the role of the Public Services Ombudsman for Wales is to consider complaints about public services, to investigate alleged breaches of the councillor Code of Conduct, to set standards for complaints handling by public bodies and to drive improvement in complaints handling and learning from complaints. I also undertake investigations into public services on my own initiative.

Purpose of letter

This letter is intended to provide an update on the work of my office, to share key issues for health boards in Wales and to highlight any particular issues for your organisation, together with actions I would like your organisation to take.

Overview of 2023/24

This letter, as always, coincides with my Annual Report – "A New Chapter Unfolds" – and comes at a time when public services continue to be in the spotlight, and under considerable pressures. My office has seen another increase in the number of people asking for our help – a 17% increase in overall contacts compared to the previous year, with nearly 10,000 enquiries and complaints received. Our caseload has increased substantially - by 37% - since 2019.

ombwdsmon.cymru
holwch@ombwdsmon.cymru
0300 790 0203
1 Ffordd yr Hen Gae, CF 35 5LJ
Rydym yn hapus i dderbyn ac ymateb i ohebiaeth yn y Gymraeg.

ombudsman.wales
ask@ombudsman.wales
0300 790 0203
1 Ffordd yr Hen Gae, CF 35 5LJ
We are happy to accept and respond to correspondence in Welsh.

During 2023/24 we considered and closed more enquiries and complaints than we ever have done before, and we reduced the average cost for each case and investigation. We started the year with a focus on reducing our aging cases, those over 12 months old, by 50% by the end of the year. These cases are often the most complex and distressing for the people making the complaint. I am extremely pleased to say we exceeded this target, reducing our aged investigations by over 70%. We are now well on track to meeting our objective to complete investigation of complaints within 12 months.

Public Service Complaints and compliance with recommendations

We received 939 complaints about health boards last year – roughly the same number as the previous year. During this period, we intervened in (upheld, settled or resolved at an early stage) 31% of health board complaints - a similar proportion to previous years.

Last year, we received 109 complaints about Cwm Taf Morgannwg University Health Board, we closed 129 (some complaints were carried over from the previous year) and intervened in 30% of cases. Further information on the complaints we dealt with last year can be found in the appendices.

We published one public report in the public interest relating to your Health Board in October 2023. As you will be aware, this case concerned treatment delivered at the Princess of Wales Hospital's Emergency Department and I am pleased that compliance with our recommendations is complete.

Also, we have raised our serious concerns about the Health Board's handling of complaints and responses to my office with your Chief Executive. As we have outlined, the Health Board's performance is affecting my office's ability to handle complaints and undermining the trust and confidence of service users who have complained about the Health Board. We are continuing to engage closely with the Chief Executive on this and ask that you ensure the Board considers this matter to scrutinise the Health Board's performance on complaint handling.

In total, we made 123 recommendations to your health board during the year. To ensure that our investigations and reports drive improvement, we follow up compliance with the recommendations agreed with your organisation. In 2023/24, 121 recommendations were due and 60% were complied with in the timescale agreed. The remainder were complied with, but outside the timescales agreed, or remained outstanding as at 9 April 2024.

Recommendations and timescales for complying with recommendations are always agreed with the public body concerned before being finalised, and we therefore expect organisations to comply within the timescales agreed.

Further to the report my office issued in June 2023, Groundhog Day 2: An opportunity for cultural change in complaint handling? I wish to thank the Health Board for its consideration of the report and recommendations. I trust that it has ensured that lessons learned from the PSOW's findings and recommendations on cases we considered last year are included in your Health Board's Annual Report on the Duty of Candour and Quality.

Supporting improvement of public services

We continued our work on supporting improvement in public services last year and worked on our second wider Own Initiative investigation. The investigation considers carers' needs assessments undertaken by local authorities in Wales. My report on this work will be finalised and published in the near future.

We have continued our work on complaints handling standards for public bodies in Wales and now have 56 public bodies following our model complaints handling policy. These public bodies account for around 85% of the complaints we receive.

We continued our work to publish complaints statistics into a third year with data, gathered from public bodies, now published twice a year. This data allows us to see information with greater context – for example, last year 4% of complaints made to Cwm Taf Morgannwg University Health Board's complaints went on to be referred to PSOW. I would encourage all Health Boards to use this data to better understand their performance on complaints and ensure that all complaints are appropriately logged.

Colleagues from my Improvement Team continue to meet regularly with Cwm Taf Morgannwg University Health Board to discuss compliance with our recommendations and our complaints standards work. We have seen real benefit come from these conversations, as well as improved working relationships, and we would like to pass on our thanks to Kellie Jenkins-Forrester and their team for their work with our officers.

Action we would like your organisation to take

Further to this letter can I ask that Cwm Taf Morgannwg University Health Board takes the following actions:

- Present my Annual Letter to the Board at the next available opportunity and notify me of when these meetings will take place.

- Consider the data in this letter, alongside your own data, to understand more about your performance on complaints, including any patterns or trends and your organisation's compliance with recommendations made by my office.

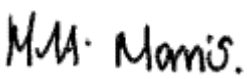
- Ensure that Board members consider the Health Board's performance on complaint handling and considers whether any further action needs to taken to improve its performance.

- Provide my office with a copy of the Health Board's Annual Report for 2023/24 on the Duty of Candour and Quality.

- Inform me of the outcome of the Board's considerations and proposed actions on the above matters at your earliest opportunity.

Finally, I would like to thank you, and your teams, for your work with my officers in the last year. Their work is important in ensuring that patients and families receive timely and thorough responses to complaints, and in improving outcomes for all service users – not just those who complain.

Yours sincerely,



Michelle Morris
Public Services Ombudsman

Cc. Paul Mears, Chief Executive, Cwm Taf Morgannwg University Health Board.

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Factsheet

Appendix A - Complaints Received

Health Board	Complaints Received	Received per 1,000 residents
Aneurin Bevan University Health Board	175	0.30
Betsi Cadwaladr University Health Board	214	0.31
Cardiff and Vale University Health Board	150	0.30
Cwm Taf Morgannwg University Health Board	109	0.25
Hywel Dda University Health Board	138	0.36
Powys Teaching Health Board	21	0.16
Swansea Bay University Health Board	132	0.35
Total	939	0.30

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Appendix B - Received by Subject

Cwm Taf Morgannwg University Health Board	Complaints Received	% share
Admissions/discharge and transfer procedures	1	1%
Adult Mental Health	4	2%
Ambulance Services	0	0%
Appointment procedures (including outpatients)	6	3%
Child and Adolescent Mental Health	0	0%
Clinical treatment in hospital	63	58%
Clinical treatment outside hospital*	7	6%
Complaints Handling	15	14%
Covid-19	0	0%
Continuing care	0	0%
De-Registration	0	0%
Disclosure of personal information / data loss	0	0%
Funding	1	1%
Independent Health Care providers	0	0%
Medical records/standards of record-keeping	0	0%
Medication > Prescription dispensing	0	0%
Non-medical services	1	1%
Nosocomial*	0	0%
Other*	6	6%
Out of Hours GP care	0	0%
Parking (including enforcement and bailiffs)	0	0%
Patient list issues	2	2%
Poor/No communication or failure to provide information	1	1%
Prisoner Care	0	0%
Recruitment and appointment procedures	0	0%
Referral to Treatment Times	0	0%
Regulation and Inspection (including private sector provision)	0	0%
Rudeness/inconsiderate behaviour/staff attitude	0	0%
Services for people with a disability inc DFGs	0	0%
Service for vulnerable Adults (eg with learning difficulties or mental health issues)	0	0%
Total	**109**	

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Appendix C - Complaint Outcomes
(* denotes intervention)

Cwm Taf Morgannwg University Health Board		% Share
Out of Jurisdiction	29	22%
Premature	14	11%
Other cases closed after initial consideration	38	29%
Early Resolution/ voluntary settlement*	16	12%
Discontinued	4	3%
Other Reports - Not Upheld	5	4%
Other Reports Upheld*	22	17%
Public Interest Reports*	1	1%
Special Interest Reports*	0	0%
Total	**129**	

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Appendix D - Cases with PSOW Intervention

	No. of Interventions	No. of Closures	% of Interventions
Aneurin Bevan University Health Board	73	195	37%
Betsi Cadwaladr University Health Board	81	256	32%
Cardiff and Vale University Health Board	34	158	22%
Cwm Taf Morgannwg University Health Board	39	129	30%
Hywel Dda University Health Board	55	154	36%
Powys Teaching Health Board	3	21	14%
Swansea Bay University Health Board	41	141	29%
Total	**326**	**1054**	**31%**

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Appendix E – Compliance performance comparison

Health Board	Number of recommendations made in 2023-24	Number of Recommendations falling due in 2023-24	% of recommendations, complied with on time
Aneurin Bevan University Health Board	209	208	75%
Cardiff and Vale University Health Board	104	95	81%
Cwm Taf Morgannwg University Health Board	123	121	60%
Swansea Bay University Health Board	119	127	62%
Hywel Dda University Health Board	160	151	81%
Betsi Cadwaladr University Health Board	253	246	58%
Powys Teaching Health Board	10	12	67%

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Information Sheet

Appendix A shows the number of complaints received by PSOW for all Health Boards in 2023/24. These complaints are contextualised by the number of people each health board reportedly serves.

Appendix B shows the categorisation of each complaint received, and what proportion of received complaints represents for the Health Board.

Appendix C shows outcomes of the complaints which PSOW closed for the Health Board in 2023/24. This table shows both the volume, and the proportion that each outcome represents for the Health Board.

Appendix D shows Intervention Rates for all Health Boards in 2023/24. An intervention is categorised by either an upheld complaint (either public interest or non-public interest), an early resolution, or a voluntary settlement.

Appendix E shows compliance performance for all Health Boards.

Agenda Item
7.1

Quality & Safety Committee

Patient Safety & Quality Dashboard

Dyddiad y Cyfarfod / Date of Meeting	18/09/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Kellie Jenkins-Forrester, Head of Concerns & Business Intelligence
Cyflwynydd yr Adroddiad / Report Presenter	Nigel Downes, Assistant Director of Quality & Safety
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	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 01.07.24 to 31.08.24 taken from systems on 03.09.24, unless otherwise specified.

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 80% (Welsh Government target above 75%)
- Decreasing trend in the number of Infection, Prevention and Control Incidents being reported
- The Nationally Reportable Incidents submitted remains relatively consistent
- Increase in number of medication incidents reported

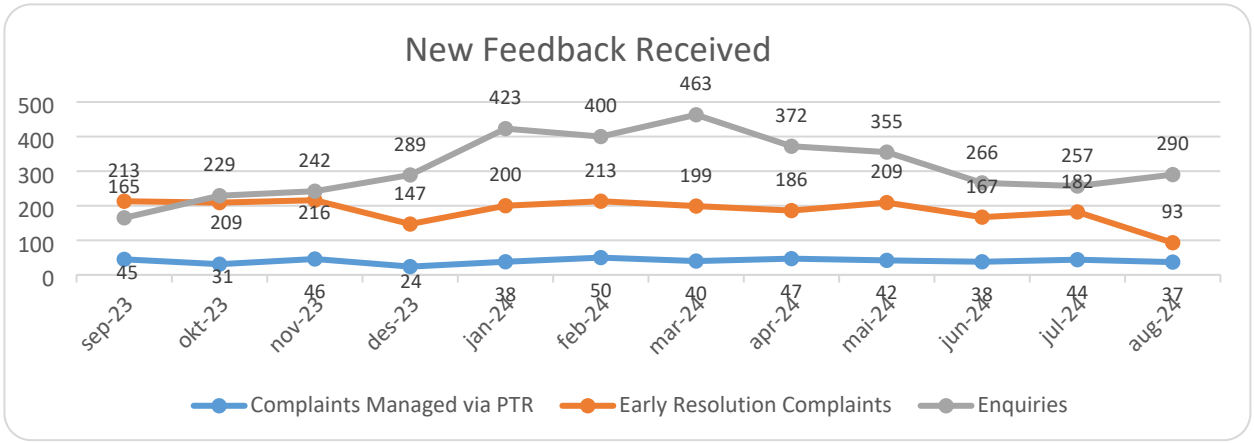
2. Specific Matters for Consideration

2.1 Patient / Service User Feedback

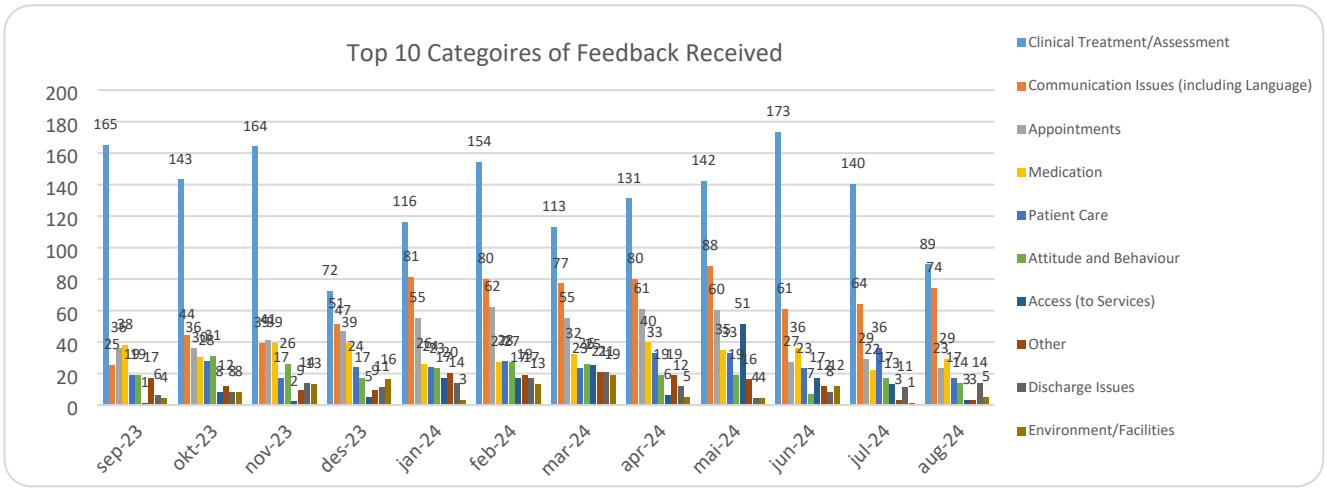
Complaints

<u>New Complaints Received</u>

Between the 01.07.24 and 31.08.24 the Health Board received a total of 356 complaints. Of these, 81 were categorised as formal and managed under the Putting Things Right Regulations (PTR). Whilst the number of formal complaints has remained relatively consistent, the number of early resolution complaints decreased significantly during August 2024, which partially correlates with an increase in the number of enquires logged during the same period.

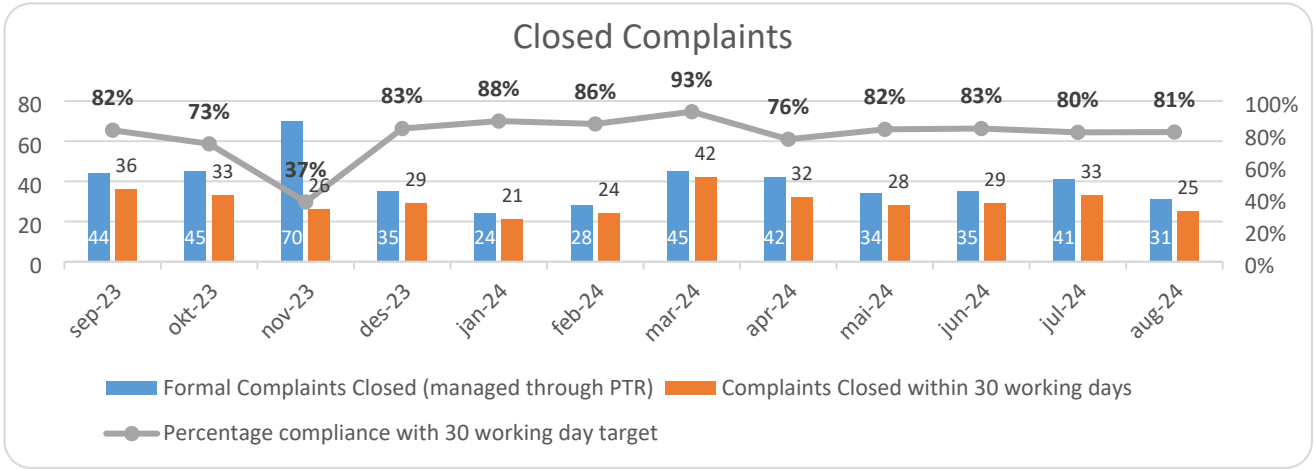


For all feedback (Complaints and Enquiries) received in July and August 2024, the top 3 types of complaints received remain consistent with previous months. These relate to Clinical Treatment / Assessment (229), Communication Issues (138) and Appointments (52).



Closed Complaints

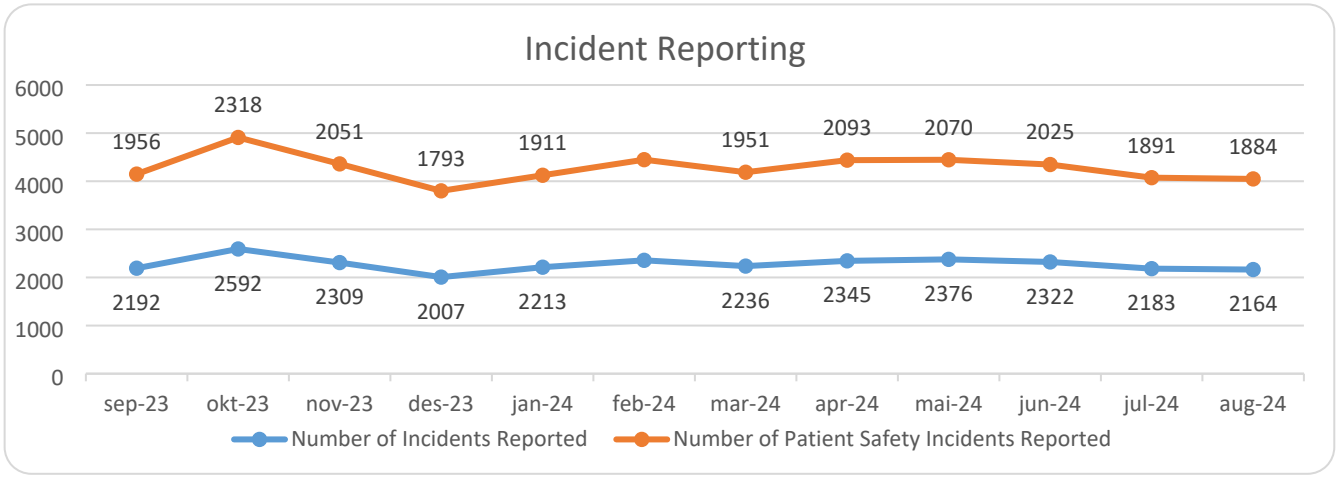
Within the period of 01.07.24 to 30.08.24, the Health Board closed a total of 72 formal complaints (managed through PTR). Whilst compliance has remained over the national target of 75% during the two month period, compliance has remained below the Health Board's internal target of 85%. Compliance continues to be impacted by the availability of clinicians to provide comments and quality assure responses. Daily complaints huddles are fully embedded to ensure open cases are reviewed and robust escalation is undertaken. As at 03.09.24, the Health Board had 66 open formal complaints. Of these, 21 complaints were open over 30 working days.



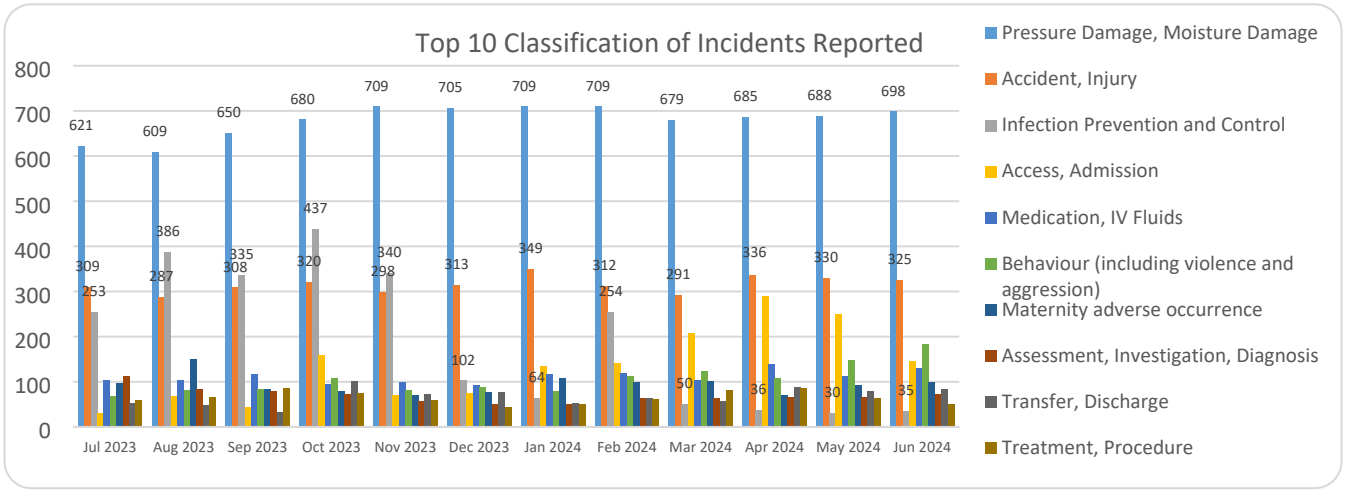
2.2 Patient Safety Incidents

Total Patient Safety Incidents

A total of 4,347 incidents were reported between 01.07.24 and 31.08.24, this represents a decrease of 351 when compared with the previous 2 months (4,698).



The proportion of incidents reported where the patient is identified as the person affected has remained relatively consistent over the last 6 months period. Of the 4,347 incidents reported, 87% (3,775) were reported as the patient affected.

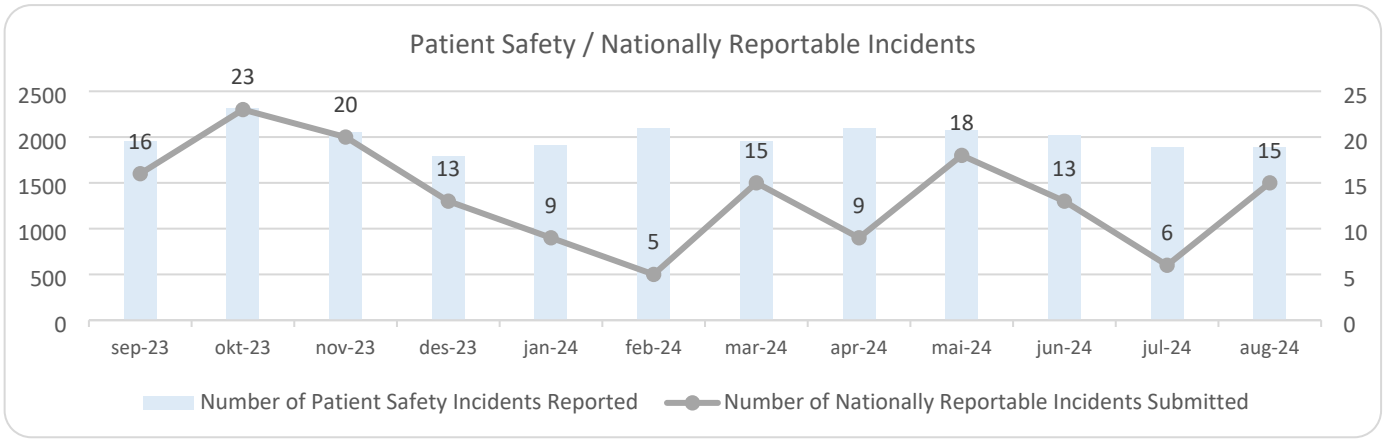


The top 3 types of incidents reported for July and August 2024, linked to a patient affected incident are: Pressure Damage /Moisture Lesion (1,493), Accident, Injury (662) and Behaviour including violence and aggression (395). This represents a change in the top 3 classifications of incidents as Behaviour including violence and aggression has replaced access, admission during this time period.

The 12 month trend data highlights a continued reduction in the number of Infection, Prevention and Control incidents since March 2024. Further analysis of the data is required to understand the decrease in numbers reported. Further detail will be provided at a future Committee.

Nationally Reportable Incidents

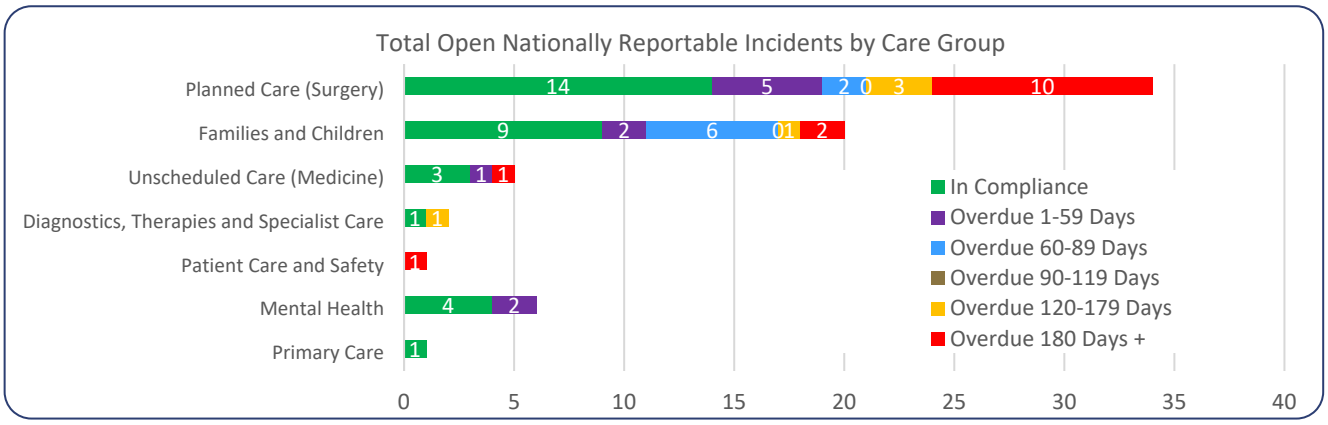
Between 01.07.24 and 31.08.24, 21 Nationally Reportable Incidents were submitted to the NHS delivery unit. The ratio of Nationally Reportable Incidents to the overall number of patient safety incidents is demonstrated in the chart below.



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"). The significant decrease in the number of incidents reported during July 2024 can be linked to the transition to the NRI Reporting Portal which resulted in some delays in the submission process. These incidents were subsequently reported in August 2024. The trend for the classification of Nationally Reportable Incidents submitted is reflected in the table below:

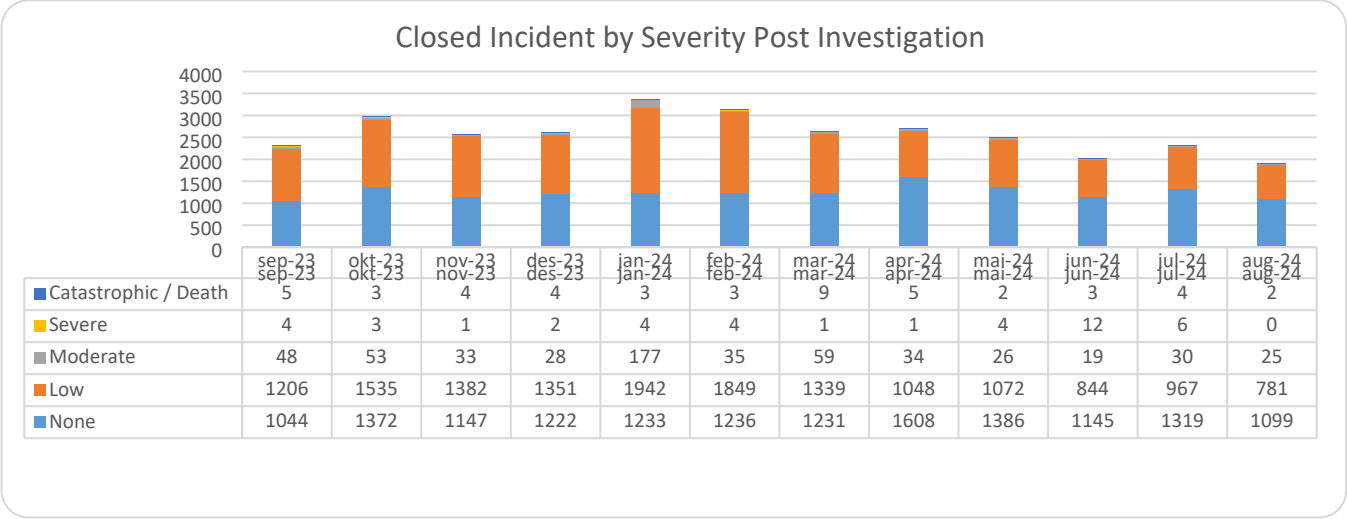
	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May - 24	Jun-24	Jul-24	Aug - 24	Total
Access, Admission	0	1	1	1	2	0	2	1	2	0	0	3	13
Accident, Injury	0	0	0	0	0	1	0	0	0	0	0	0	1
Assessment, Investigation, Diagnosis	3	0	5	2	0	0	2	0	1	2	0	2	17
Behaviour (including violence and aggression)	0	0	0	0	0	0	0	1	0	0	0	0	1
Equipment, Devices	0	0	0	0	0	0	0	0	0	0	0	0	0
Infection Prevention and Control	10	13	5	1	0	0	0	1	0	2	1	1	34
Infrastructure (including staffing, facilities, environment, security)	0	0	1	0	0	0	0	0	0	0	0	0	1
Maternity adverse occurrence	0	0	0	1	2	1	2	4	2	3	0	2	17
Medication, IV Fluids	0	1	0	0	0	0	0	0	0	0	0	1	2
Monitoring, Observations	0	0	0	0	0	0	0	0	0	0	0	1	1
Patient/service user death	0	0	0	1	1	0	2	0	1	2	1	0	8
Pressure Damage, Moisture Damage	2	7	8	5	3	3	5	1	4	3	4	3	48
Safeguarding	0	0	0	0	0	0	1	0	0	0	0	0	1
Total	0	0	0	0	1	0	0	0	1	0	0	0	2

As at the 03.09.24, the Health Board currently has 69 open Nationally Reportable Incidents, of which 37 are overdue the timescale 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

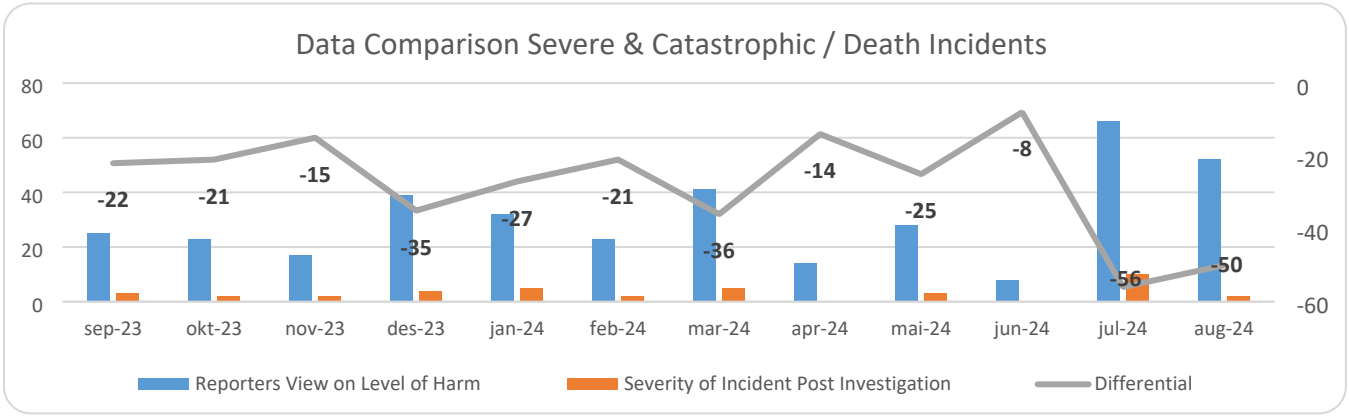
Between the 01.05.24 and 30.06.24 a total of 4,233 patient safety incidents were closed. Of the 4,233 patient safety incidents closed, 12 were closed with severity post investigation of severe harm (6) or catastrophic/ death (6). The 12 month trend is reflected in the table below. Of the 5 incidents closed with a severity post investigation of catastrophic / death, 3 are classified as Healthcare Acquired Infection, 1 as clinical assessment, clinical diagnosis, 1 as patient injury and 1 unexpected death.



	sep-23	okt-23	nov-23	des-23	jan-24	feb-24	mar-24	apr-24	mai-24	jun-24	jul-24	aug-24
Catastrophic / Death	5	3	4	4	3	3	9	5	2	3	4	2
Severe	4	3	1	2	4	4	1	1	4	12	6	0
Moderate	48	53	33	28	177	35	59	34	26	19	30	25
Low	1206	1535	1382	1351	1942	1849	1339	1048	1072	844	967	781
None	1044	1372	1147	1222	1233	1236	1231	1608	1386	1145	1319	1099

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



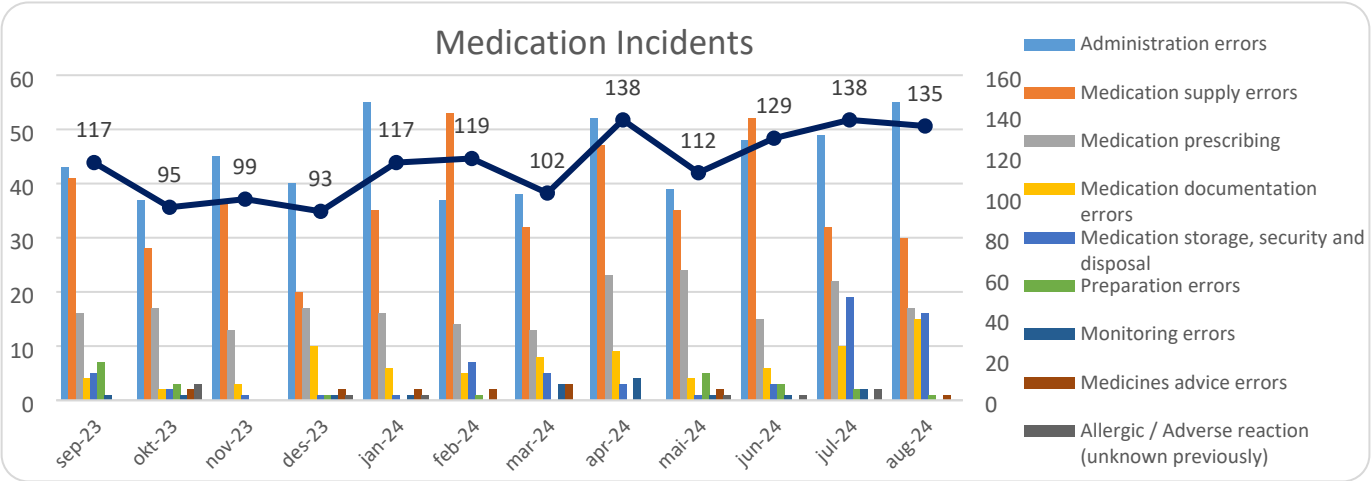
The Duty of Candour regulations where implemented from the 01.04.23. To enable monitoring of requirements, a number of metrics have been devised, which are summarised in the table below. To support the implementation of the Duty of Candour processes, dashboards have developed to provide 'live' data at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

Number of Incidents	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024
Where Duty of Candour Triggered	13	14	12	6	18	26	9	5	17	9	11	11
Where In-person notification completed	11	14	11	6	15	21	7	4	13	8	8	8
Where letter of notification sent	11	10	9	5	10	11	3	2	6	4	6	6

2.3 Specific Quality & Safety Metrics

2.3.1 Medication Safety

A total of 273 medication incidents were reported as occurring between 01.07.24 and 31.08.24. This is an increase of 32 when compared with the previous 2 month period. Of the total number of medication incidents reported, the top 3 types of medication incidents relate to administration errors (104), supply errors (62), and medication prescribing errors (39).

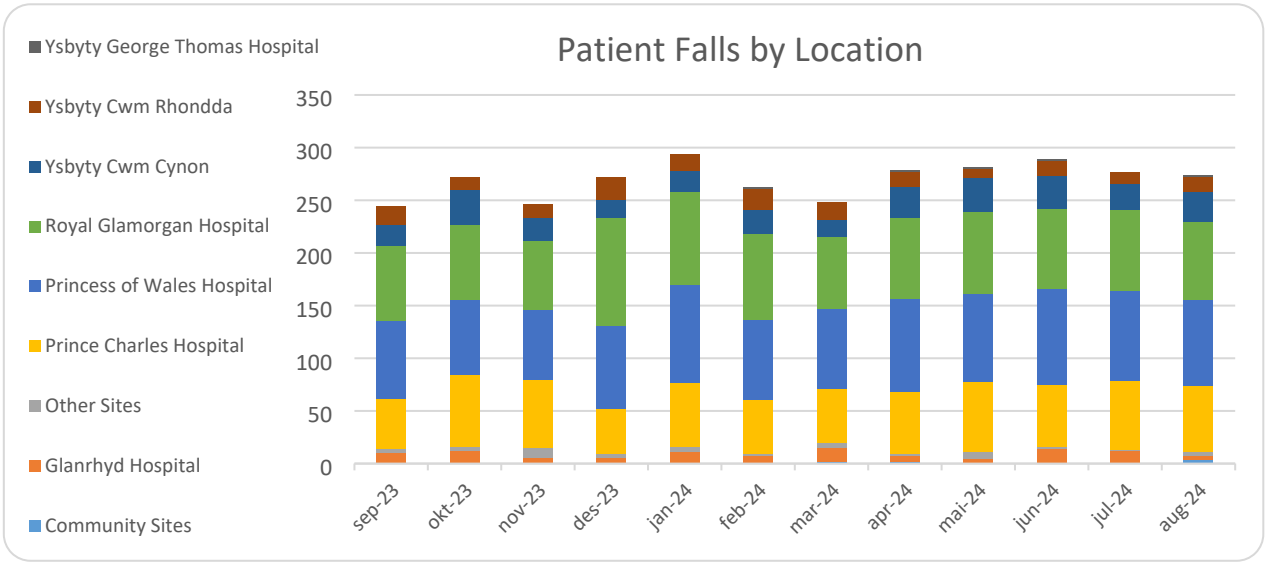


91% of the medication incidents were reported as resulting in no (115) or low (133) harm, with the remaining reported as resulting in moderate harm (22) and severe (3) harm. No incidents were reported as resulting in catastrophic harm/death. It should be noted that this is the reporter's view of the level of harm and is subject to change following investigation.

2.3.2 Patient Falls Incidents

A total number of 551 falls, where the person affected was a patient, were reported during July and August 2024. This represents a slight decrease of 20 compared with the previous two months.

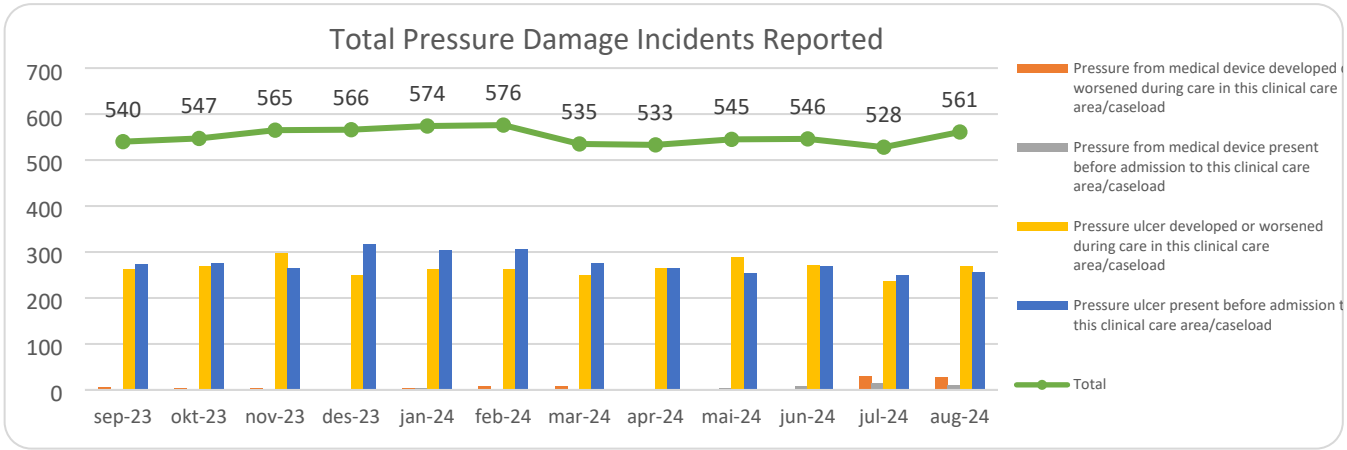
Of the falls incidents within the time period, 93% were reported as no (201) or low (313) harm. The remaining incidents were reported as moderate (30) and severe (7) harm. No incidents relating to patient falls were reported as resulting in death. Once again, it should be noted that this is the reporter's view of the level of harm and is subject to change following investigation.



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

2.3.3 Pressure Damage

Between the 01.07.24 and 31.08.24, a total of 1,068 pressure damage incidents were reported, of which 562 were reported as developing or worsening during the current case load. The remaining pressure damage incidents (506) were reported as being present before admission to this clinical care area/caseload.



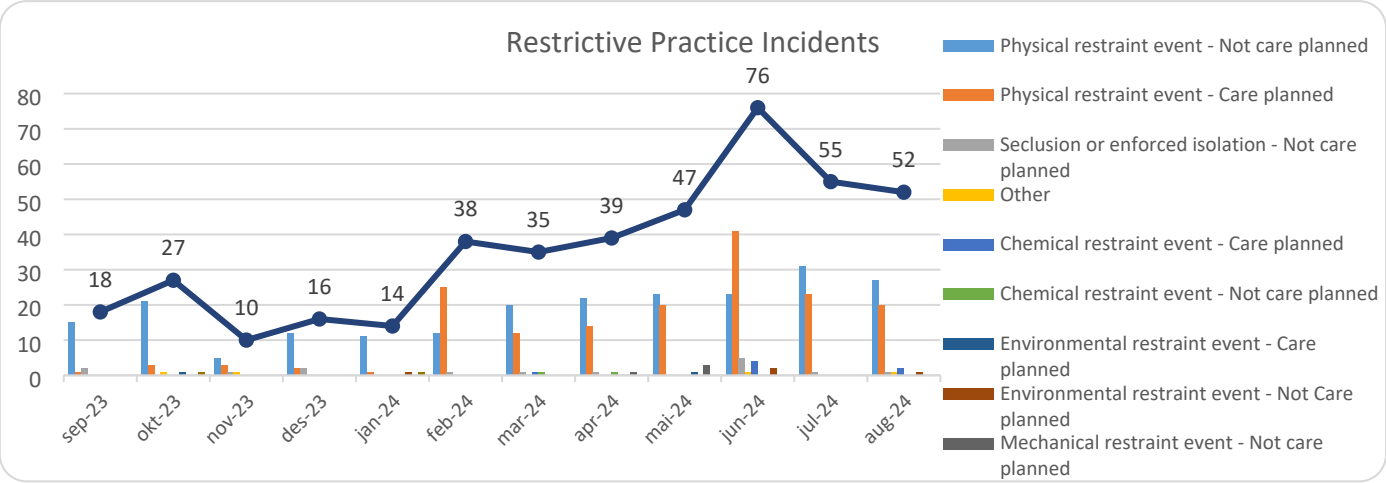
Of the 562, identified as developing or worsening during current caseload, 274 were identified as occurring within the community, which is an increase compared to the previous two month period.

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

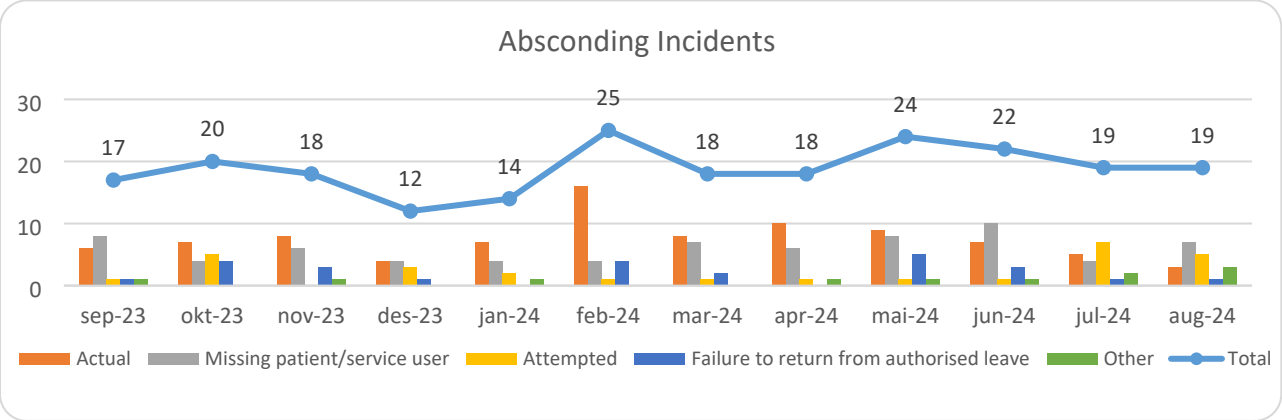
Between 01.05.24 and 30.06.243, a total of 107 incidents relating to using Restrictive Practices were reported within Mental Health. This is a decrease of 16 incidents when compared to the previous two months.



Of the 107 incidents, 61 were reported as not care planned (not included in the care and treatment plan for the patient), 45 were reported as care planned (included in the care and treatment plan for the patient) and 1 was reported as other. The highest number of incidents were reported as occurring on the Seren Unit, Royal Glamorgan Hospital (35) and Coity Clinic, Princess of Wales Hospital (15).

Absconding incidents

During July and August 2024, a total of 38 Absconding incidents were reported, a decrease of 8 when compared with the previous 2-month period. 12 were recorded as attempted absconding, with the remaining recorded as missing patient / service user (11), actual absconding (8), failure to return from authorised leave (2), and other (5). The highest number of incidents were reported as occurring in the Emergency Department at Prince Charles Hospital (6).



3. Key Risks / Matters for Escalation

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

- The transition to the new operating model poses a challenge in relation to the extraction and presentation of data. Work continues to align the Datix Cymru System to the Care Group Structure and ensure up-to-date information is accessible across the Health Board on a range of metrics.
- Maintaining compliance with the 30 working days' complaints response rate.
- Continuing the reduction of open Nationally Reportable Incidents

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM /Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM /Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant /Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Learning, Improvement & Research
	If more than one applies please list below:
Dolen i Feysydd Ansawdd	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: 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	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

Quality & Safety Committee

People's Experience Activity Report June-August 2024 for Quality & Safety Committee

Dyddiad y Cyfarfod / Date of Meeting	18/09/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Jenny Oliver, Head of People's Experience and Nigel Downes, Assistant Director of Patient Safety
Cyflwynydd yr Adroddiad / Report Presenter	Nigel Downes, Assistant Director of Patient 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**
People's Experience Forum	6th August 2024	

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf Morgannwg University Health Board
PET	People's Experience Team
VBHC	Value Based Healthcare
WPAS	Welsh Patient Administration System

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 (PET) and the areas that fall within this remit.

2. Specific Matters for Consideration

Population Engagement Events

Date	Event	Staff member
	Rhondda Cynon Taf Carers	Carers Co-ordinator
	Carers Event, Ystrad Rhondda Leisure Centre	Carers Co-ordinator

NHS Wales People's Experience Framework and Toolkit

NHS Wales Executive team are being asked to endorse a Framework and Toolkit, which will provide a Framework for the Health Board to highlight the work that is undertaken in conjunction with our community, how this can be developed by the Health Board to drive service improvement and shared learning to ensure a person centred care approach. An update is expected in September/October 2024.

Ongoing Projects

Patient's Lost Property

A joint project between the Patient Experience Team and the Value Based Healthcare (VBHC) Team is underway to address the issue of loss of patient's property. We are currently:

- Sourcing and evaluating various storage solutions.
- Once suitable option is selected, plan to implement a pilot program in Theatres and a Ward area.

The project aims to enhance patient experience and operational efficiency by reducing property loss incidents.

Engagement of Third Sector

Head of People's Experience, Head of Engagement & Involvement and Head of Charity and Income Generation meet weekly to review and develop a corporate engagement and event calendar for the Health Board.

- The calendar's aim is to promote and enhance engagement with both internal and third-sector partners.

- A strategic planning meeting is scheduled for September to outline initiatives for the upcoming year.
- Preparations are in progress for a Christmas campaign designed to showcase the valuable contributions and support provided by our communities during the holiday season.

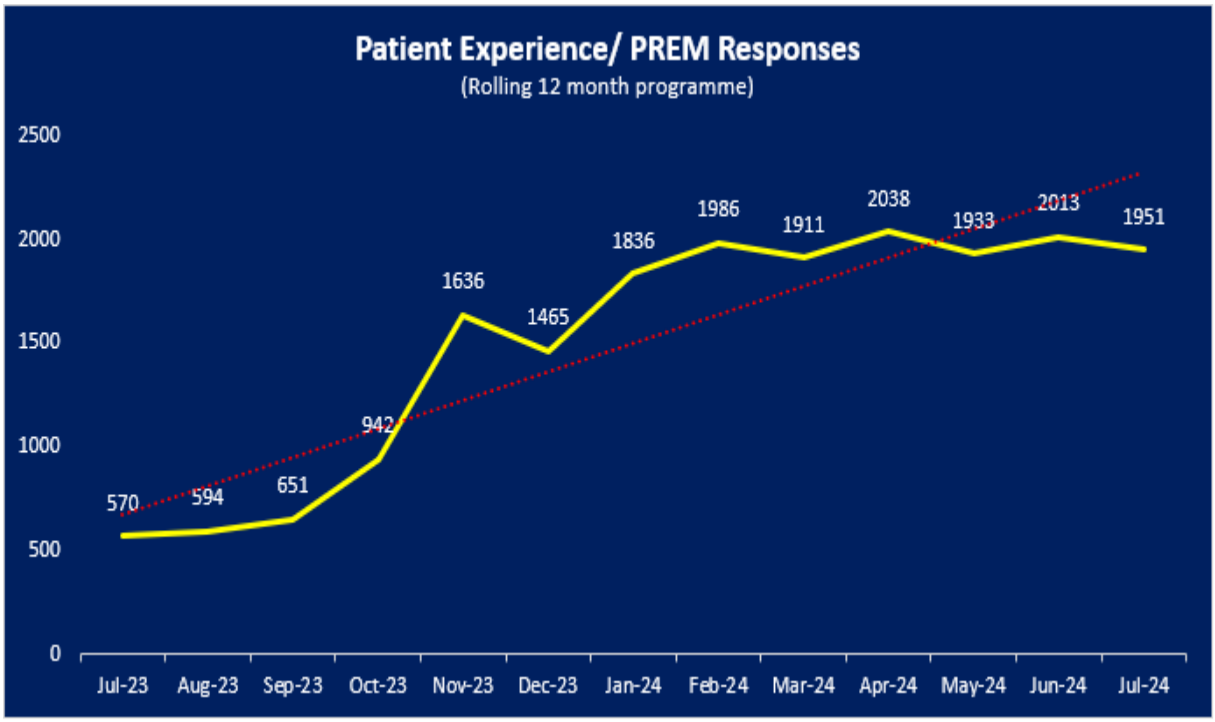
Patient Satisfaction Feedback

A new People's Experience Toolkit and All Wales Survey is currently undergoing approval by the NHS Executive, implementation anticipated for September/October 24.

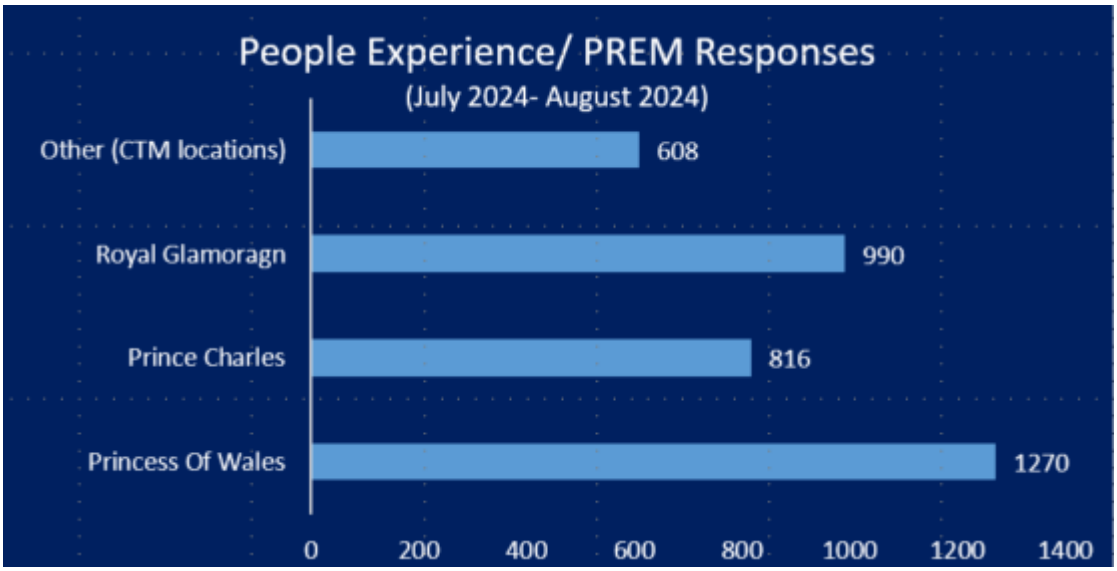
VBHC Team and People's Experience collaborating to promote current patient feedback methods pending agreement on new approach, including:

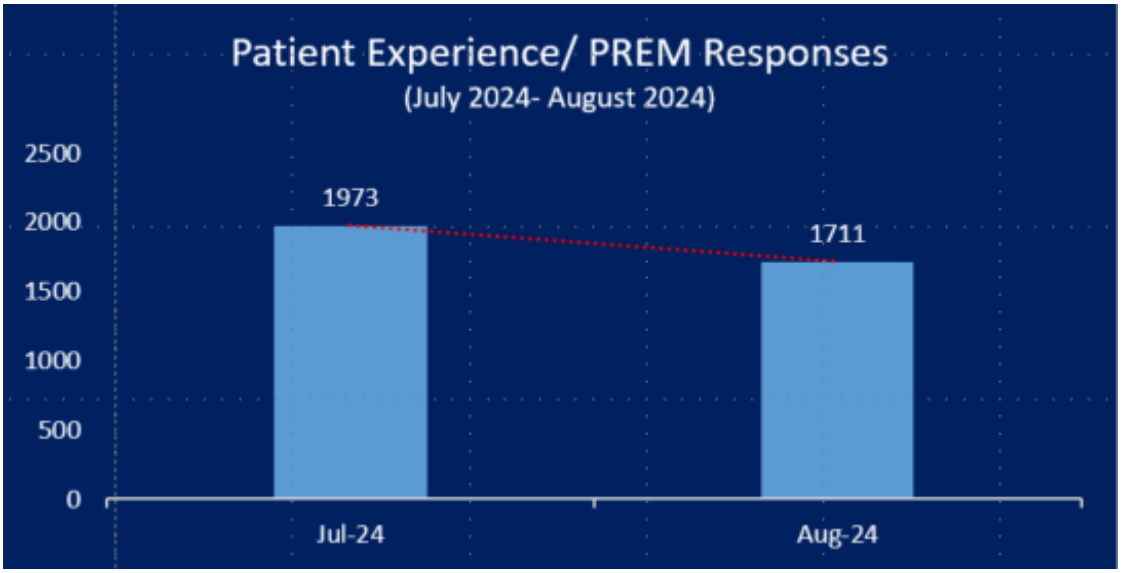
- Engaging with District Nursing to address feedback challenges in community-based settings:
    - Reviewing system data to reflect service changes and Primary Care links
    - Implementing 'Have your say cards' as interim solution
- Collaborating with Senior Nurse, Older Person's Mental Health Team:
    - Exploring feedback mechanisms, including carer input
    - Deploying 'Have your say cards', QR codes, posters, and feedback boxes
- Partnering with Nursing Director Unscheduled Care to pilot new survey on select wards
- Evaluating draft 'you said, we did' board from Emergency Department, Royal Glamorgan Hospital:
    - Pending senior leadership approval for pilot implementation
    - Aim to demonstrate Trust-wide responsiveness to community feedback

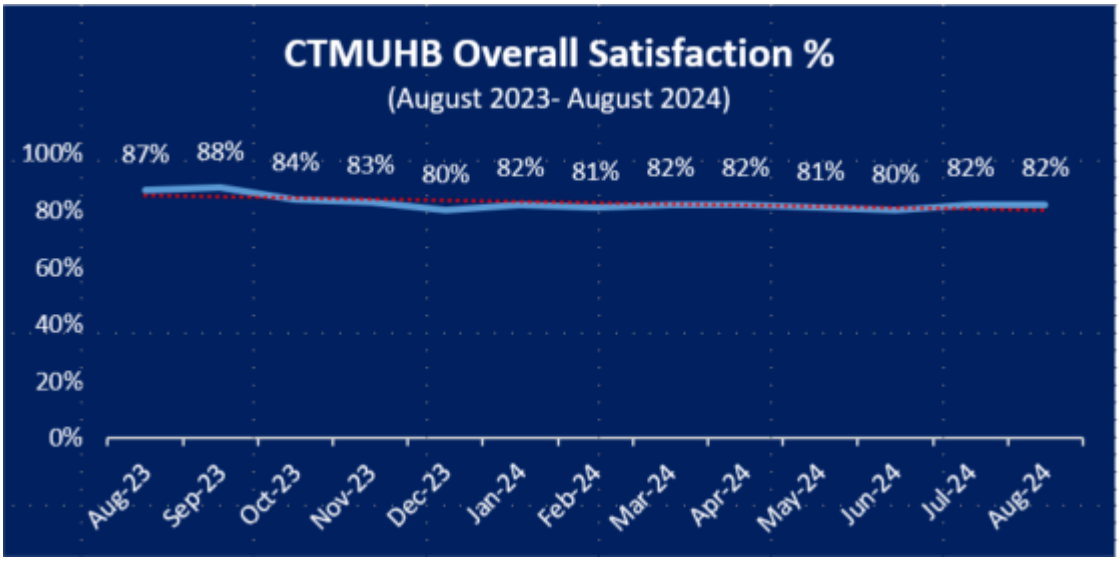
Overview of feedback responses for CTMU HB



Total number of responses (All time)	Total number of active surveys	Total number of SMS sent to patients	Total number of SMS Responses	Total number of paper/ online responses	Total number of Push Reports
30,538	84	9,884	3,250	434	313




Patient Experience/ PREM Responses
(July 2024- August 2024)
2500
2000
1500
1000
500
0
1973
1711
Jul-24
Aug-24


CTMUHB Overall Satisfaction %
(August 2023- August 2024)
100%
80%
60%
40%
20%
0%
87%
88%
84%
83%
80%
82%
81%
82%
82%
81%
80%
82%
82%
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24


Overall Satisfaction Score
83%



National Surveys currently under review through All Wales Forum:

- Looked After Children Survey.

Chaplaincy

Focus of the team remains on building awareness of holistic care to support our patients, families, unpaid carers and staff across the Health Board.

As such the team have supported:

Significant Spiritual & Pastoral Care	Numbers Involved
Patients	1165
Relatives/Carers	205
Staff	365

- To enhance holistic care practices, the Lead Chaplain conducted a Cultural Awareness training session for the Inter Professional Education Team.
- To provide comprehensive support for families and staff, the Chaplaincy team conducted 10 services across the Health Board.
- Substantive chaplains completed WPAS digital training, which enables the team to digitally record interactions/support provided.



Bereavement

- The Bereavement Lead has commenced discussions to prepare for the expanded Medical Examiners Officer role in reviewing community deaths, effective September 2024.
- Bereavement training sessions have been conducted for 18 students and Gynaecology nurses at the Princess of Wales Hospital.
- Collaborative discussions have commenced with the Head of People's Experience, Chaplaincy, and Care Group representatives to develop a comprehensive approach for supporting patients, families, and carers facing life-limiting conditions.
- Plans are commencing for organisation of events for Children's Grief Awareness Week (18th to 24th November 2024) and National Grief Awareness Week (2nd to 8 December 2024).

Family Bereavement Room

We are pleased to announce that **2wish Cymru** has funded the creation of a New Family Bereavement Room at the Paediatric Ward, Prince Charles Hospital, Merthyr Tydfil.





Volunteers

- The Volunteer Team celebrated Volunteer's Week (3 to 9 June 2024) by publishing several promotional articles, culminating in a live broadcast on GMF Radio to highlight various projects and volunteering opportunities within the Health Board.
- A meeting was held with the Digital Community Wales to discuss awareness training for digital apps and services aimed at enhancing the holistic experience of service users.
- An information session for volunteers took place on 8th July 2024, resulting in 19 applications to become a volunteer within the Health Board.

Armed Forces/Veterans

- Health Board collaborated with several teams to celebrate the Armed Forces and their families during Armed Forces Week.
- Focus on the Armed Forces Covenant and its implications for our communities and staff. Plans underway to further elevate awareness of the Covenant.
- Recognized reservists' contributions and the value they bring to their Health Board roles
- Launched inaugural Staff Armed Forces Café, focusing on supporting staff. Bi-monthly meetings will be held with staff-driven approach to determine topics for future café sessions
- Health Board awarded Silver status in the Employer Recognition Scheme for supporting Armed Forces Community.

PALS (Patient Advisory Liaison Team)

The teams continue to look at ways to highlight the support they can provide to the community and work proactively to resolve any issues raised to improve the experience of people accessing our services.

Number of PALS contacts	**Merthyr**	**Bridgend**	**Rhondda**
	108	120	122

Top three themes
Communication Issues
Clinical treatment
Patient Care

A detailed analysis of communication-related issues was prepared for the Quality & Safety Committee's July 2024 meeting. The aim was to address recurring themes in relation to the issue of communication.

The PALS team plays a crucial role in connecting with stakeholders across the Health Board. This engagement serves:

- To gain a comprehensive understanding of available support services for patients
- To enable the team to adopt a holistic approach to patient assistance.

To enhance their effectiveness, PALS team members are being assigned to specific services. This strategic alignment will allow them to:

- Develop in-depth knowledge of particular areas
- Better understand the unique support requirements of each service
- Contribute to improving overall patient experience

The areas the PALS team will be supporting are:

- Mental Health
- Learning Disability
- Armed Forces
- Nutrition & Hydration

Unpaid Carers

- Carer's Week Celebration (10th to 16th June) – the Carer's Coordinator organised a number of events to celebrate the invaluable support provided by carers in community settings.
- The first Staff Carer's Café for the Health Board was held during Carer's Week, which offered insights and support to staff in caring roles. This initiative will continue bi-monthly.
- Ongoing collaboration with various specialties across the Health Board aims to enhance awareness of unpaid carers and explore ways to support them within acute hospital environments.
- Meetings have been conducted with the Health Board's Dementia Lead, Falls Team, and Paediatric teams to ensure that the voices of unpaid carers are recognised in discharge process discussions.

3. Key Risks / Matters for Escalation

PALS cover, at present one member of the team from Royal Glamorgan Hospital is supporting the central concerns team and we also have one full time vacancy here as well. Part- time member of staff is covering on a Monday/Tuesday and PALS officer from Prince Charles is covering the Wednesday/Thursday with the telephone transferred to one of the teams on a Friday to ensure we capture contact from the public here.

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))*	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: 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	If no, please include rationale below: This is an overarching position report. If service change arises the specific areas and activity

	Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	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

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.

Agenda Item 8.1.1

Minutes of the Meeting of Cwm Taf Morgannwg University Health Board Quality and Safety Committee 23 July 2024 held via Microsoft Teams

Members Present:

Carolyn Donoghue	Independent Member (Committee Chair)
Kath Palmer	Independent Member (Vice Chair)
Dilys Jouvenat	Independent Member
Nicola Milligan	Independent Member
Patsy Roseblade	Independent Member
Helen Lentle	Independent Member

In Attendance:

Greg Dix	Executive Director of Nursing / Deputy Chief Executive
Gethin Hughes	Chief Operating Officer
Hywel Daniel	Executive Director for People (In part)
Suzanne Hardacre	Director of Midwifery & Nursing
Anthony Gibson	Deputy Medical Director
Lauren Edwards	Executive Director of Therapies & Health Sciences
Philip Daniels	Executive Director of Public Health
Richard Hughes	Deputy Executive Director of Nursing
Ana Llewellyn	Care Group Nurse Director
Emma James	Care Group Nurse Director
Sharon O'Brien	Care Group Nurse Director
Lucie Williams	Care Group Nurse Director
Hannah Wilton	Chief Pharmacist
Kellie Jenkins-Forrester	Head of Concerns & Business Intelligence
Chris Beadle	Assistant Director of Health, Safety & Fire
Paul Gimson	Assistant Director of Improvement Culture Capability and Delivery
Gaynor Jones	Staff Side Representative
Alex Brown	Care Group Medical Director
Owen Weeks	Care Group Medical Director
Ceri Bear	Llais Cymru Representative
Cally Hamblyn	Assistant Director of Governance & Risk
Emma Walters	Head of Corporate Governance & Board Business (Secretariat)

Observing:

Lloyd Griffiths	Head of Mental Health Nursing

Agenda Item

1. PRELIMINARY MATTERS

1.1 Welcome And Introductions

The Committee Chair welcomed everyone to the meeting, particularly those joining for the first time, those observing and colleagues participating for specific agenda items. The format of the proceedings in its virtual form were also noted. Members noted that the meeting would be recorded to aid the Committee Secretariat in ensuring the accuracy of scrutiny related discussions and decisions made during the meeting. Members noted that the recording would be destroyed once the minutes had been confirmed as accurate. Members confirmed they were happy to proceed.

1.2 Apologies For Absence

Apologies have been received from:

- Dom Hurford, Executive Medical Director;
- Julie Denley, Deputy Chief Operating Officer;
- Lisa Love-Gould, Care Group Clinical Director;
- Mary Self, Care Group Clinical Director;
- Nigel Downes, Assistant Director of Quality & Safety;
- Stephen Sarasin, Care Group Clinical Director;
- Sallie Davies, Deputy Medical Director

1.3 Declarations Of Interest

C Donoghue advised Members of an interest she wished to declare in relation to the Welsh Wound Innovation Centre which had been referenced within several reports within the papers and advised that she was previously Chair of the Welsh Wound Innovation Centre, which was no longer in existence. Members noted that G Dix was also a director of this previous organisation.

2.0 SHARED LISTENING AND LEARNING

2.1 Shared Listening & Learning Story – Boarding of Patients

E. James presented the video and presentation to Members of the Committee.

The Chair extended her thanks to E James for sharing the presentation and video in light of issues around boarding having been discussed a number of times and added that she found the video to be powerful as it highlighted the lived experience for patients.

N Milligan also extended her thanks to E James for sharing the presentation and video and advised that whilst this issue had been discussed over a significant period of time it is important to share the patient's perspective. N Milligan added that the video identified issues wider than boarding, in terms of lack of communication, and issues with having to move their own belongings whilst unwell to allow for another patient to be placed in a nearby bed. N Milligan noted that she had recently been advised at the Prince Charles Hospital Leadership meeting that patients were being triple boarded creating an increased risk. N Milligan referred to risk assessments and questioned whether risk assessments were being reviewed several times throughout a patient's stay as she did not feel assured that this was being undertaken. N Milligan also advised that she felt uncertain as to how the balance of risk was being considered, given that risks were being increased on the wards. N Milligan also advised that within the themes highlighted by E James in her presentation, the risk posed to staff working on the wards had not been included which needed to be further explored. N Milligan concluded that she would like to see the learning from this story, given that boarding and triple boarding was still being undertaken.

S O'Brien extended her thanks to N Milligan for highlighting some important points and advised that she had met with the Ward Manager to provide feedback from the story shared and added that the Ward Manager had met with the patient whilst they were in hospital to discuss his concerns. S O'Brien advised that lessons had been learned from the story, including the communication issues identified and the lack of information provided to the patient from the staff. S O'Brien advised that work had been undertaken with Heads of Nursing and Ward Managers at the 'Safe to Start' meetings to undertake a review of the criteria, alongside clarity and guidance around undertaking risk assessments and the completion of Datix. Members noted that the risk assessments were being reviewed each morning by the Senior Nurses, with confirmation then provided at the 'Safe to Start' meetings held in the afternoon on each day that a risk assessment has been undertaken and continuously monitored.

S O'Brien provided assurance that the patient observation risk assessments were performed for this patient, and it was evident that based on clinical criteria this patient should not have been placed in a boarded space. S O'Brien recognised the impact that boarding of patients

had on staff and this on occasion is then being seen in the communication and behaviour.

D Jouvenat shared a personal experience of one of her relatives being placed in a boarded space whilst in hospital and advised that this not only affected the dignity of the patient being boarded, this also affected the dignity of other patients within the ward area also, particularly when patients sadly pass away whilst on the ward.

C Bear advised that it was evident from the story shared that boarding was not acceptable from a patient or staff perspective and queried that whilst she was aware this was difficult to manage, queried whether there were any other solutions that could be considered, given that there were less patients being discharged as opposed to more patients being admitted to hospitals. C Bear queried whether further focus should be directed to patients who were awaiting continuing care or awaiting discharge where needs in terms of the level of nursing care may be reduced, and could these patients be moved into an area that would release beds for the patients most in need of more intensive clinical care.

G Jones expressed concern on the decision made by the Bed Manager in the story in relation to a bed becoming vacant but not being made available to the patient and sought clarity as to why the Bed Manager had made that decision given that this decision should have been made by the staff working on the Ward. G Jones also reflected how boarding is a frequent concern raised to her and Trade Union colleagues.

P Roseblade recognised the challenging position faced by the Health Board and reflected the difficulty in improving the position whilst there was no additional funding available. P Roseblade commented that as well as exploring the discharge challenges consideration needs to also be given to patients who were critically ill in their own home and not able to be taken into hospital as a result of the ambulance handover delays. P Roseblade suggested that Board Members needed to understand what practical support they could provide to try to help address the position, recognising that additional funding was not available.

H Lentle advised that given that she was a relatively new Committee Member, she had found the presentation to be exceedingly powerful, measured and constructive, particularly the comment made by the patient as to whether any of the Board would want this to happen to them. H Lentle advised that she accepted that boarding had been necessary, with risks being mitigated, however, questioned what the exit strategy was given that presentation highlighted that boarding is a temporary solution to alleviate risks. H Lentle added that it would be

important for the Board to be aware that an exit strategy was in place or whether this was a longer-term issue. H Lentle advised that from a quality perspective, patients were being treated very differently in terms of treatment being received and added that whilst this patient was able to articulate and advocate for himself, whilst having a very serious health condition, she questioned what would have happened if this patient was unable to voice their concerns. H Lentle agreed with the comments made by P Roseblade in that the Board needed to be sighted on the solutions available to mitigate the boarding challenges.

K Palmer advised that she was aware that a working group, with Local Authority support have been established to review discharges. K Palmer suggested that there needs to be a greater understanding of the balance of risk and the safest options available for patients.

G Dix welcomed the discussion on this topic which was one he has been highlighting to the Committee as a significant concern for some time and he felt that sharing the patient perspective would powerfully reflect a position that is being experienced by many patients each day Members recognised the impact and upset staff are feeling in terms of their ability to provide the care at the standard you would wish to expect. . G Dix assured the Committee that in response to the learning from this story Senior Nursing Teams have improved the process for risk assessments and flow of information from the Emergency Departments to the Wards.

In response to the query raised by K Palmer in relation to where was the safest place for patients to be, G Dix advised that in his professional opinion, whilst the experience of care in a boarded bed had resulted in lapses of care, it was safer to board patients onto a ward, than to have a critically crowded Emergency Department, which resulted in increased mortality, or a critically unwell patient waiting within the community for an ambulance. However, it is recognised that from an experience and dignity perspective this was not the best solution for a patient.

G Hughes reiterated that these decisions are not easy to make as with the challenges being faced the options available do not present a position that is optimal for the patient. G Hughes referred to the discussions held at the March Board meeting where a patient story was received on the impact of discharge delays, and added that these issues were being regularly experienced across all of the Hospitals within the Health Board, with there currently being 330 patients who were fit to be discharged from hospital who did not require an acute hospital bed or clinical input, which equated to the entire bed capacity at Royal Glamorgan Hospital.

G Hughes advised that a progress report would be presented to the Board meeting taking place on the 25 July regarding the work that had been undertaken following the story received at the March meeting, and added that a proposal had been developed to create a Crisis Intermediate Care Service for the Health Board which would enable 80% of the pathway one patients to leave beds and to be discharged home on a supported pathway into the community. Members noted that this proposal would be subject to the approval of a Business Case which was planned to be submitted to the Planning, Performance and Finance Committee at the end of August 2024. Members noted that Local Authority colleagues were supportive of the development of this model and noted this model would free up a net total of 50 beds across Hospitals within the Health Board, which would then enable the closure of boarded capacity on wards. G Hughes advised that there would be a cost associated with this which the Board would need to balance as a collective risk.

A Gibson supported the position articulated by G Dix in relation to what was being done at present in terms of boarding being the least worst option and advised that the harm that happens to patients whilst they are awaiting discharge sometimes did not feature in discussions, for example, increased deconditioning, increased risk of falls and hospital acquired infection.

The Chair reflected on the powerful and helpful discussion and advised that it was clearly not within the remit of the Committee to request that boarding of patients was ceased. The Chair advised that Committee Members needed to be cogniscent in the way in which issues had been raised in regard to whole system issues and added that it was encouraging to hear that lessons had been learnt from this particular patient's experience in relation to the risk assessment process. The Chair advised that this matter would be highlighted as a matter for escalation within the Committee Highlight report to Board and added that the Committee would support the work being undertaken on the whole system approach, which would need to include an exit strategy to stop boarding at the earliest possible time.

The Chair extended her thanks to the patient and staff who had contributed to the story presented.

Resolution:

The Committee **NOTED** the presentation.

Action:

Review to be undertaken to determine why a decision had been made by the Bed Manager to not move the patient into one of the vacant beds, as opposed to this decision being made by the staff working on the ward.

2.2 Spotlight Presentation – Mental Health & Learning Disabilities Quality Improvement Priorities

A. Llewellyn shared the presentation with Committee Members which highlighted the ongoing development of quality priorities in the Mental Health and Learning Disabilities Care Group.

The Chair welcomed the presentation and the work being undertaken by the team which was being recognised through the NHS Wales Awards for 2024.

K Palmer also welcomed the update and sought clarity on the links between estates and quality particularly within some of the Mental Health and Learning Disabilities. There is a significant backlog of estates issues and K Palmer queried whether there was any support Committee Members could provide in regards to this. A Llewellyn advised that there were challenges in relation to estates activity, both strategically and operationally and added that the Directorate Managers regularly report estates issues through to the Capital, Estates and Health, Safety and Fire meetings which is managed by the Care Group Service Director. Members noted that strategically, there was national focus on Estates and Environmental improvements, and it was likely that some national recommendations would be received.

The Chair extended her thanks to A Llewellyn for sharing the presentation.

Resolution: The presentation was **NOTED** by the Committee.

3. CONSENT AGENDA

The Committee Chair reminded Members that the consent agenda items had been moved to the end of the agenda and sought confirmation as to whether there were any items Members wished to move to the main agenda for discussion. There were no items that Members wished to move to the main agenda for discussion.

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 highlighted a concern that was challenging some of his Nursing, Midwifery and Clinical colleagues was the balance between finance and care, which had been discussed several times at Board. He further advised that whilst the Health Board was in a much-improved position in regard to quality, he remained committed to ensuring that the balance is not lost between quality and finance and that finance is not seen as the primary driver.

P Roseblade made reference to page five of the report which related to balancing clinical capacity and financial controls and sought clarity as to whether some of the unfunded ward areas had been financed with the additional recurrent monies that had been allocated to CTM in light of the break-even position, and if so, was this going to improve clinical quality. G Hughes advised that all the spend that was within the run rate at Month 9 had been funded recurrently in the £44m allocation, and added that as part of this, an invest to save process was being undertaken through several subject areas.

P Roseblade referred to paragraph 2.2.3 on page six of the report which stated there was an issue regarding damaged flooring and sought clarity as to whether this was on the list for the backlog maintenance funding that had recently been allocated to the Health Board. G Dix advised that significant focus had been placed on the estates backlog over the last few weeks, and a list had been developed identifying a significant number of backlog maintenance jobs that needed to be completed across the organisation, which was causing a level of concern and anxiety in relation to the capacity available to undertake the work required. G Dix advised that steps were being taken to ensure that wards and departments were kept as clean as possible to prevent hospital acquired infections which was challenging when faced with estates issues. Members noted that work would now been undertaken between G Dix, G Hughes and S May to review the list and risk stratify the legal requirements in addition to the issues that were affecting Infection, Prevention and Control and Nosocomial transmission.

P Roseblade referred to page eight of the report which referred to the Clinical Directors day and queried if it was possible for Members to be provided with the list of hot topics that were discussed. A Gibson advised

that he would be happy to share the Annual Programme with Committee Members.

P Roseblade and K Palmer advised that they were unclear as to what the AMaT report was describing and advised that it would be helpful if this could be accompanied by a cover report in future.

K Palmer referred to the Infection, Prevention and Control section and sought clarity as to where the Health Board was in relation to hand washing, as there appeared to be some staff who did not support the current hand washing regimes. G Dix advised that the audits undertaken identified pockets with really good hand washing compliance and areas with very poor pockets of hand washing compliance, with certain professional groups across the Health Board that needed some further focussed attention in regard to expectations about bare below the elbow. Members noted that a new Head of Infection, Prevention and Control was now in post, who would be reviewing the basic principles of Infection Prevention and Control and plans to introduce further peer reviews in relation to hand hygiene compliance and other areas of IPC compliance. A Gibson advised that the Medical Directors Team also had a plan in place to address this matter.

K Palmer made reference to the Clinical Directors day and advised that she was interested to hear that the Primary and Secondary Care interface was discussed during that session, and added that given that discussions had been taking place in relation to Primary Care and whether some secondary care services could be moved into Primary Care, she wondered what the views were from Clinical Directors in regards to this. A Gibson advised that whilst there was a real enthusiasm amongst clinical directors to move some services out of hospital into community/primary care services, there appeared to be less awareness that this would result in a transfer of resources which needed to be worked through further. Members noted that interviews would shortly be held for the Primary Care Clinical Directors who would play a pivotal role in progressing these discussions.

K Palmer advised that she welcomed hearing about the projects being undertaken within Therapies and Health Sciences.

In response to a query raised by K Palmer in regard to weight management services and the weight management research group, P Daniels advised that Children's weight management service would be developed and national research undertaken. P Daniels added that a review of best practice elsewhere would also be explored and advised that as part of the HENRY programme, there would be an appreciative

enquiry involving families and service users to ensure that the service was fit for purpose for the Health Board's communities.

Resolution: The report was NOTED.

Actions: List of hot topics discussed at the Clinical Directors Day annual programme to be shared with Members

Cover report to be developed to accompany the AMaT report being presented to future meetings to explain the data .

5.2 Care Group Highlight Reports

5.2.a Children and Families Care Group Highlight Report

S. Hardacre presented the matters contained within the alert/escalate section of the report.

K Palmer referred to the inequity of service provision across CTM in relation to Special School Nursing and questioned whether this had an impact on services. S Hardacre advised that whilst it likely had an impact, no concerns had been raised by parents, however, concerns had been raised by education. S Hardacre advised that given this was such a complex service to navigate, there needed to be an understanding of what the offer was from education and provided assurance to Members that those children who were receiving continuing care for complex health needs were receiving nursing care input. Members noted that inequity was being seen in regard to the way in which nursing staff were being deployed within the schools.

Resolution: The Committee **NOTED** the report.

5.2.b Unscheduled Care Group Highlight Report

E. James presented the matters contained within the alert/escalate section of the report. Members noted that in relation to Stroke Services, since the report was drafted, a Locum had now been secured to support the service whilst work would still be undertaken on a longer-term solution.

E James made reference to the Thematic Review that was being undertaken in relation to identifying the themes and trends around the 15 Nationally Reportable Incidents in order to identify root causes of the ambulance delays and learning from these incidents, and advised that she would like to present this review to a future of meeting of the

Committee for further discussion. This suggestion was welcomed by the Chair.

R Hughes advised that he was pleased to hear that the Care Group had managed to take the work forward with the Welsh Ambulance Services NHS Trust in relation to shared learning, and added that there was learning to be gained, particularly in relation to advanced care planning from some of our patients.

P Roseblade advised that she felt this was a positive piece of work in relation to the review that had been undertake of all patients, and added that given that this related to nationally reportable incidents, for which the criteria had changed and had reduced quite significantly, she questioned if the same comparisons were made with the locally reportable incident criteria and would the numbers remain the same or would the numbers increase. E James advised that she would be happy to undertake an analysis of this outside the meeting and present an update at a future meeting. R Hughes advised that he would be happy to support E James with this analysis.

Resolution: The report was **NOTED**.

Actions: Thematic Review undertaken in relation to identifying the themes and trends around the 15 Nationally Reportable Incidents to be presented to a future meeting

Analysis to be undertaken on locally reportable incidents to determine whether numbers would increase or remain the same as the data for nationally reportable incidents

5.2.c Planned Care Highlight Report

S. O'Brien presented the matters contained within the alert/escalate section of the report. S O'Brien highlighted that the five nationally reportable incidents that occurred at Prince Charles Hospital related to procedures undertaken by one interim Trauma & Orthopaedic Surgeon who no longer worked for the Health Board. Members noted that each patient had been contacted under Duty of Candour to advise that an independent surgical review would be undertaken of the surgical procedures undertaken.

G Hughes welcomed the efforts that had been made within the Urology Service with a recognition that significant improvements had been made in relation to Urological Cancer performance, alongside the improvements in the quality of service that was being provided. G Hughes added that

the work undertaken by S O'Brien on the workforce model had been excellent and had helped to move the Urology service into a very different position of sustainability over the next few years.

P Roseblade referred to the issues experienced with the interim Clinician as highlighted by S O'Brien earlier and questioned whether the outcome of the investigation was reported to the medical governing bodies, to ensure this individual did not repeatedly cause harm elsewhere. A Gibson advised that because the individual was employed by an agency and not by the Health Board, and had a different responsible officer, the responsible officer had been informed of the concerns that had been raised, and it would be their responsibility to restrict their practice if it was felt necessary, and would be dependent on the outcome of the report. Members noted that the General Medical Council would be informed if it was considered that gross negligence had occurred.

Resolution: The Committee **NOTED** the report.

5.2.d Primary & Community Care Group Highlight Report

L. Williams presented the matters contained within the alert/escalate section of the report.

K Palmer raised a query in relation to dentistry, which had been included on the risk register for some time and sought clarity as to what the timescales were for addressing the waiting lists which were quite lengthy. G Hughes advised that he would provide an update to Members outside the meeting on relation to the trajectory to reduce the waiting lists for dental services.

K Palmer also referred to prison services and how difficult things were for staff and sought clarity on what support was being provided to staff working within this service in regard to setting up new systems and introducing new ways of working. L Williams advised that staff were being supported by the Wellbeing Team and a Health Board Psychologist and added that as managers were now based on site, they were working closely with Teams. L Williams advised that whilst there were vacancies, sickness absence rates within the service were low. Members noted that staff had found it a challenge to adapt into Health Board processes, however, were assured that support was in place.

Resolution: The report was **NOTED**.

Action: Trajectory to reduce the waiting lists for dental services to be shared with Members outside the meeting.

5.2.e Diagnostics, Therapies, Pharmacy & Sciences Care Group Highlight Report

H. Wilton presented the matters contained within the alert/escalate section of the report.

P Roseblade referred to the statement made within the report to the Health Board not currently having an MRI pacemaker service which would result in noncompliance unless several matters are resolved. P Roseblade sought to understand how the Health Board could not be compliant with a service that it did not have in place. H Wilton advised it was of her understanding that as a result of the change on the MHRA regulations, the service could now only be provided at Prince Charles Hospital. H Wilton advised that she would discuss with colleagues outside the meeting to ensure this was more clearly articulated.

P Roseblade referred to Parc Prison, which had been referenced in several reports, and had been included in the assure section of this report. P Roseblade advised that the report referred to 11 deaths and added that earlier in the meeting an update was provided as to the support being provided to staff and queried what support was being provided to the prisoners. L Williams apologised that this had not been made clear within the report and provided assurance that a significant amount of work is underway to support prisoners, including steps to increase education and provide public health support in relation to raising awareness regarding drug potency.

Resolution: The Committee **NOTED** the report.

5.3 Stroke Progress Report

Alex Brown presented the report and highlighted the key areas for Members attention.

P Roseblade advised that the report referred to thrombolysis door to needle and queried that whilst she recognised this was a national target, should this be referred to as scan to needle as opposed to door to needle. A Brown advised that the main aim was to get patients to thrombolysis as quickly as possible regardless of target description.

P Roseblade referred to the Welsh Ambulance Services NHS Trust (WAST) policy around patient conveyance and sought clarity as to whether WAST had changed their policy. A Brown advised that this related to whether WAST were willing to convey patients to tests within Hospital directly from

the ambulance, through triage, onto a CT scanner and then back into an ambulance if there was no immediate space available to release the patient into.

P Roseblade advised that the report referred to two business cases and questioned whether if funding was not approved for the business cases, what could be achieved without funding, and if funding was approved, would the Health Board be able to recruit. G Hughes drew attention to the investment decisions made by the Board at the start of the year which included a decision not to invest into the stroke nurse practitioner model at that point. Members noted that the Unscheduled Care Group were reviewing their budget position to establish if it would be possible to fund some of these posts this year.

P Roseblade advised that the report did not refer to joint working with other Health Board's which Members had been notified previously of being the only way forward given the current circumstances. In relation to regional working, G Hughes advised that the Health Board were working closely with Cardiff and Vale UHB on a Central South Wales solution for Stroke. G Hughes added that whilst this programme had been delayed slightly, a new Programme Lead was now in place and the Health Board were working hard to push forward an accelerated more sustainable solution with Cardiff.

N Milligan advised that the fragility of Stroke Services had been discussed for several years. N Milligan referred to slide 10 which highlighted what progress had been made, with the first point referring to Brainomix AI. N Milligan advised that this did not highlight what difference this had made or what progress had been made. A Brown outlined the primary benefits of Brainomix, one being that it allowed for very rapid assessment of CT and CT Angiogram in terms of making decisions around thrombosis and thrombolectomy. A Brown advised that it would be difficult to identify the percentage increase that had been achieved through Brainomix given the other changes that had been made to the stroke pathway but added that it had been identified as a key enabler within the pathway. L Edwards advised that an evaluation process was underway to evaluate the impact, but it was too soon to draw any conclusions from this as yet.

N Milligan commented that the second bullet point referred to a Programme Board being established but did not refer to the programme outputs.

N Milligan also referred to the key priorities, one of which stated that a proposal was being developed to increase the workforce to enable expansion of the service to seven days and sought clarity on this. A Brown

advised that the business case for the Care Practitioners had been completed and had been discussed at the Unscheduled Care Senior Management Team meeting, and added that as stated by G Hughes earlier, the Team were exploring funding options for these posts from within existing budgets. The Chair suggested that future reports would need to be updated to reflect that business cases had been completed and that no funding had been identified.

C Bear sought clarity, from a patient perspective, whether the Health Board were able to quantify the impact on patients of this poor performance as a result of targets not being met and whether this would be something that could be included within the report moving forwards. A Brown advised that one of the criticisms around the Sentinel Stroke National Audit Programme (SSNAP) data was that it was very process driven as opposed to outcome driven. Members noted that in relation to the latest data sets there were changes to some outcome measures. L Edwards added that within the regional work being undertaken, there is a patient engagement activity underway which would enable the Health Board to map across to the patient experience so that the impact could be seen.

Resolution: The report was **NOTED.**

6. GOVERNANCE, RISK AND ASSURANCE

6.1 Organisational Risk Register – Risks assigned to the Quality & Safety Committee

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.

K Palmer raised a query in relation to the risk relating to Public Health Funding and advised that she did not get a sense as to how much this had gone down by and what the impact of this reduction was. P Daniels advised that he would provide a response to K Palmer on this query outside the meeting.

Resolution: The report was **NOTED**.

Action: Update to be provided outside the meeting in relation to the Public Health Funding risk. Update to identify how much reduction in funding there had been and what the impact would be of this reduction.

6.2 Mortality Reviews and Mortality Indicators

A Gibson presented the report that updated Members on the mortality review process in line with the All-Wales Learning From Mortality Review Model Framework and highlighted the learning from mortality reviews to ensure lessons learnt are shared to improve the quality of patient care.

The Chair extended her thanks to A Gibson for presenting the report which she had found to be comprehensive and welcomed the progress that had been made in this area.

P Roseblade advised that from reading the report it appeared that Rhondda Cynon Taff had the most people living in the comparatively smallest region with the highest death rate and queried whether this was because of the demographic or age profiles of the people living within this area. P Daniels advised that he would interrogate the data further and would provide a response outside the meeting. A Gibson added that the data being pulled together by the Getting it Right First Time Emergency Department process, had highlighted that in Rhondda Cynon Taff there was a very different admission profile into Emergency Departments, so a sicker group of patients were being admitted from that area which may explain some of the data highlighted.

P Daniels advised that the national report on avoidable mortality had been published recently and advised that he would be happy to circulate this with Members for information.

K Palmer advised that she had recently attended a session with the Coroner, the Medical Examiner and GP's to talk through the change that would be coming into place in September in relation to the Medical Examiner Service reviewing deaths in community settings in addition to in-hospital deaths, and advised that she had found the session to be informative. Members noted that there would also be lessons learnt that the Health Board would need to consider moving forwards. K Palmer advised that the session also highlighted the importance of Primary Care working with Secondary Care in relation to the review of deaths. A Gibson advised that there was a need to increase the number of GP's who take part in Mortality Review panels as it was sometimes difficult for secondary care clinicians to review a death in the community.

H Lentle asked if the responses that P Daniels was going to share to questions raised outside the meeting were shared with all Committee Members, which P Daniels advised he would be happy to action.

Resolution: The Committee **NOTED** the update and contents of the report.

Actions: Further interrogation of the data to be undertaken to determine why Rhondda Cynon Taff had the most people living in the comparatively smallest region with the highest death rate

National report on avoidable mortality to be shared with Members outside the meeting

6.3 Quality & Safety Committee Annual Self-Assessment

The Committee Chair presented the report and drew Members attention to the areas requiring further action and the action plan section.

Resolution: The report was **NOTED**.

6.4 Body Store Recommendations from Welsh Government

A. Gibson presented the report that provided an update with regards to the outcome of the Fuller Inquiry (Phase 1) which has implications for the application of current Human Tissue Act standards within the Health Board mortuary services.

The Chair welcomed the report which she had found to be comprehensive and was pleased to see that appropriate actions were being taken.

Resolution: The Committee **NOTED** the report.

6.5 Evaluation of the Success of the Falls and Pressure Damage Programme

R. Hughes presented the report that provided an update on the current situation, recent initiatives, and recommendations for continued improvement in these areas as part of the 'harm-free care' agenda.

The Chair advised that she had found the report to be helpful and informative and advised that she was lucky to hear the presentation from P Gimson at the ICTM day, which answered the 'so what' question and identified the steps being taken and methodology being used to make changes. The Chair added that the Committee could take assurance from this report that change was happening.

Resolution: The report was **NOTED**.

6.6 Duty of Quality Annual Report

R. Hughes presented the annual report that informed the Committee on how the Health Board had implemented the duty of quality within the organisation.

P Roseblade advised that she had found the report helpful and easy to read and advised that when she looked through the report for information on falls, the report appeared to focus on Mental Health falls, and felt that the report could be strengthened to include all areas of activity that had been highlighted by R Hughes in his presentation of the report. R Hughes advised that much of what he presented today extended past the end of March 2024 and related to the new reporting year, so would not have been included within this report but would feature in next year's report for 2024/2025. P Roseblade advised that whilst she understood this, she still felt the report focussed narrowly on Mental Health falls R Hughes agreed to review this matter further.

K Palmer advised that she found the report to be excellent and commented on Chapter three, 'Plans for the Future', and queried whether reference needed to be made to the future of children's services, particularly in relation to weight management. R Hughes advised that he would take this comment on board and would ensure it features within the annual report in relation to work undertaken and the commitments that had been made to address this.

The Chair thanked R Hughes for presenting the report and urged Committee Members to provide any further comments on the content of the report outside the meeting.

Resolution: The Committee **ENDORSED** the report for **BOARD APPROVAL**.

6.7 CTM Quality Strategy Work Plan Update

L. Edwards presented the report that updated the Committee on progress of delivery against agreed deliverables within the Quality Strategy.

P Roseblade advised that whilst she recognised the importance of demonstrating the work that had been undertaken, she queried whether it was an accurate reflection from a CTM perspective. She advised that a number of actions had been rated as green or amber which suggested that actions were going to be achieved quite soon and reflected that she felt that some of the actions needed a caveat that highlighted whilst all of this work was being undertaken there was a further way to go to achieve them. L Edwards advised she accepted the points raised by P Roseblade and that whilst the ambitions were agreed as part of the

Quality Strategy, she would give some further thought as to how the significant challenges that were still being faced could be better reflected.

Resolution: The report was **NOTED**.

6.8 Health, Safety & Fire Sub Committee Highlight Report

N. Milligan presented the report that provided the Quality & Safety Committee with details of the key issues considered by the Health, Safety & Fire Sub Committee at its last meeting, which included the Annual Report for 2023-2024.

G Hughes advised Members that the issues highlighted in relation to funding of replacement batteries for core equipment had now been resolved.

Resolution: The Committee **NOTED** the Highlight Report and **APPROVED** the Sub Committee Annual Report.

6.9 Quality Impact Assessment

R. Hughes presented the report that updated the Committee on the development of the Quality Impact Assessment (QIA).

The Chair requested that the appendix was circulated to Members as a separate document as it was difficult to read on the Admincontrol system.

Resolution: Members of the Quality and Safety Committee **SUPPORTED** and **NOTED** the QIA process for its adoption within the Health Board.

Action: Appendix to be circulated to Members as a separate document as it was difficult to read on the Admincontrol system.

7. DELIVERING OUR PLAN

7.1 Patient Safety, Quality and Experience Dashboard

K. Jenkins-Forrester presented the Patient Safety & Quality Dashboard to the Committee that provides data from 01.05.24 to 30.06.24 taken from systems on 15.07.24, unless otherwise specified.

D Jouvenat extended her congratulations to the team for achieving the 75% target for responding to complaints within 30 working days and sought clarity as to whether there were any themes or trends that could be identified for the complaints that were not responded to within 30

working days. K Jenkins-Forrester advised that these complaints tended to be more complex in nature which either spanned a number of services or where a breach of duty of care needed to be considered, which would then require seeking an expert opinion or obtaining advice from the Legal Services team.

Resolution: The report was **NOTED**.

8. DELIVERING OUR IMRPOVEMENT PROGRAMMES

8.1 Mental Health In-Patient Improvement Progress Report

A. Llewellyn presented the report that provides Committee Members with an overview of progress of the Mental Health Adult Inpatient Improvement Programme.

K Palmer extended her thanks to A Llewellyn for the significant amount of work undertaken within this area and advised that a recommendation was made in 2022 to have a single electronic patient record which was still not in place two years later. K Palmer referred to the risks to Mental Health systems and wondered whether, given this was impacting on services, this needed to be escalated to the Board. K Palmer advised that in relation to the suggestion made to reduce reporting frequency, she would not want the Committee to lose sight of this key action and questioned how this action could be kept live.

A Llewellyn advised that the issues regarding the single electronic patient record remained a standing action on the Health Board's risk register and added that if the frequency of reporting for this report was reduced, this risk would still feature in the Organisational Risk Register report presented to each Committee meeting. A Llewellyn advised that discussions were being progressed nationally in regard to different options and reassured the Committee that this was a live issue for the Care Group with discussions being held in several areas and support was in place through the NHS Executive.

The Chair advised that she would be happy to reduce frequency of reporting and would provide an update to A Llewellyn outside the meeting to confirm future reporting requirements.

Resolution: The report was **NOTED**.

Action: Future reporting requirements to be confirmed by the Committee Chair outside the meeting.

9. CONSENT AGENDA

9.1 FOR APPROVAL

9.1.1 Unconfirmed Minutes of the meeting held on 16 May 2024

Resolution For Approval

9.1.2 Unconfirmed In Committee Minutes of the meeting held on 16 May 2024

Resolution For Approval

9.2 FOR NOTING

9.2.1 Action Log

Resolution For Noting

9.2.2 Committee Annual Cycle of Business 2024

Resolution For Noting

9.2.3 Forward Work Programme

Resolution For Noting

9.2.4 Healthcare Inspectorate Wales Action Plan Tracker

Resolution For Noting

9.2.5 Recognition of Acute Deterioration and Resuscitation Committee (RADAR) Committee - Annual Report

Resolution For Noting

9.2.6 Clinical Audit Quarterly Update report

Resolution For Noting

9.2.7 Annual Unpaid Carer's Report 2023/24

Resolution For Noting

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.

C Hamblyn suggested that the following matters would need to be included in the alert/escalate section on the Committee Highlight report to Board:

- Boarding of patients
- Fragility of Stroke Services
- Positive escalation in relation to the Mental Health & Learning Disability Improvement Priorties and Healthcare Inspectorate Wales acceptance of the Ty Llidiard Action plan

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.

C Hamblyn advised that whilst recognising that it had been a long meeting there was appropriate focus on the key areas of risk and challenges facing the Health Board.

A Llewellyn reflected that whilst the meeting had overrun slightly, she welcomed the time spent on the the Listening & Learning story.

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. Items discussed at the In Committee Quality & Safety Committee held prior to this meeting

There were no items requiring In Committee discussion on this occasion.

12. DATE AND TIME OF NEXT MEETING

The next meeting take place on Wednesday 18 September 2024 at 14:00pm.

13. CLOSE OF MEETING

Agenda Item
8.1.3

Quality & Safety Committee

Putting Things Right Annual Report

Dyddiad y Cyfarfod / Date of Meeting	18/09/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Kellie Jenkins-Forrester, Head of Concerns & Business Intelligence
Cyflwynydd yr Adroddiad / Report Presenter	Kellie Jenkins-Forrester, Head of Concerns & Business Intelligence
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For 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	
PTR	Putting Things Right

1. Situation /Background

The purpose of this report is to provide a summary of people's experience with Cwm Taf Morgannwg University Health Board (the "Health Board"), including complaints, incidents, claims and redress between 1st April 2023 and 31st March 2024.

2. Specific Matters for Consideration

The key areas to note from within the Putting Things Right annual report for 2023/2024 include:

- Reduction in the number of formal complaints received
- Improvement in compliance with the 30 working day target
- Decrease in the number of Public Service Ombudsman for Wales referrals received
- Decrease in number of new claims received
- Increase in number of cases referred to Redress from the incident process
- Themes arising from complaints and patient safety incidents remain consistent with previous years

3. Key Risks / Matters for Escalation

The key risks / matter for escalation associated with the Putting Things Right Annual report relate to:

- Maintaining compliance with the 30 working day target
- Effective and timely management of Ombudsman Cases
- Reducing the number of open nationally reportable incidents
- Timely conclusion of redress cases

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*Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality***Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☒	No: ☐
	Outcome: This report outlines key areas of quality across the Health Board.	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language	If no, please include This is an overarching position report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment.
Cyfreithiol / Legal	Yes (Include further detail below)	
	The report outlines clinical negligence, personal injury and redress activity within the Health Board.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
	Activity where performance falls short of the Health Board's quality & safety performance measures may result in impact to the trust and confidence in the Health Boards processes.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

The Quality & Safety Committee are asked to approve the content of the report.

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

PUTTING THINGS RIGHT

Annual Report 2023/2024

Head of Concerns & Business Intelligence

PUTTING THINGS RIGHT ANNUAL REPORT 2023/2024

1.0 Introduction

2.0 How we manage Concerns

3.0 Complaints

4.0 Redress

5.0 Claims

6.0 Inquests

7.0 Public Service Ombudsman for Wales

8.0 Patient Safety Incidents and Reportable Serious Incidents

9.0 Never Events

10.0 Learning from Events Reports

11.0 Conclusion

PUTTING THINGS RIGHT ANNUAL REPORT 2023/2024

SUMMARY OF ACTIVITY

568 Formal Complaints Received

122 Redress

130 Claims

76 Ombudsman



23,791 Patient Safety Incidents

145 NRI's

1 Never Event

286 Inquests

PUTTING THINGS RIGHT ANNUAL REPORT 2022/2023

1.0 Introduction

The purpose of this report is to provide a summary of people's experience with Cwm Taf Morgannwg University Health Board (the "Health Board"), including complaints, incidents, claims and redress between 1st April 2023 and 31st March 2024.

Putting Things Right (2013) was established to review the existing processes for the raising, investigation of and learning from concerns. Concerns are issues identified from patient safety incidents, complaints and, in respect of Welsh NHS bodies, claims about services provided by a Responsible Body in Wales. The aim is to provide a single, more integrated and supportive process for people to raise concerns which:

- Is easier for people to access;
- People can trust to deliver a fair outcome;
- Recognises a person's individual needs (language, support, etc.);
- Is fair in the way it treats people and staff;
- Makes the best use of time and resources;
- Pitches investigations at the right level of detail for the issue being looked at; and
- Can show that lessons have been learnt

2.0 How we manage concerns

To support the effective management of complaints, patient safety incidents and redress, the Health Board has implemented the Concerns Policy and Procedures along with the Incident Management Framework. These should be read in conjunction with the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 and Putting Things Right Guidance (2013).

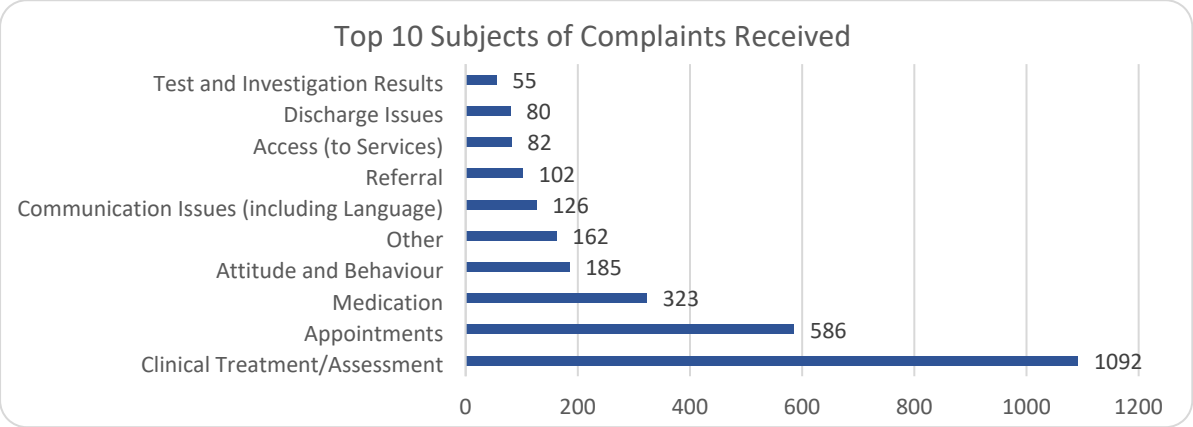
During 2023/2024, the Health Board made progress in implementing its Care Group operating model, with a focus on embedding Quality & Safety Governance structures. A key development was the establishment of a Central Quality & Safety Governance Team that works in collaboration with Care Groups to develop robust governance frameworks that support clinical services in identifying and addressing adverse events, ensure appropriate support for patients and their families and facilitate continuous improvement through the timely identification of lessons learned.

3.0 Complaints

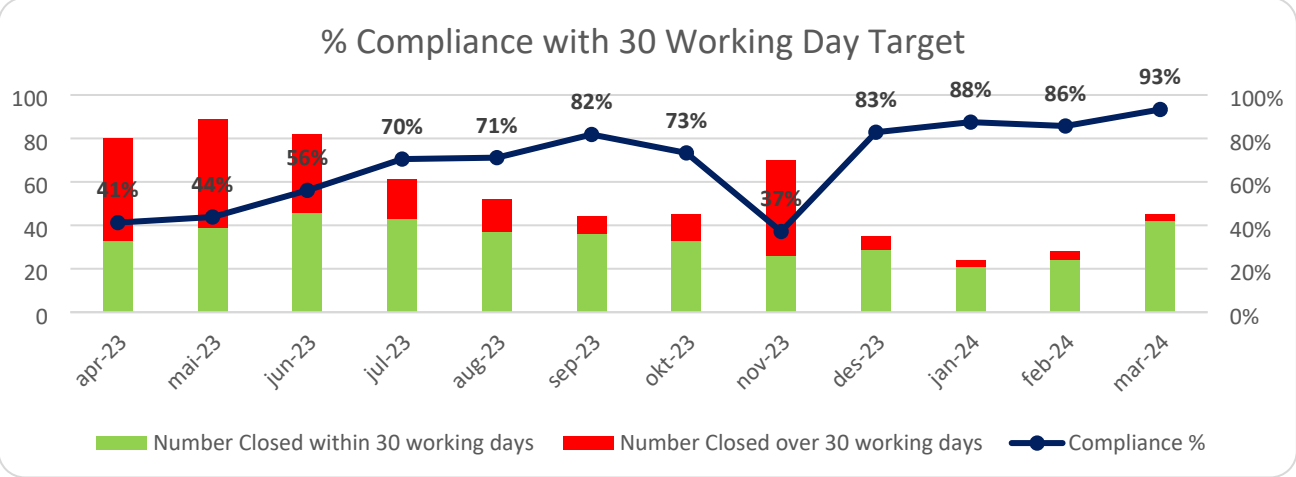
Complaints Received during 2023/2024
During 2023/2024 at total of 2,958 complaints were received by the Health Board, representing a small decrease when compared with the previous year (2022/2023).

Of the new complaints received during 2023/2024, 568 complaints were managed via putting things right, a significant decrease from the 863 received during 2022/2023. The remaining 2,390 were managed as early resolution complaints.

Complaints will often highlight a number of issues of concern regarding the services or care and treatment being provided by the Health Board. Identification of these complaints assists in highlighting themes and trends, to inform areas for focused improvement work. The top 10 complaints for 2023/2024 are provided in the chart below:



Complaints Closed during 2023/2024
A total of 655 complaints managed via Putting Things Right ("PTR") were closed during 2023/2024. Of these 409 (62%) were responded to within 30 working days. During November 2023, focused work was undertaken to address the number of historic cases open (those over 30 working days) and provide a final response to patients or their families. As a result this focused work there was a planned decrease in the compliance with the 30 working day target to 37%. Compliance returned to above the national target of 75% for the remainder of the year as reflected in the chart below.



During 2023/2024 to improve compliance with the 30 working day target to respond to complaints a number of actions were undertaken which include:

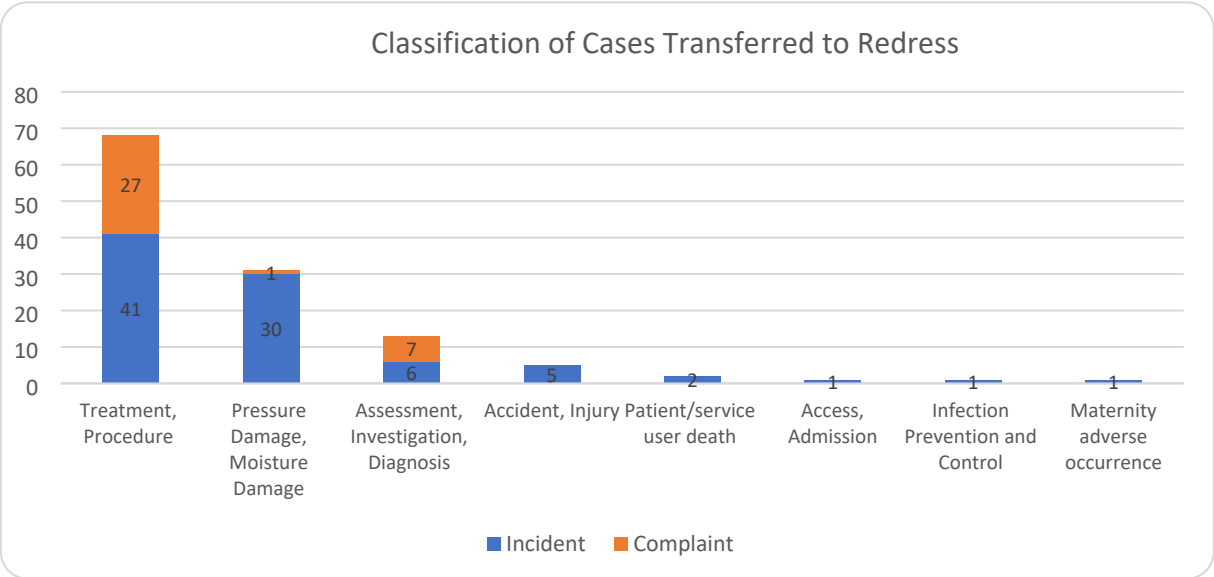
- Robust triaging of complaints received to ensure appropriate management resulting in an increase complaints managed via the early resolution process
- Implementation of a revised process for the management of formal complaints that highlights the requirement for early escalation.
- Daily Complaint Team Huddles embedded to review cases and support the escalation process
- Focused work undertaken during November 2023 to address the number of historic cases open (those over 30 working days) and provide a final response to patients or their families
- Reporting of compliance with the 30 working day target at weekly Executive Quality & Safety Meeting
- Enhanced process for managing MP/MS correspondence
- Monitoring in place to ensure that are updates are provided to all complainants where cases have been open over 30 working days

4.0 Redress

New Cases Transferred to Redress during 2023/2024

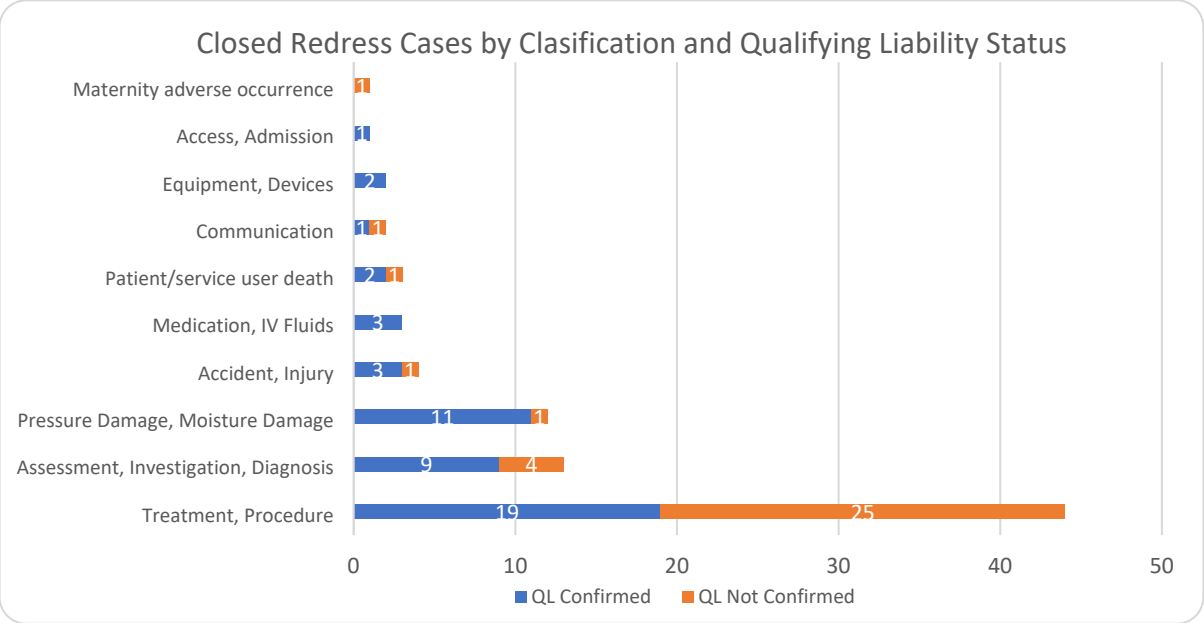
If during the investigation of a complaint or incident a breach of duty of care is identified which has potentially resulted in harm to the patient, there may be a qualifying liability. At this stage, the complaint will transfer into the Redress process for a further detailed investigation.

Between 01.04.23 and 31.03.24, 122 cases were referred to Redress for review of breach of duty and for consideration as to whether the case is suitable for Redress. 87 were referred from the incident process and 35 from the complaint process. A breakdown of the classification of cases transferred to Redress is provided in the chart below:



Redress Cases Closed during 2023/2024

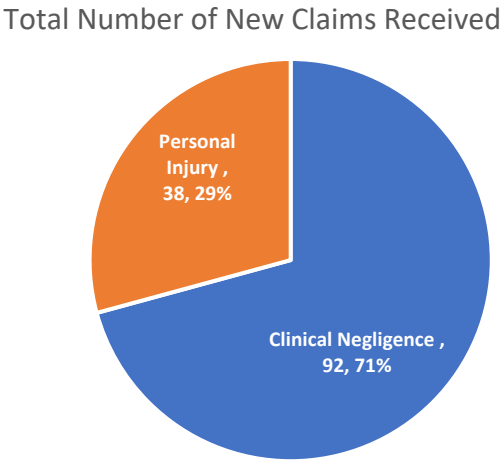
It should be noted that Redress cases will not always be referred and closed within the same financial year. Therefore, the cases closed during 2023/2024 may have been received in previous years. 85 redress cases were closed between the 01.04.23 and 31.03.24, of these 51 were concluded with confirmation of a qualifying liability. A breakdown of closed redress cases by classification and qualifying liability status is provided in the chart below.



5.0 Claims

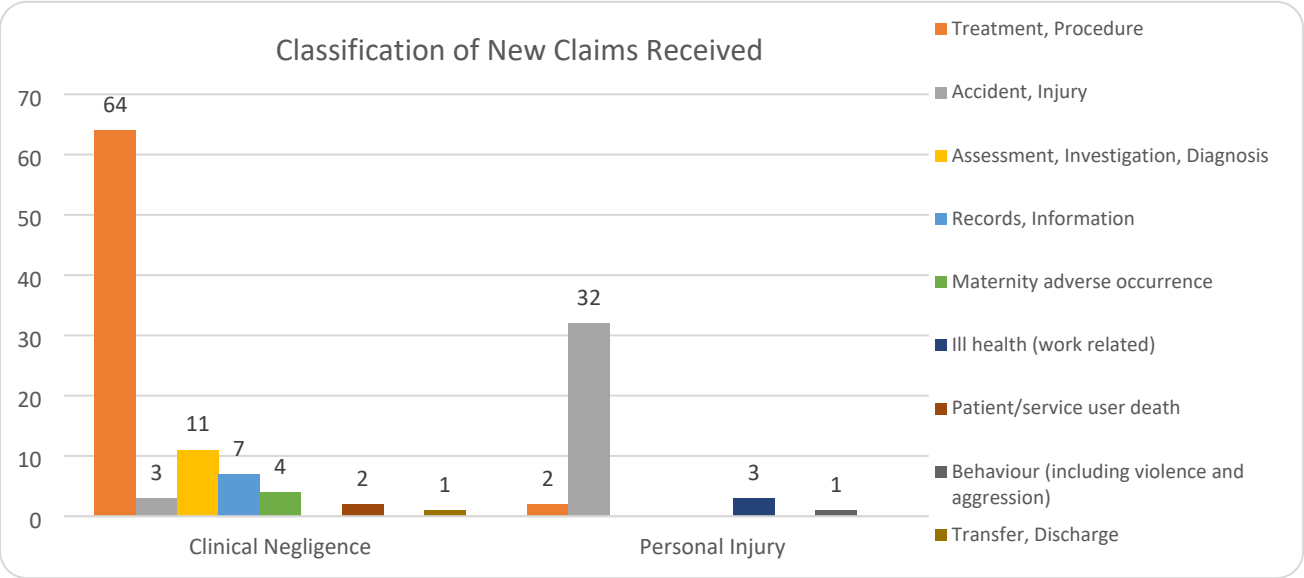
Where a case is of a higher value than £25,000, it will be transferred out of the Redress process and managed as a claim.

<u>New Claims Received during 2023/2024</u>
Between the 01.04.23 and 31.03.24 the Health Board received notification of 130 new claims. These take the form of a clinical negligence and personal injury claims.



A breakdown of the classification of new claims received during 2023/2024

is provided in the chart below.



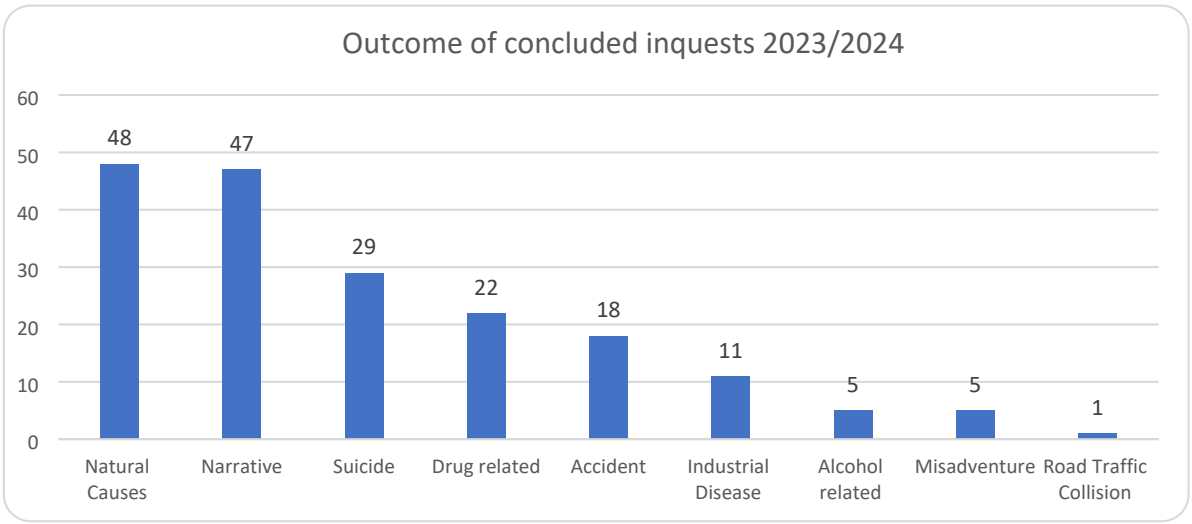
Claims Closed during 2023/2024

During 2023/2024 a total 69 claims were closed. Of these, 52 were concluded with an admission of liability or risk based settlement.

6.0 Inquests

An inquest is a formal investigation by the Coroner to determine how a person died. They are held in certain circumstances, for example if the death was sudden or unexpected. The Health Board must provide information in line with the directions of Coroner.

Between the 01.04.23 and 31.03.24 the Health Board received notification of 286 new inquests. During the same period 197 inquests were concluded with the following outcome. It should be noted that inquests will not always be referred and closed within the same financial year.

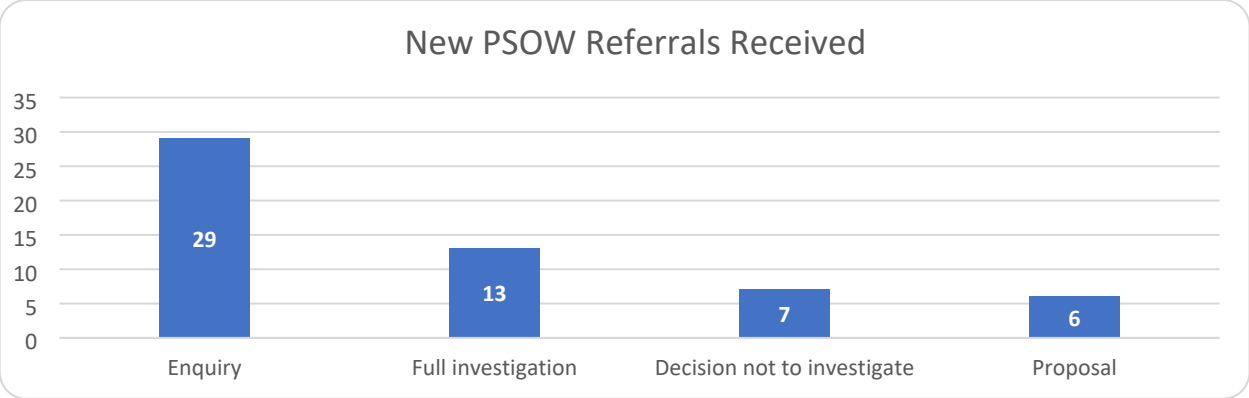


On conclusion of an Inquest, under the Coroners Regulations 2013, the Coroner has the power to make a report to prevent future deaths, referred to as Regulation 28 reports. During 2023/2024 the Coroner issued one regulation 28 report to the Health Board. A further regulation 28 was issued to Welsh Government for improvement action on a national level as a result of learning from a Cwm Taf Morgannwg UHB inquest.

7.0 Public Service Ombudsman for Wales (PSOW)

The Public Service Ombudsman for Wales (PSOW) has the power to review complaints about public services in Wales. If a complainant is not content with the response they receive from the Health Board, they can request the PSOW to review the case independently.

Between 01.04.23 and 31.03.24 the Health Board received notification of 55 referrals to the PSOW. Of these, 13 were proceeded to full investigation. A breakdown of PSOW referrals is provided in the chart below.



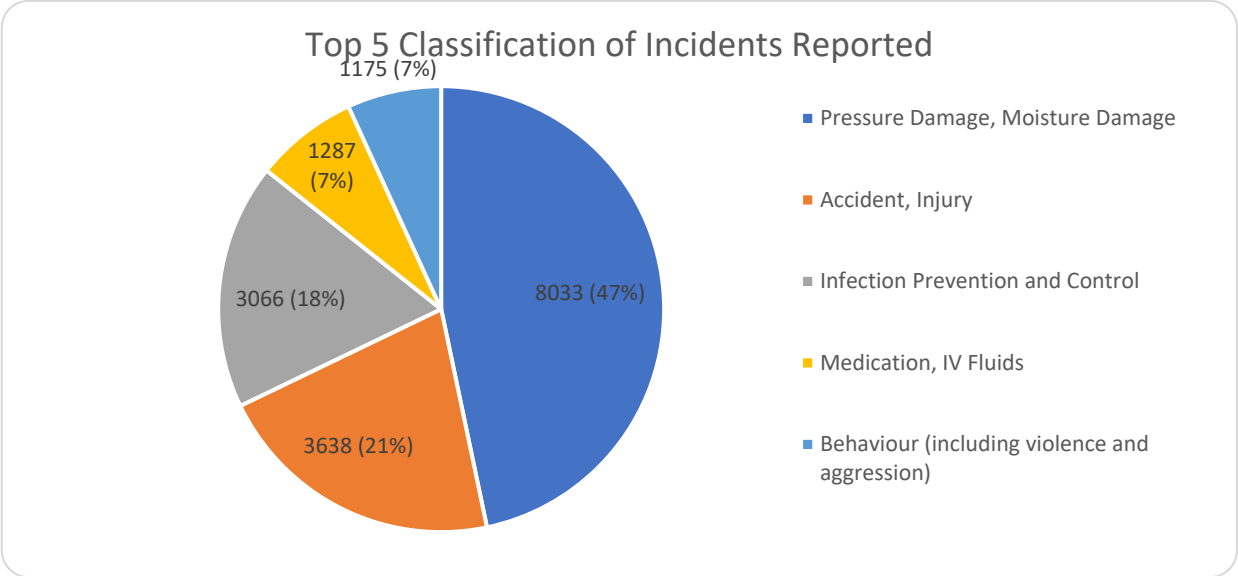
During 2023/2024 the PSOW issued 31 final reports to the Health Board. Of these, 8 were fully upheld and 15 partially upheld, whereby the Health Board accepted the recommendations and implemented actions to address the learning identified. A summary of the outcome of PSOW investigation final reports is provided in the table below.

PSOW Final Reports Issued	Total
Upheld - Section 27	7
Partially Upheld – Section 27	15
Not Upheld – Section 27	8
Upheld - Section 23	1
Total	**31**

8.0 Patient Safety Incidents and Nationally Reportable Incidents

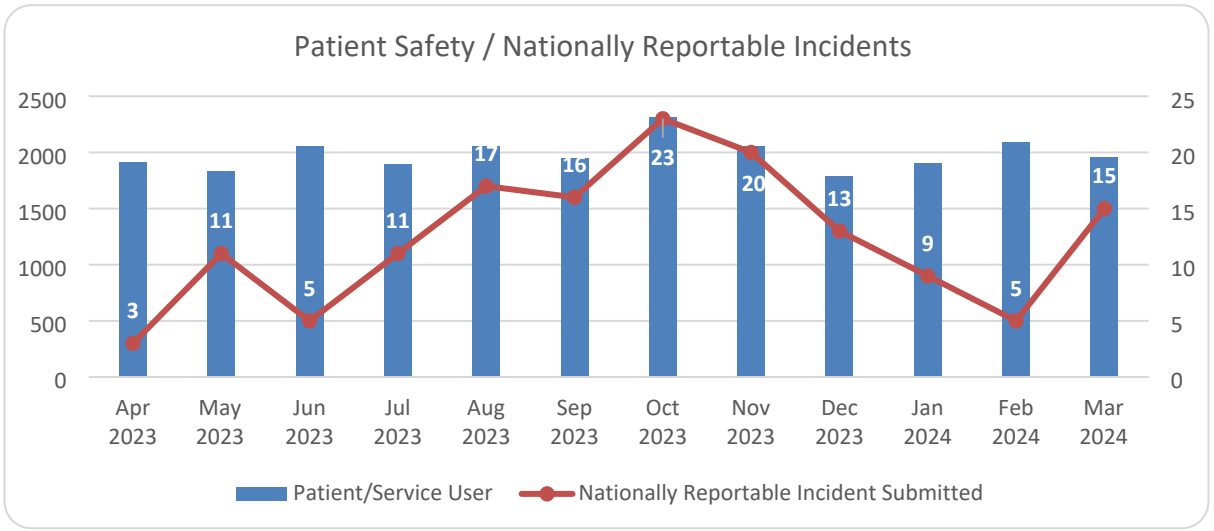
There were 26,940 incidents reported between 01.04.23 and 31.03.24, of which 23,791 (88%) were reported as the patient being the person affected (patient safety incidents).

Accounting for 70% (17,199) the top five Patient Safety incidents reported for the year relate to: Pressure Damage/Moisture Damage; Patient Falls; Infection Prevention & Control; Medication, IV Fluids; Behaviour (including violence and aggression). A breakdown of these is provided in the chart below.



Within the time period, 148 nationally reportable incident notifications were submitted to the NHS Executive (Delivery Unit). As a result of a change in the Nationally Reportable Incident criteria, a direct comparison with the previous year is not available.

The incident reporting trend for 2022/2023 is reflected in the chart below.



9.0 Never Events

Never Events are patient safety incidents that are wholly preventable, where there is guidance and safety measures that provide strong systemic protective barriers available at a national level.

Never events have the potential to cause serious harm or death, although serious harm or death does not have to occur for it to be classed as a never event.

The Health Board reported 1 never events between 01.04.23 and 31.03.24, which relate to the administration of medication by the wrong route.

10.0 Learning from Event Reports

The Health Board is required to submit a signed Learning from Events Report (LFER), within 60 working days of the decision to settle a case, to the Welsh Risk Pool. During 2022/2024, 109 Learning from Events Reports were triggered for submission.

A summary of activity for Learning from Events Reports due during 2023/2024 is summarised below:

	Claims	Redress	Total
Number of LFERs Due	71	45	116
Number of LFERs submitted	70	45	115
Number of LFERs Approved	36	36	72

All cases considered for reimbursement by the Welsh Risk Pool (WRP) are scrutinised for evidence of the lessons learned and improvement actions taken by the Health Board. Reimbursement, both interim and final reimbursement, will be deferred until the WRP Committee is satisfied with learning and the actions taken in a case. Between 01.04.22 and 31.03.23, the WRP deferred 90 cases for reimbursement for the Health Board.

11.0 Conclusion

The key areas to note in relation to Concerns for 2023/2024 include:

- Reduction in the number of formal complaints received
- Improvement in compliance with the 30 working day target
- Decrease in the number of Public Service Ombudsman for Wales referrals received
- Decrease in number of new claims received
- Increase in number of cases referred to Redress from the incident process
- Themes arising from complaints and patient safety incidents remain consistent with previous years

Agenda Item
8.1.4

Quality & Safety Committee

Energy Policy

Dyddiad y Cyfarfod / Date of Meeting	18/09/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Christopher Lewis, Assistant Head of Assets, Governance & Tech Services
Cyflwynydd yr Adroddiad / Report Presenter	Sally May, Executive Director of Finance
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Sally May, Executive Director of Finance

Pwrpas yr Adroddiad / Report Purpose	For Approval

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Energy Compliance Group - Approved	25/07/2024	ENDORSED FOR APPROVAL
Capital and Estates Governance Board	23/07/2024	ENDORSED FOR APPROVAL

Acronyms / Glossary of Terms	
CO_2	Carbon Dioxide
Re:Fit	Welsh public sector energy efficiency investment framework

1. Situation /Background

1.1 The Energy Policy aims to ensure that the use of all forms of energy within Cwm Taf Morgannwg University Health Board is done in a controlled, efficient and sustainable manner, reflecting the financial and environmental initiatives instigated by or placed upon the Health Board and to ensure compliance with all relevant energy-related legislation and guidance.

1.2 The Energy Policy defines what objectives the Health Board aims to achieve by providing a comfortable and efficient environment for patients, staff, volunteers, visitors, external partners working in Health Board properties & contractors, whilst reducing CO_2 emissions and expenditure through energy efficiency measures.

1.3 Decarbonisation is a key element of the Energy Policy and the policy supports the CTM Decarbonisation Strategy 2022-2030 in addressing the aims and objectives set out in that document in relation to energy usage.

2. Specific Matters for Consideration

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

Name Title	Date Consulted/Completed
Equality Impact Assessment	05/07/2024
Informal Consultation with interested parties	Via Energy Compliance Group and Capital & Estates Governance Board
Formal Consultation	Via Energy Compliance Group and Capital & Estates Governance Board
Committee – For approval	Going before Quality & Safety Committee 18/09/24

2.2 The policy has been reviewed and is consistent with the approach across NHS Wales / legislation.

2.3 Internal stakeholders have been engaged in the consultation including Energy Compliance Group, Head of Health, Safety & Fire, Deputy Director Strategy & Partnerships and Capital & Estates Governance Board.

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 and updates have been made:

- Incorporated the aims of the NHS Wales and the CTM Decarbonisation Strategies
- Clarified and updated roles and responsibilities
- Clarified and updated the heating procedure
- Incorporated the Re:Fit energy investment programme

3.2 Energy costs are volatile and over recent years the CTM Health Board energy budget has risen to over £18.5 million in 2023-24. Therefore managing and controlling energy costs is an important consideration and challenge for the Estates function and a responsibility for all staff in CTMUHB.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Sustaining Our Future
	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 Resilient Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Whole-systems Perspective
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / **Link to Domains of Quality**	Efficient
	If more than one applies please list below:

(Duty of Quality Statutory Guidance (gov.wales))	
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	Yes - Reduce If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☒	No: ☐
	Outcome: Quality Impact Assessment completed, has identified no indicators for a full QIA.	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar 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:
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)	
	Implementation of the Energy Policy is important in controlling energy costs	

5. Recommendation

5.1 The Quality and Safety Committee are asked to **APPROVE** the Energy 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.

Energy Policy

Document Type:	Non Clinical Organisational Wide Policy
Ref:	EST 004
Author:	Christopher Lewis – Assistant Head of Assets, Governance and Technical Services
Executive Sponsor:	Executive Director of Finance & Procurement
Approved By:	**Quality & Safety Committee**
Approval / Effective Date:	(dd/mm/yyyy)
Review Date:	(dd/mm/2027)
Version:	2.0

Target Audience:

People who need to know about this document in detail	Ward & Department Managers, Estates Managers & Staff, Facilities Managers
People who need to have a broad understanding of this document	Heads of Nursing, Senior Estates Managers, Senior Facilities Managers, Service Managers, ILG Directors
People who need to know that this document exists	All staff

Integrated Impact Assessment:

Equality Impact Assessment Date & Outcome	**Date: 05/07/24** **Outcome: No impacts**
Welsh Language Standard	No
Date of approval by Equality Team:	N/A
Aligns to the following Wellbeing of Future Generation Act Objective	Ensure sustainability in all that we do, economically, environmentally and socially



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INTRODUCTION

It is the purpose of this policy to ensure, as far as is reasonably practicable, that the use of all forms of energy within Cwm Taf Morgannwg University Health Board (hereafter referred to as *the Health Board*) is done, in a controlled, efficient and sustainable manner, to reflect the financial and environmental initiatives instigated by or placed upon the Health Board and to ensure compliance with all relevant energy-related legislation and guidance.

It defines what objectives the Health Board aims to achieve by providing a more comfortable and efficient environment for patients, staff, volunteers, visitors, external partners working in Health Board properties & contractors, whilst reducing carbon dioxide (CO_2) emissions and expenditure through energy efficiency measures.

1. POLICY STATEMENT

The Health Board recognises that the consumption of energy (including water) is necessary for the provision of healthcare services and that it has a responsibility to be energy and resource efficient by minimising unnecessary energy usage.

This will deliver benefits of:

- Minimising cost which will allow investment back into healthcare.
- Minimising the impact on the environment and reducing CO_2 emissions.

As part of the CTM2030 Strategy development the Health Board has identified 'Sustaining our Future' as one of the four strategic goals. This means the Health Board are committed to:

- Becoming a green organisation
- Ensuring financial sustainability of our services
- Embedding value based healthcare
- Ensuring our estate is fit for the future

Becoming green and being sustainable in all that we do is vital to deliver on our responsibilities as a population health organisation - we are putting it at the heart of our decision-making at every level.

To support this, the Health Board has established the Environmental Sustainability Group which is part of the formal governance arrangements for the health board. This group provides focus and oversight on the delivery of the strategy and monitor progress towards our strategic goal of 'Sustaining Our Future' and becoming a carbon neutral organisation in line with Welsh Government's NHS Wales Decarbonisation Strategic Delivery Plan.

The Health Board is also keen to maximise the input in the green agenda of our greatest asset – our workforce. Therefore, we have also established a CTM Green Group, which is a network of people who are passionate about making changes to how we work to have a positive impact on the decarbonisation agenda.

2. SCOPE OF POLICY

This Policy applies to the management of energy and water consumed at all owned & leased Health Board premises. The Policy shall apply to all personnel (including, but not limited to) staff, visitors, contractors, mechanical & electrical consultants, tenants, and volunteers who must comply with the Policy and its supporting procedures. The policy shall apply to temporary contractor accommodation and demountable / mobile clinical services.

3. DEFINITIONS

The following definitions of abbreviations and acronyms used within the document:

BMS – Building Management System

BREEAM – Building Research Establishment Environmental Assessment Methodology

CCL – Climate Change Levy

CHP – Combined Heat and Power

CO_2 – Carbon Dioxide

CRC – Carbon Reduction Commitment

CTM / CTMUHB – Cwm Taf Morgannwg University Health Board (referred to as the Health Board in this policy)

DEC – Display Energy Certificate

ECM – Energy Conservation Measures

EFAB – Estates Funding Advisory Board

EFPMS – Estates and Facilities Performance Management System

EPC – Energy Performance Certificate

EV – Electric Vehicle

HLA - High Level Assessment (part of the Re:Fit programme)

IGP - Investment Grade Proposals (part of the Re:Fit programme)

IPMVP - International Performance Measurement and Verification Protocol

ISO 14001 – International Standards Organisation, standard for environmental management

kW – Kilowatt, a measure of power 1,000 watts

kWh – Kilowatt hour, a measure of energy consumption

LED – Light Emitting Diode (low energy lighting technology)

M&V – Monitoring & Verification

MCPD – Medium Combustion Plant Directive

MW – Megawatt, a measure of power 1,000 kilowatts

NWSSP - NHS Wales Shared Services Partnership

NWSSP SES - NHS Wales Shared Services Partnership Specialist Estates Services

OFGEM – Office of Gas & electricity Markets

PPE – Personal Protective Equipment

PV – Photovoltaics (Solar electricity generation)

QA – Quality Assurance

Re:Fit - a procurement framework for public bodies to implement measures to improve energy efficiency

RHI – Renewable Heat Incentive

TM44 – Inspection regime for air conditioning systems

WEG - Wales Energy Group

WEOG - Wales Energy Operational Group

WG – Welsh Government

WGES – Welsh Government Energy Service

WHTM – Welsh Heath Technical Memoranda

4. AIMS AND OBJECTIVES

Achieve the aims and objectives set out in the NHS Wales Decarbonisation Strategic Delivery Plan and the Cwm Taf Morgannwg Decarbonisation Strategy. These include (see strategy documents for full details):

- Retrofit replacement of conventional lighting with LED Lighting
- Low Carbon Heat Studies
- Installation of renewable energy generation (on-site and potentially off-site)
- BMS strategy
- Electric Vehicle (EV) charging infrastructure

Other key aims and objectives include:

- For qualifying major Capital schemes to achieve a target of Excellent for new build and Very Good for major refurbishments in the BREEAM sustainable building certification tool. Additionally to comply with requirements for the NHS Net Zero Building Standard for qualifying major new build schemes.
- The procurement of all energy and water, wherever possible utilising the most cost effective contracts. The procurement of all energy supplies (gas, electricity, biomass, fuel oil) is undertaken on an all Wales basis, co-ordinated by NHS Wales Shared Services Partnership (NWSSP) Procurement Services, managed through the Wales Energy Group (WEG) and the Wales Energy Operational Group (WEOG)
- Maintain an energy reporting system and provide Managers with information regarding consumption and performance.
- Maintain energy usage, targeting and invoicing system (Energy Targeting and Monitoring) in order to verify consumptions and unit costs.
- Provide accurate information to the Health Board's finance department to enable realistic forecasting and revenue accruals.
- To assess the energy performance, compare and benchmark against set standards and other NHS wales organisations.
- To support the Green CTM Group in the promotion of a culture of energy and environmental awareness throughout the organisation.
- To support the Green CTM Group to proactively engage all staff in energy awareness training and good housekeeping initiatives on a regular basis.

5. RESPONSIBILITIES

5.1 Managerial Responsibilities

The management of energy and utilities is a vital component of the Health Board's overall management of the environment and the following is a list of the key persons / groups and their responsibilities in respect of energy and utilities.

5.2 The Chief Executive

The Chief Executive retains accountability for the statutory compliance of energy and water management and associated carbon emissions

5.3 Executive Directors

- Ensure that all departments and personnel within their areas of responsibility adhere to this Policy.
- Ensure that all tenants and other organisations using Health Board premises within their areas of responsibility are aware of and adhere to this Policy.
- Ensure good housekeeping measures are practiced to meet the aims of this Policy.

- Actively promote energy saving measures.

5.4 **Executive Director of Strategy & Transformation** holds overall responsibility in CTMUHB for the carbon reduction programme

5.5 **Executive Director of Finance** holds overall responsibility for energy management within Capital & Estates, including energy performance, costs and utilities procurement.

5.6 **The Head of Assets, Governance & Technical Services** has overall responsibility for the implementation of this Policy and will maintain professional and technical knowledge in respect of current good practice and statutory requirements. Additionally providing the lead in respect of energy cost management and to monitor progress of the CTM Decarbonisation strategy and plans (specific to Capital & Estates responsibilities) which shall incorporate activities in achieving energy savings through new plant, equipment, maintenance and increased user awareness.

5.7 **Assistant Head of Assets, Governance & Technical Services** supports the department head with overall responsibility for the implementation of this Policy and will maintain professional and technical knowledge in respect of current good practice and statutory requirements. Additionally providing a strategic lead in respect of decarbonisation and to monitor progress of the CTM Decarbonisation strategy and plans (specific to Capital & Estates responsibilities) which shall incorporate activities in achieving energy savings through new plant, equipment, maintenance and increased user awareness.

5.8 **Energy Manager and Energy Support Officer** have responsibility for the day to day management of energy and utility issues together with the longer term requirements and objectives set out in this Policy, with support from the health board's Re:Fit team. They will maintain a professional and technical knowledge in respect of current good practice and statutory requirements. They provide day to day responsibility for checking, validating and processing all utility bills and all known matters relating to energy costs, that they are able to control. They are responsible for reporting, monitoring and verification of all energy consumption data. They will provide suitable and sufficient information and awareness to Health Board staff and contractors, where required, to ensure that this Policy is fully understood and adhered to. They are also the first point of contact for local energy or utilities issues.

5.9 **Operational Maintenance Managers** are responsible for site specific energy related matters including the operation, maintenance and optimum use of building management systems (BMS) and other energy related systems in controlling boiler plant, Combined Heat & Power units (CHP), heating, hot water, lighting, air conditioning systems, renewable energy systems (eg. PV Photovoltaic arrays) and any other energy consuming / generation plant installed. They are also responsible for providing the

Energy Manager with accurate and timely information regarding all utilities consumption readings on a monthly basis.

Operational Maintenance Managers are also responsible for notifying the energy manager of any breakdown in plant, temporary energy consuming plant brought to site and any requests they receive for a decrease or increase in departmental operating hours.

5.10 Operational Maintenance Staff are responsible for site specific energy related matters including optimum use of building management and other energy related systems including heating, hot water, lighting and air conditioning systems and the appropriate maintenance service visits for this equipment. Estates staff shall ensure that all plant room lighting is switched off when leaving plant rooms unattended. Operational Maintenance Staff shall not manually open motorised valves or remove motorised heads from valve bodies without the authority of an estates supervisor or on call estates officer if out of normal working hours.

5.11 Capital Project Managers shall ensure that schemes meet the required BREEAM and Net Zero Building Standards where applicable. Also to ensure that adequate provision for metering and automatic controls via a central Building Management System are incorporated in all new and upgrading projects. "Life Cycle Costing" criteria is applied to ensure that energy and water efficient plant, equipment and materials are incorporated into all new and upgrading projects where possible. Where necessary additional capital funding is provided to ensure that cost effective revenue saving opportunities are not missed. Capital project managers are to provide design criteria for energy consumption and revenue costs for major property refurbishments and developments.

Capital Project Managers are also responsible for notifying the energy manager of any temporary energy consuming plant brought to site and to ensure all contractor site accommodation units are separately metered for utilities.

5.12 All Managers with a procurement responsibility must take into consideration the energy and water efficiency ratings or performance on equipment or appliances purchased. If in any doubt then advice from the Energy Manager, Procurement and/or the Estates Directorate should be sought. All purchasing activity must comply with NHS Wales Guidelines and domestic policies governing public procurement and will be based on the achievement of value for money and energy efficiency. All Managers should also:

- Ensure good housekeeping measures are practiced to meet the aims of this Policy.
- Ensure that heating, lights and computer equipment is turned off out of hours or when not in use
- Actively promote energy and water saving measures.

- To actively discourage the use of kettles & toasters in offices which are also a fire risk.

5.13 Facilities & Estates Technical and Environmental Compliance Manager monitors and supports on compliance through the Energy Governance and Compliance scorecard; including any updates on legislation. The role provides scrutiny of Energy compliance issues; for example:

- Energy Policy
- Maintenance records of all CHP's and associated equipment
- Maintenance records for all gas boilers, flue gas analysis and gross efficiency testing
- Energy risk register which identifies all outstanding risks is readily available and prioritises risks
- Staff are suitably trained for the work they undertake and accurate training records are maintained

As part of the Health Board ISO 14001 management system, the role:

- Monitors Objectives and targets relating to significant Energy impacts
- Reviews the Aspects and Impacts register and ensures all relevant health board activities are included
- Provides regular update relating to any changes to current legislation and advises on impact to health board working practice, and requirements to comply with legislative update.
- Provides support and guidance in relation to ISO 14001 internal and external audit requirements.

5.14 Environment & Sustainability Group comprises part of the formal governance arrangements for the Health Board. This group provides focus and oversight on the delivery of the Health Board's decarbonisation strategy and the Welsh Government's NHS Wales Decarbonisation Strategic Delivery Plan.

5.15 Wales Energy Group (WEG) & Wales Energy Operational Group (WEOG)

These two groups co-ordinate and manage the purchase of energy utilities for NHS Wales. The WEG is comprised of Directors of Finance or their deputies and its role is to ensure a consistent approach to the procurement / sourcing of Gas and Electricity for the NHS in Wales. The WEG is to develop, agree and manage the Purchasing Strategy for the All-Wales Gas and Electricity contracts.

The WEOG comprises Health Board and Trust representatives with knowledge, expertise and responsibility for energy management. Its role is to ensure a consistent approach to the contract management of the supply of all utilities (including but not limited to Gas, Electricity, Fuel Oils, and Biomass) across the NHS in Wales. Additionally to monitor the performance of suppliers against the terms of the All-Wales Utilities contracts and where necessary agree strategies for enforcing contractual terms.

5.16 Energy Compliance Group

The Energy Compliance Group made up of members from across the Health Board with agreed terms of reference in line with this policy will:

- Set, agree and monitor targets for energy reduction in line with standards, policies and legislation listed in section 5 of this policy.
- Monitor performance against the Energy Compliance Scorecard
- Check performance and compliance to requirements of DECs, EPC's, MCPD and TM44 legislation
- Overseeing the participation in and response to any energy and decarbonisation audits
- Promote the use of technology throughout the Health Board for the control of energy and water.
- Identify areas where new Low or Zero Carbon technologies could be used to reduce the Health Board's carbon emissions.
- Identify the major sources of energy and water consumption within Health Board properties and investigate potential savings.
- Work closely with, and support other groups involved with carbon reduction such as transport, environmental and waste teams and CTM Green Team.
- Develop and monitor key performance indicators for energy management.
- Supporting the review of the Energy Policy as required.

5.17 All Health Board Employees, volunteers, tenants and contractors have a responsibility to assist in implementing this Policy and resulting procedures on energy and water management in order for it to be successful. Good housekeeping must be practiced by all staff.

Every member of staff shall ensure that where appropriate, photocopiers, computer equipment, including medical diagnostic equipment (only where safe and appropriate) should not be switched on unnecessarily, and also should be switched off at the end of the working day, when not in use.

Every member of staff shall ensure that energy is not used unnecessarily. In particular, lights and computer equipment shall be switched off when not required, and on leaving the room / department. Additionally, unnecessary

water use should be avoided by ensuring taps are turned off and that any faults, leaks etc are reported through the Estates Helpdesk to be addressed.

6. INFORMATION, INSTRUCTION AND TRAINING

There are no specific training implications arising from this Policy. However, awareness of the importance of compliance with the document will require reference to it in induction programmes and during Individual Performance Reviews.

The HB has developed and introduced an e-learning module on Environment Waste & Energy. This is now a mandatory requirement for all staff to undertake.

7. PROCEDURE

7.1 Heating Procedure

In order to reduce CO_2 emissions, consumption of utilities, improve energy efficiency, and ensure occupant comfort, all space heating services will be shut down throughout the summer period, from 1st May through to the 30th September each year.

7.1.1 Temperature Guidelines

Target Temperature: During the heating season (1st October to 30th April), the Health Board aims to maintain an indoor minimum temperature of **18°C** for non-patient areas**.** This target balances occupant comfort with energy efficiency and adheres to statutory temperature requirements. Staff working in colder areas will be expected to wear the appropriate PPE.

7.1.2 Individual Comfort Concerns

If staff report feeling cold, this should be reported via the Estates Helpdesk and the Estates team will measure the room temperature, any reading of **18°C** or higher is considered acceptable. If the temperature is below **18°C**, the estates team will prioritise appropriate actions to address the existing permanently installed heating issue based on a risk based approach considering the whole of the heated zone.

- The Estates Officer will verify the room temperature to ensure it falls above the acceptable minimum stated above.
- Staff with no patient contact & office based staff are encouraged to consider personal measures to improve their comfort, such as using additional layers of clothing or temporarily re-locating to a warmer location. The aim is to avoid adjusting the heating settings for an entire department based on individual comfort levels, as this may not be suitable for everyone and will lead to energy inefficiencies.

- Prior to enabling the heating systems, the Estates Officer will consider any adverse impact on the entire department or zone that the heating system will affect.
- Risk assessment may be conducted to identify any underlying factors contributing to the individual's discomfort.

7.1.3 Definition of a Cold Spell

A "cold spell" is defined as a period outside of the heating season, when outdoor temperatures are significantly below the seasonal average, which may cause indoor temperatures to drop below the acceptable level of **18°C** in many areas of a property simultaneously.

For illustration, if the outdoor daytime temperature drops below **15°C** during summer months, it could be considered a cold spell.

7.1.4 During Cold Spells:

- The Estates Officer will assess the need for reinstating heating services during the summer shutdown period if it is determined that general comfort levels are affected.
- Any reinstatement of heating during a cold spell must be communicated to the Energy Manager or their deputy.

7.1.5 During Warmer Spells:

If staff report feeling hot during the heating season, this should be reported via the Estates Helpdesk and the Estates team will adjust or turn off the heating system.

Once the heating system is off, fans may be used for localised cooling however comfort cooling systems may only be used in line with section 7.2 of this policy.

7.1.6 Definition of a Warmer spell

A "warmer spell" is defined as a period during the heating season, when outdoor temperatures are significantly above the seasonal average, which may cause indoor temperatures to rise above the temperature at which the heating system is needed. The opening of windows by staff is a good indicator that areas are becoming uncomfortably warm.

For illustration, if the outdoor daytime temperature rises above **20°C** during autumn or winter months, it could be considered a warm spell.

- If warmer spells occur during the heating season, the site-specific Estates Officer will consider switching off the heating services temporarily.
- The decision to switch off heating during warmer spells will be made in agreement with the Estates Managers, other relevant stakeholders and the energy manager or their deputy. Heating will be reinstated as required on a case by case basis.

7.1.7 Rationale for Temperature Control

Maintaining consistent indoor temperatures ensures safety and maintains productivity. When temperatures are not within the comfortable range, staff may exhibit unsafe behaviours, such as:

- Taking shortcuts to escape cold environments.
- Improperly wearing personal protective equipment (PPE).
- Experiencing reduced concentration, increasing the risk of errors.

7.1.8 Risk Assessment

A departmental workplace risk assessment must be undertaken if any workplace identifies a problem with thermal comfort. This assessment will consider a range of clinical, environmental, work-related, and personal factors to determine what constitutes a comfortable and safe workplace temperature.

7.2 Portable Electric Heaters & Cooling Systems

Portable electric heaters and cooling systems are not to be used within the Health Board premises, except under the following criteria:

- Where permanently installed by Capital or Estates as part of the designated heating or cooling system.
- In areas where the Estates department has agreed that electric heaters / cooling equipment are necessary. In such instances the Estates department will provide suitable equipment and monitor the continued requirement.
- Cooling systems will be permitted where a need is identified for clinical processes or critical equipment and not for "comfort cooling"
- It shall be the Health Board's policy wherever practicable, to modify such areas through additional insulation and eliminate the need for temporary electric heaters.

Portable electric heaters are not permitted by the Electrical Safety Group, the Fire Safety Department nor the Estates Energy Team. Personally owned portable heating or comfort cooling devices shall not be used on Health Board Premises. Any contravening devices identified will be removed from site and reported through the Health Board Electrical Safety Group.

7.3 Electric Vehicles

The connection of private or non-Health Board electric vehicles to the Health Board's electrical infrastructure is prohibited. On site charging of non-Health Board electric vehicles may only be undertaken using designated public EV charging points.

7.4 Re:Fit and Future Investment

The Health Board will endeavour to invest in energy improvement schemes where it is proven to be cost effective. Such schemes will include improvements to building services, boilers, insulation, new technologies in energy management systems, and low carbon technologies.

The Health Board has commenced a long-term decarbonisation retrofit (Re:Fit) contract with Veolia Energy & Utilities Ltd to become our partner to undertake energy and carbon saving schemes.

Re:Fit is a procurement framework for public bodies including Health Boards wishing to implement measures to improve energy efficiency, to implement retrofit projects, to invest in energy efficiency improvements and develop renewable energy projects, and then to achieve financial savings using an energy performance contracting approach.

The Capital & Estates Team will work with Veolia Energy & Utilities Ltd to follow the Re:Fit process to identify opportunities for energy and carbon reduction eventually leading to the installation of agreed energy conservation measures (ECMs):

- The first stage is to undertake High Level Assessments (HLAs) at agreed sites to identify the potential opportunities
- This progresses to Investment Grade Proposals (IGPs), which are detailed, designed and costed proposals including the details of ECMs proposed, kWh and tonnes of CO_2 to be saved, capital costs, guaranteed cost savings, payback periods and an M&V plan (monitoring & verification).
- The IGP will also detail how and when Veolia propose to install the ECMs. It will detail a price cap for the works and binding guarantees of energy & carbon savings
- Throughout the payback period, Veolia will measure and report the performance of the ECMs that have been installed within our buildings. This is carried out through an M&V plan, agreed following the IGP and in line with the International Performance Measurement and Verification Protocol (IPMVP)

REFIT is intended to continue through multiple phases of works which will see the above process repeated across the CTM estate and addressing aims and objectives of the NHS Wales Decarbonisation Strategic Delivery Plan.

7.5 Energy Surveys

The Re:Fit programme incorporates energy surveys of Health Board properties to identify areas for developing via HLA's and IGP's and to potentially progress into capital schemes.

The use of electrical & mechanical specialists / consultants for energy surveys of areas found to be inefficient should be considered and their recommendations for improvements evaluated on a cost benefit for both short and long term.

The Capital & Estates Team will work closely with Welsh Government Energy Service (WGES) to maximise opportunities to obtain support for specialist energy surveys.

Other forms of mandatory surveys include:

- Display Energy Certificates (DECs) and Energy Performance Certificates (EPC's), displayed at the main entrance to a building visited by the public.
- Air Conditioning System Surveys (TM44 inspection), this is an inspection on all air conditioning plan above 12kW in size. Inspections must be carried out by a suitably qualified / certified assessor.
- Medium Combustion Plant Regulations: The regulations require the permitting of any qualifying combustion plant (including boilers, generators and CHP). The regulations also require the analysis of emissions (chimney stack emissions from boilers etc.) to be undertaken periodically to ensure ongoing compliance.

8. REVIEW, MONITORING AND AUDIT ARRANGEMENTS

Adherence to the Energy Policy will be monitored by the Facilities & Estates Governance Team through the energy compliance scorecard. Monitoring is recorded via the scorecard and reported to the:

- Environment & Sustainability Group
- Energy Compliance Group.
- ISO 14001 Environmental Management Systems Group
- External audit for ISO 14001

High risk compliance issues will be reported through the Capital & Estates Health, Safety & Risk Group.

Energy related schemes undertaken through Re:Fit will be monitored in line with agreed Re:Fit parameters as set out in 7.4 above.

Energy related schemes undertaken through EFAB funding will be managed and monitored to completion by the Estates Capital Team.

The Policy will be reviewed on a tri-annual basis. An earlier review may be warranted if one or more of the following occurs:

- Significant regulatory or statutory changes or developments.
- Results from feedback and/or audit outcomes.
- For any other relevant or compelling reason.

The following audits are carried out as required:

- Internal Compliance Balanced Scorecard audit, carried out by the Estates and Facilities Technical and Environmental Compliance Manager. This is on an annual basis, or if required by the results of audit or any significant changes or incidents
- As part of the Environmental Management System, internal audits will be carried out over a broad range of environmental aspects. For operational management of energy systems this will take place on an annual basis.
- ISO 14001 annual audit carried out by an external environmental consultancy service in line with the requirements for certification to the standard.
- Other external energy / carbon / sustainability audits, carried out by NHS Wales Shared Services Partnership Audit & Assurance

Additionally a number of formal reporting and monitoring requirements:

- EFPMS – Estates & Facilities Performance Management System, an annual formal reporting tool maintained and managed by NWSSP - SES
- Welsh Government Carbon Reporting – an excel-based tool reporting carbon footprint data to WG on an annual basis
- CHP QA – annual inspection and report by an independent verifier to confirm that CHP is exempt from Climate Change Levy (CCL) on gas consumed
- Renewable Heat Incentive OFGEM Reporting – Heat meter readings submitted to OFGEM (Office of Gas & Electricity Markets) quarterly in order to confirm compliance to RHI requirements and show performance of biomass systems
- Air Conditioning Systems TM44 reporting – this is an inspection report by an independent inspector assessing the performance of air conditioning systems, inspection outcomes are reported to the Energy Compliance Group and the site responsible estates officer to rectify non-conformities.

9. IMPLEMENTATION/POLICY COMPLIANCE

It is the policy of the organisation to comply with NHS, WG, UK statutory and other legislative requirements in relation to the use and management of energy. The legislation and Health Service guidance documents that must be considered in the development and maintenance of this policy are listed in section 13 – Main

Relevant Legislation / Standards.

10. RETENTION OR ARCHIVING

In cases of complaints / claims and other legal processes it is often necessary to demonstrate the policy in place at the time of the investigation or incident. The Board Secretary / Corporate Director will therefore ensure that copies of this policy are archived and stored in line with the Records Management Strategy and are made available for reference purposes should the situation arise.

11. NON CONFORMANCE

There is a requirement of all staff to comply with the provisions of the Energy Policy and, where requested, to demonstrate such compliance. Failure to comply will be dealt with in accordance with the appropriate Cwm Taf Morgannwg University Health Board Workforce and Organisational Development Policy.

12. EQUALITY IMPACT ASSESSMENT STATEMENT

This policy has been screened for relevance to Equality. No potential negative impact has been identified.

13. MAIN RELEVANT LEGISLATION / STANDARDS

The Health Board is committed to achieving the minimum standards for energy consumption and control placed upon it by the UK and Welsh Governments.

The following legislation and guidance apply:

- Climate Change Act 2008.
- Energy Performance of Buildings Regulations 2012.
- Carbon Reduction Commitment CRC Energy Efficiency Scheme (Amendment) Order 2014 (until 2025)
- Heat Network (Metering and Billing) Regulations 2014.
- Building Regulations (Wales) 2014 - Part L Conservation of Fuel and Power.
- Environmental Permitting Regulations 2016 (Medium combustion Plant & Specified Generators)
- Water Industry Act 1991
- Water Resources Act 1991
- Wellbeing of Future Generations Act (Wales) 2015.
- Environment (Wales) Act 2016.

- WHTM 07-02 EnCO_2de 2015
- BS EN ISO14001 Environmental Management System.
- NHS Wales Decarbonisation Strategic Delivery Plan
- Cwm Taf Morgannwg Health Board Decarbonisation Strategy

This list is not exhaustive. The Energy Compliance Group is updated on a quarterly basis with any changes to legislation as an agenda item reported by the Estates and Facilities Compliance Manager. References to legislation amendments in this policy will be updated as deemed appropriate by the Energy Compliance Group.

Agenda Item
8.1.5

Quality & Safety Committee

Management of High Voltage Electrical Systems Policy

Dyddiad y Cyfarfod / Date of Meeting	18/09/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Jason Williams, Assistant Head of Estates
Cyflwynydd yr Adroddiad / Report Presenter	Sally May, Executive Director of Finance
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Sally May, Executive Director of Finance

Pwrpas yr Adroddiad / Report Purpose	For Approval

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Electrical Safety Group - Approved	10/07/2023	ENDORSED FOR APPROVAL
Capital and Estates Governance Board	09/06/2023	ENDORSED FOR APPROVAL

Acronyms / Glossary of Terms	
HV	High Voltage
HVAP	High Voltage Authorised Person

1. Situation /Background

1.1 The Management of High Voltage Electrical Supply Systems Policy has been developed to introduce a structured procedure and reporting schedule for the management and control of High Voltage Systems and equipment in compliance with current legislation and other guidelines.

1.2 The primary objectives of the policy is to take all reasonable precautions to ensure HV Systems and Equipment are managed & maintained correctly for the safety of patients and staff.

1.3 Although the policy states that it is to be read by all Estates staff, Estates Managers, Contractors and anyone involved with high voltage works in Health Board premises. The policy specifically applies to members of the Electrical Safety Group, to Estates High Voltage Authorised Persons (HVAPs) and specialist HV contractors engaged with and employed by the HVAP.

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	02/03/2020
Informal Consultation with interested parties	Via Electrical Safety Group and Health, Safety & Risk Group
Formal Consultation	Via Electrical Safety Group and Health, Safety & Risk Group
Committee – For approval	Going before Quality & Safety Committee 18/09/24

2.2 The policy has been reviewed and is consistent with the approach across NHS Wales / legislation.

2.3 Internal stakeholders have been engaged in the consultation including Electrical Safety Group, Health, Safety & Risk Group, and Capital & Estates Governance Board.

2.4 Organisational values and behaviours have been reflected within the policy.



3. Key Risks / Matters for Escalation

3.1 Policy has undergone an informal review of it's content and the list of HVAP's in the Health Board has been updated. The core of the policy remains unchanged.

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

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☒	No: ☐
	Outcome: Quality Impact Assessment completed, has identified no indicators for a full QIA.	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar 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:
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 are asked to **APPROVE** the Management of High Voltage Electricity Systems 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.

High Voltage Electricity Supply Systems Policy

Document Type:	Non Clinical Organisational Wide Policy
Ref:	EST.HV
Author:	Jason Williams Assistant
Executive Sponsor:	Executive Director of Finance & Procurement
Approved By:	**Quality & Safety Committee**
Approval / Effective Date:	(dd/mm/yyyy)
Review Date:	(09.06.2026)
Version:	2.0

Target Audience:

People who need to know about this document in detail	All Estates staff, Estates Managers, Contractors and anyone involved with high voltage works in Health Board premises.
People who need to have a broad understanding of this document	Heads of Nursing, Senior Estates Managers, Senior Facilities Managers, Service Managers, ILG Directors
People who need to know that this document exists	All staff

Integrated Impact Assessment:

Equality Impact Assessment Date & Outcome	02.03.2020 **Outcome: No impacts**
Welsh Language Standard	No
Date of approval by Equality Team:	N/A
Aligns to the following Wellbeing of Future Generation Act Objective	Provide high quality, evidence based, and accessible care



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1. PURPOSE

1.1 The High Voltage (HV) systems serving the Cwm Taf Morgannwg University Health Board (CTMUHB) healthcare properties shall be managed and operated in accordance with this document and HTM 06-03. Which should be followed as Best Practice. Adherence to these two documents should normally be sufficient to comply with the legislation relevant to HV systems (*Electricity at Work Regulations 1989)*.

1.2 The arrangements contained in this document must be agreed by the Authorising Engineer (HV) and the CTMUHB - Electrical Safety Group (ESG).

1.3 The Policy applies to the HV systems in the following hospitals:

- Royal Glamorgan Hospital
- Llantrisant Health Park
- Prince Charles Hospital
- East Glamorgan Community Offices/Laundry
- Ysbyty Cwm Cynon
- Princess of Wales Hospital

2. POLICY STATEMENT

Cwm Taf Morgannwg University Health Board (CTMUHB) has issued a Policy for Management of High Voltage Electricity Supply Systems as part of the Corporate Health and Safety Policy.

This High Voltage Electricity Supply System Policy is the practical implementation of the CTMUHB Health & Safety Policy from which it derives its authority, it meets the requirements of *chapter 3*, *Health Technical Memorandum (HTM) 06-03: Electrical safety guidance for high voltage systems* and is required due to the inherent dangers.

3. PRINCIPLES

Cwm Taf Morgannwg University Health Board, through its Chief Executive, will ensure that its duties and responsibilities for the safe management of HV systems are fully met.

4. SCOPE

This Policy is intended for use by the University Health Board and their contractors, involved with HV systems and related equipment as defined in *Health Technical Memorandum HTM06-03.* It applies throughout the University Health Board to all HV systems.

5. LEGISLATIVE AND NHS REQUIREMENTS

The main Guidance Document for HV Systems in the NHS is HTM 06-03, there is also the Electricity at Work Regulations 1989 and the Health & Safety at Work Act 1974 that must be adhered to in conjunction with this guidance.

6. PROCEDURES

All work with HV systems shall be carried out in accordance with the procedures contained in HTM 06-03.

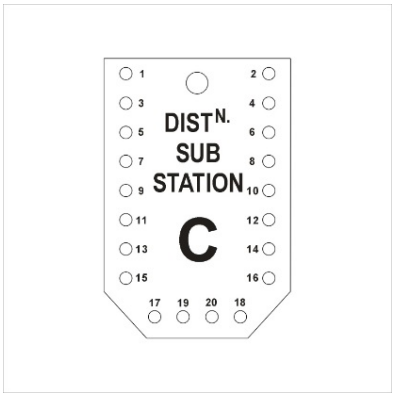
7. DESIGN, OPERATION AND MAINTENANCE OF HV ELECTRICAL SYSTEMS GENERAL PRINCIPLES AND REQUIREMENTS.

7.1 The CTMUHB HV Policy specifies the requirements for Design, Operation and Maintenance of HV electrical systems and derives these requirements from HTM 06 - 03.

7.2 Maintenance shall also include the buildings/enclosures and associated building engineering services. This work will normally be carried out by UHB staff or contractors working under a "Limitation of Access" (L.O.A.) document or Permits to Work (PtW).

8. ACCESS CONTROL TO DANGEROUS AREAS, ENCLOSURES & SWITCHGEAR

8.1 HV switch rooms and other dangerous areas containing HV equipment shall be kept locked at all times with access restricted to the APs (HV), in addition to this, all switchgear should be locked with the use of working locks to stop any unauthorised operation of the switchgear and the keys kept in lockable key cabinets to again stop unauthorised access or operation of the switchgear. Keys should be kept on key holder / key plate systems (as below) as detailed in HTM 06-03, Chapter 6, and locks numbered for easy of identification. Key cabinets should be located within the associated Intake Sub Stations (ISS), Switch Rooms or AP rooms, again access to these cabinets should be via a key or combination lock and meet the requirements of HTM 06-03, Chapter 6, and paragraphs 6.1 - 6.12.



Numbered Key Holder / Plate



Numbered Lock



Lockable Key Cabinet

Visitors must be accompanied by the AP (HV) or enter the HV switch room under a L.O.A permit if they have the necessary training, experience and competence.

The AP (HV) can authorise access to the following people by issuing safety documents but has absolute authority and can deny or withdraw access at any time:

- Employees of the Maintenance Contractor.
- Those working under a L.O.A. safety document.
- Anyone working with one of the above and under their control.

8.2 Where HV areas contain equipment belonging to the District Network Operator (DNO) their staff have a legal right to enter at any time which is usually arranged by some form of joint key arrangement.

8.3 Keys giving access to HV areas and equipment shall be controlled by the AP (HV) in accordance with *Chapter 6, General Precautions, 6.1 – 6.6 of HTM 06-03.*

The Site Logbook shall be completed by the CTMUHB AP (HV) on issue and receipt of keys. Further requirements are set out in HTM06-03, Chapter 8, paragraphs 8.3 – 8.8.

9. L.O.A & SAFETY DOCUMENTATION

9.1 An L.o.A., defined in Chapter 8 of HTM 06-03, is a written authority issued for specific non-HV work to be undertaken in a HV area which is under the control of the AP (HV).

Any person accepting a L.O.A. becomes a temporary Competent Person (CP) HV and must comply with the guidance contained in *paragraphs 4.23 to 4.29 of HTM 06-03.*

Since a painter or similar craftsman is unlikely to be familiar with *HTM 06-03*, particular care must be taken to ensure the meaning of the guidance is explained and understood.

A printed copy of paragraphs *4.23 to 4.29 of HTM 06-03* shall be readily available to issue to the CP HV, as well as a statement included on the LOA that states:

"The CP (HV) and any assistants must NOT touch or interfere with the HV system" should be encapsulated and issued with and noted on the L.O.A.

In certain circumstances when work is undertaken on a L.O.A. the AP (HV) will consider whether supervision is required.

Full requirements of an L.o.A can be found in HYM 06-03, Chapter 8, paragraphs 8.104 – 8.128.

Other Safety Documentation is listed below:

9.2 A Permit to Work (PtW) – A written authority issued by the duty Authorised Person (AP) for work to be undertaken on electrical equipment. Details of which can be found in HTM 06 – 03, Chapter 8, paragraphs 8.57 – 8.79.

9.3 Isolation & Earthing Diagram – A diagram attached to a PtW or sanction for test illustrating the safety measures taken. Details of which can be found in HTM 06 – 03, Chapter 8, paragraphs 8.34 – 8.41

9.4 Safety Programme – Is a written programme issued by the duty AP, setting out the sequence of operations to be followed before a PtW or a sanction for test is issued.

Details of which can be found in HTM 06 – 03, Chapter 8, paragraphs 8.44 – 8.56

9.5 Sanction for test – A written authority issued by the duty AP for testing to be undertaken on the electrical equipment. Details of which can be found in HTM 06 – 03, Chapter 8, paragraphs 8.80 – 8.103.

9.6 Log Book – This can be in terms of a site log book or substation log book, entries of access, maintenance and any other activity should be noted in the log books, requirements for the log books and entries can be found in HTM 06-03, Chapter 8, Paragraphs 8.9 – 8.12.

10. OPERATING & MAINTENANCE RECORDS

10.1 Records for the operation and maintenance of HV electrical systems shall be available together with back-up copies, as detailed in *HTM 06-03*.

Suitable documents matching those in *HTM 06-03* shall be purchased & procured from TSO book shop.

Full requirements are set out in HTM 06-03, Chapter 8, paragraphs 8.21 – 8.24

10.2 The following manuals and documentation must be available for the operation and maintenance of HV system/s and are held in:

- Royal Glamorgan Hospital (RGH) – AP Office, RGH
- Llantrisant Health Park (LHP) – AP Office, RGH
- Prince Charles Hospital (PCH) – (Estates Officer's Office)
- East Glamorgan Community – AP Office, RGH
- Ysbyty Cwm Cynon (YCC) – (Estates Officer's Office)
- Princess of Wales Hospital (POW) – Intake Substation – DSS1

10.3 Operational Procedure Manual (HTM document)

10.3.1 This shall hold the information listed in paragraphs 8.14 - 8.20 of HTM 06-03 and:

- Copy of HB contract with Maintenance Contractor for carrying out maintenance works on the HV system/s
- Policy for Management of HV Electricity Supply Systems (this document)

10.4 Operating and Maintenance Manual

10.4.1 This shall hold the information listed in paragraphs 8.21 - 8.24 of HTM 06-03 and:

- Site drawings showing HV system and standby generators
- Switchgear and transformer schedules for the system
- Protection grading charts for the system
- Maintenance and Inspection reports, paragraphs 8.25 - 8.28 of HTM 06-03
- Contractor schedules of maintenance.

10.5 Record Documentation Control

The site AP (HV) listed in Appendix 1 have the responsibility for the control and upkeep of all Operating Records as above and those in Chapter 8 of HTM 06-03.

11. POSTERS & SIGNAGE

Full requirements for switch room posters & signage are set out in HTM 06 – 03, Chapter 9. Design specification for each sign or poster is also detailed in this section.

These are broken down into:

11.1 Posters

In each room containing high voltage equipment, the following should be prominently displayed.

- A poster displaying an approved method of treatment for electric shock.
- Extracts from HTM 06 – 03
- A single line drawing of the high voltage system/network up to and including final circuit distribution boards under the control of the AP HV.
- If the contains equipment containing Sulphur Hexafluoride, a notice stating this should be displayed.

Other information and posters to be displayed may include:

- The Electricity at Work Regulations 1989 (EaWR 1989)
- Other relevant H&S information

11.2 Permanent Safety Signs

Permanent safety signs are needed, when:

- A "gas flooding system" is installed in a substation or accommodation where high voltage is present, a safety sign with appropriate text should be installed in a prominent position.
- A warning sign should be displayed on any pole that supports high voltage conductors or equipment.
- A warning sign and notice identifying the installation should be displayed in a prominent position, at every angle of approach, outside every substation and high voltage standby set house to comply with table 11C of the Electricity Safety, Quality and Continuity Regulations 2002, which requires 3 types of notice at substations.

A. One or more "Danger of Death" safety signs complying with Schedule 1 of the regulations.
B. A property notice giving the unique identification number or location of the substation and an emergency telephone contact number, each property notice must carry the name of the substation's current owner or operator.
C. Where necessary, other signs commensurate with the risk of interference, for example "Keep Out" signs.

Some example are shown below.







Further examples of signage currently employed within CTMUHB



11.3 Temporary Safety Signs

Caution signs (see below) are to be prominently displayed and securely fitted/fixed at all points of isolation before the start of, and for the duration of, any work or testing, and before the issue of any PtW or Sanction for Test.



Danger Signs (see below) are to be prominently displayed so that they are visible from every angle of approach to a high voltage enclosure before any testing at high voltage is carried out and before the issue of, and for the duration of, any work or testing and before the issue of any PtW or sanction for test.

Danger Signs are to be prominently displayed on any equipment which remains "Live" and is adjacent to equipment to be worked on or tested before the start of, and for the duration of, the work or testing, and before the issue of any PtW or sanction for test. Further description could be sort from HTM 06-03, Chapter 9, paragraphs 9.16 – 9.20.



Authorised Persons HV, should carry and have enough signage stock to be able to fulfil the isolation/testing safely, securing all points of isolation and identifying all adjacent live compartments / conductors.

12. SULPHUR HEXAFLUORIDE 6 (SF6)

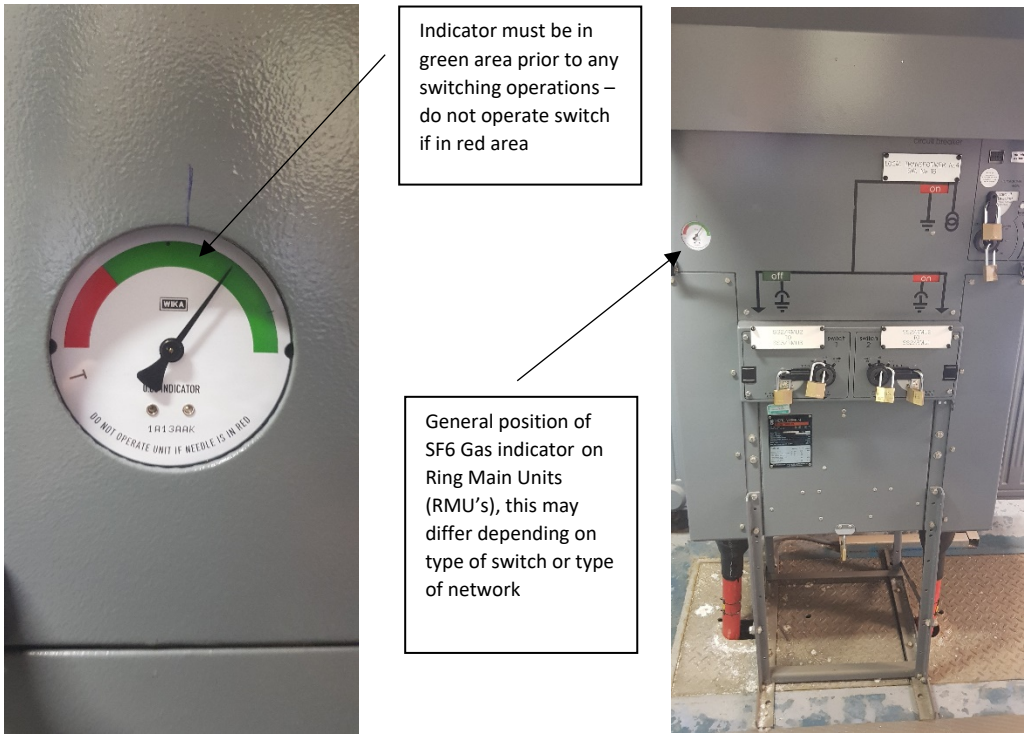
Work on any equipment containing SF6 should be carried out in accordance with special instructions specified by the manufacturer (see also HTM 06 – 01)

Under normal circumstances, SF6 is non-toxic; however, when exposed to an electric arc, it decomposes to form toxic compounds which will normally be contained within the equipment. In the rare event of any decomposition products being present in the atmosphere, warning

indications such as a pungent odour similar to rotten eggs or irritation of the upper respiratory tract and eyes will become apparent. Where this occurs, personnel should immediately get fresh air even if no equipment failure is apparent. The AP HV must be informed, who should then report the incident to the AE HV and manufacturer.

The vast majority of HV switchgear installed / utilised within CTMUHB contains SF6, therefore a sign stating this should be erected outside the relevant switch room and if practicable on the switchgear itself to warn operators of its presence.

If a smell of rotten eggs can be smelt on entering the switch room then caution must be taken. Similarly, if a "low gas pressure alarm flag" has operated, or the indicator on more modern switch gear is in the red area then the switch/s must not be operated under any circumstances.



Old type HV panel with IDMT Relays, fuses and ammeters





Protection Relays – This will also include an SF6 Low Pressure Gas Alarm (if the switch is an SF6 switch)

If there is a problem with the switchgear and the HV switch loses its SF6 Gas, the switch will lose pressure. There is a relay that senses this loss in pressure and operates the low gas pressure alarm – indicated by the use of a "Flag" – (white type plaque with a red stripe struck through diagonally). If this is present then operation of the switch is strictly prohibited and should not by operated under any circumstances until the switch has been inspected by a specialist or the manufacturer..

If there is suspicion or confirmed SF6 gas escape or low pressure then the maintenance contractor must be contacted. Currently the maintenance contractor is (Western Power Distribution - WPD), WPD have their own "in-house" SF6 emergency response teams to be able to cope with emergency incidents associated with SF6 equipment/leaks and are contactable via the contract or via their normal operating telephone number.

ISS, Switch rooms and switchgear containing SF6 must have signage proximately displayed to indicate this, normally on or adjacent to the points of entry to the switch room and/or on the equipment if able to do so. Examples illustrated below.





13. TRAINING IMPLICATIONS

13.1 **Maintenance Contractor's staff**

13.1.1 The Maintenance Contractor employees should have the necessary technical knowledge as covered in relevant sections of *HTM 06-03*.

This should include Cardio-Pulmonary Resuscitation (CPR) (training records to be kept).

13.1.2 Training should, so far as possible, include an assessment of safe switching practice on CTMUHB HV equipment.

13.1.3 The Maintenance Contractor is responsible for ensuring its employees are adequately trained and that a register of training is maintained.

13.1.4 The UHB may request at any time to view the training & CPR records and reserves the right to refuse access to employees of the Maintenance Contractor whom the UHB considers are not adequately trained.

13.2 **CTMUHB staff**

UHB Authorised Persons (HV) shall be trained in accordance with *Appendix 9 of HTM 06-03* and be appointed in writing by the Designated Person (DP) prior to any switching operations on HV equipment.

14. PROGRAMME FOR MAINTENANCE OF HV ELECTRICAL SYSTEM

14.1 The work shall be carried out as required in the contract between the HB and the Maintenance Contractor and the schedule of maintenance submitted by the Maintenance Contractor and included in the Operational Procedure Manual. Any additional work specified by the manufacturer must also be undertaken and details recorded.

14.2 The Maintenance Schedules should include as a minimum:

- Inspection and cleaning of the HV equipment and associated protection relays
- Partial discharge testing
- Maintenance and testing of the switchgear and arc control/insulating medium (as applicable) as well as protection relays, including secondary injection
- Maintenance and testing of all transformers, including any necessary testing of and replacement of insulating medium (as applicable) and cleaning
- Maintenance and testing of battery tripping units (as applicable)
- Maintenance, testing and calibration of operational equipment such as high voltage potential indicators

15. REVIEW, MONITORING AND AUDIT ARRANGEMENTS

Auditing the safe operation, maintenance and compliance arrangements of the HV electrical system is detailed in Appendix 3 of *HTM 06-03* and, generally, is the responsibility of the Authorising Engineer (HV).

16. MANAGERIAL, OPERATIONAL ROLES & RESPONSIBILITIES

The roles involved in the management and operation of HV electrical supply systems are defined in *HTM 00: Policies & Principles of Healthcare Engineering, HTM 06-03.* Additional roles or duties are defined below.

16.1 Chief Executive

The Chief Executive of the UHB has ultimate responsibility for all the organisation's activities, including the implementation of this Policy and associated legislation.

16.2 Designated Person (Director of Finance)

The "Designated Person" is appointed by the Chief Executive to have management responsibility for the implementation of this Policy within the organisation.

16.3 Authorising Engineer (AE) HV

The "Authorising Engineer" is a Chartered / Incorporated Engineer with required knowledge, training and experience who is appointed by the Designated Person to advise CTMUHB on the implementation of this Policy and related High Voltage safety.

16.4 Co-Ordinating Authorised Person (C-AP) HV

CTMUHB will appoint a Co-Ordinating AP HV on the recommendation of the (AE) HV. The role of the (C-AP) HV, is to act as the overall monitoring aid to ensure this policy is adhered to and to ensure the networks are maintained, operated and managed safely in accordance with HTM 06-03 and any other legislative or regulatory requirements. The (C-AP) HV, will have the same responsibilities as an (AP) HV and undertaken the same training and appointment process as the other (AP) HV's and may be appointed for one site where there are a number of (AP) HV's or a number of sites across the estate depending on the needs of CTMUHB.

The (C-AP) HV will be responsible for carrying out switching and issuing of safety documents and ensuring compliance with this policy. Each AP HV will be appointed in writing by the DP on the recommendation of the AE HV after successfully completing the required training or refresher training detailed in HTM 06-03, Appendix 9, sections 8 – 19 & 20 thru 29 and after successful interview & assessment by the AE HV. Please also refer to the section 16.5 below for more detail & further requirements of the role.

16.5 Authorised Person (s) (AP) HV

CTMUHB shall appoint one or more "Authorised Persons" on the recommendation of the Authorising Engineer, to take responsibility for the site specific day-to-day operation of High Voltage supply systems. The AP will be responsible for carrying out switching and issuing of safety documents and ensuring compliance with this policy. Each AP HV will be appointed in writing by the DP on the recommendation of the AE HV after successfully completing the required training or refresher training detailed in HTM 06-03, Appendix 9, sections 8 – 19 & 20 thru 29 and after successful interview & assessment by the AE HV.

In the event of a Health Board (AP) HV not being available arrangements are in place for the Maintenance Contractor HV (Western Power Distribution - WPD) to provide backup for the Health Board (AP) HV function. In these circumstances, a Transfer of Control Certificate (ToCC) should be used to temporarily transfer control of the relevant CTMUHB HV network/system over to the Maintenance Contractor HV following the guidance detailed in Appendix 3.

Transfer of Control of the CTMUHB HV network will then be issued back to CTMUHB after maintenance, breakdown or failure of the network or equipment has been completed / rectified.

An example form has been included in Appendix 4, N.B. - this may look different to the type issued by the Maintenance Contractor HV and is included for information purposes only.

16.6 Accompanying Safety Person/s (ASP)

An accompanying Safety Person is a person not involved in the work or test who has received emergency first-aid for electric shock and who has adequate knowledge, experience and the ability to avoid danger, keep watch, prevent interruption, apply first-aid and summon help. The person should be familiar with the system or installation being worked on or tested and is to have been instructed on the action to be taken to safely rescue a person in the event of an accident.

16.7 Maintenance Contractor (defined in HTM 06-03)

A specialist contractor, appointed by CTMUHB under agreement of the (AE) HV to carry out maintenance work on the HV system.

The Maintenance Contractor shall be fully conversant with the following:

- The HV distribution for the particular CTMUHB site
- This CTMUHB HV Policy for the Management of HV Electricity Supply Systems
- HTM 06-03
- The Electricity at Work Regulations 1989
- Health and Safety at Work Act 1974
- Report of Injuries Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)

Any incident reports will also be copied to the AP (HV). When the incident involves HV, the Authorising Engineer (HV) should be advised and will carry out an investigation as detailed in HTM 06-03 chapter 4, Appointment, Roles and Duties of Personnel section 4.10

If required by the AP (HV), the Maintenance Contractor shall remove an employee from the site and if necessary provide a replacement. Such actions would be subject to a review between the UHB and the Maintenance Contractor.

Only CP's (HV) employed by the Maintenance Contractor shall maintain the HV electrical systems and receive/clear safety documents. Their role and duties are as described in HTM 06-03 Chapter 4, Appointment, Roles and Duties of Personnel, section 4.53 – 4.57.

17. RETENTION OR ARCHIVING

In line with the Health Board's Policy all Manuals and Records as detailed in "this" Policy for Management of High Voltage Electricity Supply Systems shall be kept for the life of the system to ensure full & accurate records are kept on the operation and maintenance of the HV system/s. All Documents & records specified in HTM 06-03 should be kept in a lockable document cabinet as described in HTM 06-03, Chapter 6, and paragraph 6.13.

18. NON CONFORMANCE

There is a requirement of all staff to comply with the provisions of the policy for management of HV electricity supply systems and, where requested, to demonstrate such compliance.

19. EQUALITY IMPACT ASSESSMENT STATEMENT

This policy has been subject to a full equality assessment and no impact has been identified (See Appendix 5)

Appendix 1 - List of Specific Roles within CTMUHB

The following is a list of individuals responsible for the management & operation of the HV electrical supply systems in Cwm Taf Morgannwg University Health Board.

- **Chief Executive,** Cwm Taf Morgannwg University Health Board
- **Designated Person (Director of Finance),** Cwm Taf Morgannwg University Health Board
- **Authorising Engineer (AE) HV,** Specialist Estates Services
- **Co-Ordinating Authorised Person (C-AP) HV (*), *** Royal Glamorgan Hospital, * East Glamorgan Community Offices/Laundry, * Llantrisant Health Park.
    - Assistant Head of Operational Estates – C-AP HV
- **Authorised Person (s) (AP) HV,** Royal Glamorgan Hospital and East Glamorgan Community Offices/Laundry.
    - Estates Officer – HV AP / Assistant Head of Operational Estates – HV AP
- **Authorised Person (s) (AP) HV,** Prince Charles Hospital and Ysbyty Cwm Cynon.
    - Senior Projects Officer – HV AP / Assistant Head of Operational Estates – HV AP / Estates Officer – HV AP
- **Authorised Person (s) (AP) HV,** Prince Charles Hospital
    - Senior Projects Officer – HV AP / Assistant Head of Operational Estates – HV AP / Estates Officer – HV AP / Estates Officer – HV AP
- **Authorised Person (s) (AP) HV,** Princess of Wales Hospital
    - Estates Officer – AP HV / Operational Maintenance Manager - AP HV
- **HV Approved Contractor - Competent Persons (CP)**

    NGED (National Grid) – formally Western Power Distribution

Appendix 2 - Definitions

Health Technical Memorandum (HTM)

A suite of documents issued by the Department of Health which provides guidance on technical issues with particular relevance to NHS healthcare facilities.

Due to differences in NHS policy between England and the devolved administration in Wales, the Welsh Assembly Government may modify these documents for use in Wales.

HTM 06-03, Electrical safety guidance for high voltage systems. A UHB which follows this guidance should normally be operating sufficiently to satisfy the requirements of the *Health and Safety at Work Act 1974* and the *Electricity at Work Regulations 1989.*

Users with access to the intranet or internet can find these documents on the Shared Services Partnership Specialist Estates website at WWW.NWSSP.WALES.NHS.UK

Sulphur Hexafluoride 6 – SF6, A gas that is used in electrical power equipment. It is colourless, odourless, non-flammable and chemically stable. SF6 is a very good electrical insulator and can effectively extinguish electrical arcs. Which makes high and medium voltage apparatus filled with SF6 highly popular.

Key Cabinet – A cabinet for the sole purpose of retaining all keys relative to the sites HV/LV system(s) to which the duty AP HV has control.

Lockable Document Cabinet – A lockable cabinet suitable for storing the electrical safety documents, temporary safety signs, distribution system records etc. used in the application of HTM 06-03 guidance.

Operational Maintenance Manual – A ring binder or similar containing information relating to the control & operation of the High Voltage system(s).

Duty Authorised Person – An Authorised Person who has current responsibility for the system(s) or installation(s) as recorded in the site log book, whose name is displayed at the mimic diagram and who personally holds or carries the AP HV Key(s).

Mimic Diagram – A single line diagram of an electrical distribution system so made that the symbol for each item of switchgear may be adjusted to indicate the "ON", "OFF" or Earthed positions.

Personal Supervision – Supervision is given by a person having adequate technical knowledge and experience, who is present at all times through the work or testing.

Site Logbook – A book in which all matters relating to the electrical system should be recorded

Substation Logbook – A book held in each substation into which every entry to the room is recorded and the reason; this book is also used to record the AP HVs three-monthly inspections.

Substation – Any premise, or part thereof, which contains equipment for either transforming or converting energy to or form High Voltage (other than transforming or converting solely for the operation of switching devices or instruments), or for switching, controlling or regulating energy at High Voltage.

Electrical System / Network – A system / network in which all the equipment is, or may be, connected to a common source of electrical energy, including the source and its associated equipment.

Appendix 3 – High Voltage Transfer of Control Procedures

PROCEDURES TO BE FOLLOWED TO ISSUE A TRANSFER OF CONTROL CERTIFICATE

Scenario 1: The CTMUHB AP (HV) or suitable CTMUHB Estates Manager will contact the AP Maintenance Contractor if there is a problem/emergency with the HV electricity supply system to the hospital. During working hours the national telephone contact number is (NGED - 0800 052 0400) Emergency / OoH No – 02920 332887.

Scenario 2: The CTMUHB AP (HV) or suitable CTMUHB Estates Manager and the AP Maintenance Contractor will have previously made arrangements to carry out maintenance to the HV network / system.

1. The CTMUHB AP (HV) will check that the AP Maintenance Contractor employee attending is suitably authorised. (This requirement will be part of the contract).
2. The CTMUHB AP (HV) or suitable UHB Estates Manager will issue access keys and accompany the AP Contractor to the sub-stations to ensure the AP Maintenance Contractor is familiar with their geographical location. Logbook entries are required.
3. The AP Maintenance Contractor will create a Safety Programme. NOTE that this should include details of any Low Voltage (LV) switching required.
4. The AP Maintenance Contractor should identify with the CTMUHB AP (HV) or suitable CTMUHB Estates Manager which parts of the LV system (if any) will be affected by the programme.
5. The CTMUHB AP (HV) or suitable CTMUHB Estates Manager will decide whether a *Permission for disconnection or interruption of electrical services* form (Copy only in *HTM 06-02)* is required and make any arrangements necessary such as back up generation. It should be cross-referenced with the Transfer of Control Certificate, Appendix 4 (ToCC), and the copy stored in the Operational Procedure Manual.
6. When arrangements are complete, parts 1 and 2 of the ToCC should be completed to pass control of the HV network / equipment to the AP Maintenance Contractor.

   The issue of the ToCC means only that CTMUHB has completed arrangements to protect the operation of the hospital (so far as possible), and the AP Maintenance Contractor can start the HV work.
7. All LV switching required will be carried out by CTMUHB LV AP's but only when directed by the AP Maintenance Contractor who will also fit any safety locks and signs.
8. On completion of the work to, the HV network / equipment, parts 3 and 4 of the ToCC will be signed off by the AP Maintenance Contractor and the CTMUHB AP (HV) or suitable CTMUHB Estates Manager. The Mimic Panel must now be adjusted by the AP Maintenance Contractor to represent any changes.

   The CTMUHB AP (HV) shall ensure the Site Logbook for HV Systems is completed and paperwork filed.

Appendix 4 - Transfer Of Control Certificate (ToCC) For High Voltage Supply Systems (For Example Purposes only, may Appear Differently to the Maintenance Contractors Version)

Cwm Taf Morgannwg University Health Board Serial Number……

Estates Department

Part 1 - ISSUE

I, ……the representative of the AP Maintenance Contractor.wish to carry out the following high voltage works or switching at Hospital.

……..
……..
……..
……..
……..
Safety Document No (s): …… will be issued for this work.

Your agreement to proceed is required taking full account of any local hospital restrictions relating to the HV/LV installation.

Signed:…… Print Name: ……

Designation: ……...Date:…… Time: ……

Part 2 - AGREEMENT by HV Officer

Agreement to the above works is made on behalf of the Cwm Taf Morgannwg University Health Board and note should be taken of the following circumstances (if none write NONE). Any arrangements necessary to protect hospital services have been completed.

Permission for disconnection form No……
……..
……..
……..
……..
……..
Signed:…… Print Name: ……

Designation: AP (HV) .Date:…… Time: ……

Part 3 - CLEARENCE

As the Authorised Person I hereby declare that the work for which this certificate was listed is now suspended/completed (delete as necessary) and that the system is safe and operational.

Signed:…… Print Name: ……

Designation: ……..Date:…… Time: ……

Part 4 - RETURN

Clearance is noted and the HV system accepted back on behalf of …… Hospital

Signed:…… Print Name: ……

Designation: HV Officer Date:…… Time: ……

Appendix 5 - Equality Impact Assessment

Approved 12th January 2011 as part of the Policy for the Management, Identification and Authorisation of Policies and Procedures – Operational 1 January 2011

All Public Sector bodies have a legal duty to undertake an equality impact assessment (EqIA) as a requirement of the equality legislation.

EqIA's provide a systematic way of ensuring that legal obligations are met and are a practical means of examining new and existing policies and practices to determine what impact they may have on equality for those affected by the outcomes.

The process itself ensures that individual staff, managers and teams think carefully about, and record, the likely impact of their work on staff, patients and other members of the community.

The need for collection of evidence to support decisions and for consultation mean the most effective and efficient EqIA is conducted as an integral part of policy development, with the EqIA commenced at the outset.

The documentation consider the effects that decisions, policies or services have on people on the basis of their gender, race, disability, sexual orientation, religion or belief, age, Welsh Language and human rights. Assessing impact across a broad range of equality dimensions (not just those required by law), helps organisations to embed equality and human rights and assist them in the delivery of their services.

Policies will not be approved by the Board/Sub Committee of the Board without a completed EqIA Report.

For further information or advice, contact the Diversity, Equality & Standards Manager on 01443 744800.

Form 1: Preparation

Part A must be completed at the beginning of a Policy/function/strategy development or review, and for every such occurrence. (Refer to the Step-by-Step Guide for additional information).

Step 1 – Preparation		
1.	**Title of Policy** - what are you equality impact assessing?	
2.	**Policy Aims and Brief Description** - what are its aims? Give a brief description of the Policy (The What, Why and How?)	
3.	**Who Owns/Defines the Policy?** - who is responsible for the Policy/work?	
4.	**Who is Involved in undertaking this EqIA? -** who are the key contributors and what are their roles in the process?	
5.	**Other Policies** - Describe where this Policy/work fits in a wider context. Is it related to any other policies/activities that could be included in this EqIA?	
6.	**Stakeholders** - Who is involved with or affected by, this Policy?	
7.	**What might help/hinder the success of the policy?** These could be internal or external factors.	

Form Two – Information Gathering

Is the policy relevant to the public duties relating to each equality strand. Tick as appropriate.							
	Race	Disability	Gender	Sexual Orientati	Age	Religion Belief	Welsh Languag
Is the policy relevant to "eliminating discrimination and eliminating harassment?"							
Is the policy relevant to "promoting equality of opportunity?"							
Is the policy relevant to "promoting good relationships and positive attitudes?"							
Is the policy relevant to "encouragement of participation in public life?"							
In relation to disability, is the policy relevant to "take account of difference, even if it involves treating some individuals more favourably?							

Ref: EST HV
Policy Title: High Voltage Electricity Supply Systems
Page Number: 4

The Human Rights Act contains 15 rights, all of which NHS organisation have a duty to act compatibly with and to respect, protect and fulfil. The 7 rights that are particularly relevant to healthcare are listed below. For a fuller explanation of these rights and other rights in the Human Rights Act please refer to Appendix A: The Legislative Framework. Consider the relevance of your Policy to these Human Rights and list any available information to suggest the Policy may interfere with, or restrict the enjoyment of these rights.
The right to life
The right not be tortured or treated in an inhuman or degrading way
The right to liberty
The right to a fair trial
The right to respect for private and family life, home and correspondence
The right to freedom of thought, conscience and religion
The right not be discriminated against in relation to any of the rights contained in the Human Rights Act

Equality Strand	Evidence Gathered
Race	
Disability	
Gender	
Sexual Orientation	
Age	
Religion or Belief	
Welsh Language	

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Form 3: Assessment of Relevance and Priority

Equality Strand	Evidence: Existing evidence to suggest some groups affected. Gathered from Step 2. (See Scoring Chart A)	Potential Impact: Nature, profile, scale, cost, numbers affected, significance. Insert one overall score (See Scoring Chart B)	Decision: Multiply 'evidence' score by 'potential impact' score. (See Scoring Chart C)
Race			
Disability			
Gender			
Sexual Orientation			
Age			
Religion or Belief			
Welsh Language			
Human Rights			

Scoring Chart A: Evidence Available

3	Existing data/research
2	Anecdotal/awareness data only
1	No evidence or suggestion

Scoring Chart B: Potential Impact

-3	High negative
-2	Medium negative
-1	Low negative
0	No impact
+1	Low positive
+2	Medium positive
+3	High positive

Scoring Chart C: Impact Decision

-6 to -9	High Impact (H)
-3 to -5	Medium Impact (M)
-1 to -2	Low Impact (L)
0	No Impact (N)
1 to 9	Positive Impact (P)

FORM 4: (Part A) Outcome Report

Policy Title:	Management of High Voltage Electricity Supply Systems
Organisation:	Cwm Taf Morganwwg University Health Board
Name: **Title:** **Department:**	Assistant Head of Operational Estates Estates Department
Summary of Assessment:	
Decision to Proceed to Part B Equality Impact Assessment:	**Yes/No** **Please record reason(s) for decision**

Action Plan					
You are advised to use the template below to detail any actions that are planned following the completion of Part A or Part B of the EqIA Toolkit. You should include any remedial changes that have been made to reduce or eliminate the effects of potential or actual adverse impact, as well as any arrangements to collect data or undertake further research.					
	Action(s) proposed or taken	**Reasons for action(s)**	**Who will benefit?**	**Who is responsible for this action(s)?**	**Timescale**
What **changes** have been made as a result of the EqIA?					
Where a Policy may have differential impact on certain groups, state what arrangements are in place or are proposed to **mitigate** these impacts?					

Justification: For when a policy may have adverse impact on certain groups, but there is good reason not to mitigate.					
Describe any **mitigating actions** taken?					
Provide details of any actions planned or taken to **promote equality**.					

Date:	
Monitoring Arrangements:	
Review Date:	
Signature of all Parties:	

Appendix 6 - Training Impact Assessment

If training requirements are identified a policy training impact assessment is to be completed and forwarded to the Workforce and Organisational Development Directorate

1. Will training be required as a result of the policy?

Yes	Proceed to question 2
No	If no, please state how this policy will be communicated within the LHB

2. Please complete the following information relating to training

Course/ policy title	
Course type	
Reference to KSF/NMC Dimensions	
Target Audience (refers to scope of policy)	
Course / policy training objectives	
Course / policy training content	
Duration of course / programme	
Name of trainer (or policy lead)	
Approximate cost of providing training	
Please embed lesson plan, link to e-learning, presentation or other relevant learning material	

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 July 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.	Executive 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.
7.3	23 January 2024	**CTM Quality Strategy Work Plan Update**	Executive Director of	16 May 2024	**Proposed for Closure - Completed**

		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	Therapies & Health Sciences	Now 23 July 2024	Report received at the July 2024 meeting of the Committee.
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	**Proposed for Closure – Completed** Acute Oncology Team attended the Operational Management Board on 4 September 2024 to discuss this matter
2.1	14 March 2024	**Listening & Learning Story – Acute Oncology Service** Team to attend a future meeting of the Operational Management Board to discuss the operational issues experienced in detail.	Executive Director of Nursing/Deputy Chief Operating Officer	16 May 2024	**Proposed for Closure – Completed** Acute Oncology Team attended the Operational Management Board on 4 September 2024 to discuss this matter

5.2c	16 May 2024	**Diagnostics, Therapies, Pharmacy and Sciences Care Group Highlight Report** Spotlight report to be presented to a future meeting in relation to the introduction of an Occupational Therapist into the Clinical Team based at the Navigation Hub, which had resulted in the prevention of conveyance of patients into hospitals by providing care in the patient's homes	Clinical Director, Allied Health Professionals	18 September 2024	**Proposed for Closure – On agenda** Team to present this to the meeting taking place on 18 September 2024
5.2e	16 May 2024	**Primary Care and Communities Care Group Highlight Report** Detailed update to be provided at a future meeting in relation to progress being made against the plan to address the waiting list position for special care dentistry	Chief Operating Officer	18 September 2024	**Proposed for Closure - On agenda** Update to be provided at the meeting taking place on 18 September 2024
5.2e	16 May 2024	**Primary Care and Communities Care Group Highlight Report** Update to be presented to a future meeting in relation to progress being made to	Care Group Nurse Director	18 September 2024	**Proposed for Closure – On agenda** An update has been included in the Highlight Report being presented to the 18 September 2024 meeting.

		address training in Care Homes			
5.2f	16 May 2024	**Planned Care Group Highlight Report** CTM Escalation Policy to be presented to a future meeting for information and awareness	Chief Operating Officer	18 September 2024	**Proposed for Closure – included on the Forward Work Programme** A review of the Escalation Policy is in the process of being undertaken. The Policy is likely to be available in early 2025 where it can then be made available to Members
6.3	16 May 2024	**Infection, Prevention & Control Strategy** Implementation Plan to be presented to the Quality & Safety Committee on an annual basis for monitoring of progress	Executive Director of Nursing	May 2025	**In progress** To be added to the Annual Cycle of Business for 2025
7.1	16 May 2024	**Patient Safety, Quality & Experience Dashboard** Lessons learnt and identified themes from Public Services Ombudsman Reviews to be presented to a future meeting.	Assistant Director of Quality & Safety	18 September 2024 Now 19 November 2024	**In progress** This was due be presented to the September Quality & Safety Committee. This will now be presented to the meeting taking place on 19 November 2024
7.2	16 May 2024	**Nursing & Midwifery Plan** Periodic updates to be presented to the Committee in relation to progress being made against the Nursing & Midwifery Plan	Care Group Nurse Director	May 2025	**In progress** Agreed that annual updates on progress would be included in the Clinical Executives report.

2.1	23 July 2024	**Listening & Learning Story** Review to be undertaken to determine why a decision had been made by the Bed Manager to not move the patient into one of the vacant beds, as opposed to this decision being made by the staff working on the ward.	Care Group Nurse Director	August 2024	**In progress** Response provided from E James and S'O Brien and shard with G Jones and Committee Members by email on 23 August 2024. Further assurance sought by Committee Members who felt response did not address the concerns raised
5.1	23 July 2024	**Report from the Clinical Executives** List of hot topics discussed at the Clinical Directors day annual programme to be shared with Members	Deputy Medical Director	August 2024	**Proposed for Closure - Completed** List of hot topics shared with Members by email on 23 August 2024
5.1	23 July 2024	**Report from the Clinical Executives** Cover report to be developed to accompany the AMaT report being presented to future meetings to explain the data being presented	Executive Director of Nursing/Deputy CEO	To be agreed	**In progress** Cover report will be developed when AMaT report is presented in future
5.2b	23 July 2024	**Unscheduled Care Group Highlight Report** Thematic Review undertaken in relation to identifying the themes and trends around the 15 Nationally Reportable Incidents to be presented to a future meeting	Care Group Nurse Director	19 November 2024	**In progress** An update on this will be included in the Highlight report being presented to the meeting taking place on 19 November 2024

		Analysis to be undertaken on locally reportable incidents to determine whether numbers would increase or remain the same as the data for nationally reportable incidents			
5.2d	23 July 2024	**Primary Care and Community Care Group Highlight Report** Trajectory to reduce the waiting lists for dental services to be shared with Members outside the meeting	Chief Operating Officer	18 September 2024	**On agenda – Proposed for Closure** This has been included in the report being presented to the meeting taking place on 18 September 2024
6.1	23 July 2024	**Organisational Risk Register – Risks assigned to the Quality & Safety Committee** Update to be provided outside the meeting in relation to the Public Health Funding risk. Update to identify how much reduction in funding there had been and what the impact would be of this reduction.	Executive Director of Public Health	18 September 2024	**Proposed for Closure – Completed** Update shared with Members by email on 5 September 2024
6.2	23 July 2024	**Mortality Reviews and Mortality Indicators** Further interrogation of the data to be undertaken to determine why Rhondda	Executive Director of Public Health	July 2024	**Proposed for Closure - Completed** Explanation shared with Committee members by email on 23 July 2024 by

		Cynon Taff had the most people living in the comparatively smallest region with the highest death rate National report on avoidable mortality to be shared with Members outside the meeting			the Executive Director of Public Health.
6.9	23 July 2024	**Quality Impact Assessment** Appendix to be circulated to Members as a separate document as it was difficult to read on the Admincontrol system	Head of Corporate Governance & Board Business	August 2024	**Proposed for Closure - Completed** Document shared with Members by email on 22 August 2024
8.1	23 July 2024	**Mental Health In-Patient Improvement Progress Report** Future reporting requirements to be confirmed by the Committee Chair outside the meeting.	Committee Chair	January 2025	**Proposed for Closure – Completed** Agreed at the agenda planning session held on 6 August 2024 that these reports would move to six monthly (next report due January 2025)

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 September 2024)
5.1	16 May 2024	**Report from the Clinical Executives** Update to be provided to a future meeting as to the nature of incidents that were occurring in relation to boarded patients	Executive Director of Nursing/Deputy CEO	23 July 2024	**Completed - On agenda** Listening & Learning story in relation to Boarding of patients presented to the Quality & Safety Committee held on 23 July 2024
2.2	16 May 2024	**Spotlight Presentation – Maternity & Neonates Metrics and Assurance Framework** Update on the plans in place to address staff cultural issue to be presented to a future meeting	Director of Midwifery	23 July 2024	**Completed** Update included in Highlight report to the Quality & Safety Committee held on 23 July 2024
5.1	16 May 2024	**Report from the Clinical Executives** Concerns raised in relation to continued issues being experienced with boarding of patients to be included in the alert/escalate section of the Committee Highlight Report to Board.	Head of Corporate Governance & Board Business	25 July 2024	**Completed** Report drafted by the Head of Corporate Governance and Board Business and discussed at the Board meeting held on 25 July 2024
5.1	16 May 2024	**Report from the Clinical Executives**	Committee Chair/Executive	23 July 2024	**Completed**

		Committee Chair to have a discussion with the Executive Director of Nursing/Deputy Chief Executive as to what further support the Committee could offer regarding the concerns around boarding of patients. Focussed discussion to take place at future meeting in relation to boarding of patients.	Director of Nursing/Deputy CEO		Listening & Learning story in relation to Boarding of patients received and discussed at the Quality & Safety Committee held on 23 July 2024
5.1	16 May 2024	**Report from the Clinical Executives** Update to be provided at a future meeting in relation to the impact of the HENRY Programme and programme outputs	Executive Director of Public Health	23 July 2024	**Completed** Update included in the Clinical Executives Report presented to the Quality & Safety Committee on 23 July 2024
6.5	16 May 2024	**Welsh Health Specialised Services Committee (WHSSC) Quality & Patient Safety Committee Chairs Report** List of services that would be commissioned by the Joint Commissioning Committee to be obtained Clarity to be sought as to governance structures within the Joint Commissioning	Committee Chair	4 June 2024	**Completed** Committee Chair has received the following updates from the JCC: • The list of services are outlined in the predecessor WHSSC joint committee annual report, and were referenced in the transition plan. Enquiries will be made with the JCC

		Committee and whether structures would be similar as per previous hosted bodies organisations			Director of Planning for a new comprehensive list to encompass all of JCC's services. • We are currently in the transition phase for the new JCC and the predecessor WHSSC Sub Committee the "Quality & Patient Safety Committee" will continue to be held, until a new Sub Committee structure is agreed for the JCC. At present the same arrangement will continue. A Transition Director has also been appointed to support the transition phase.
7.1	16 May 2024	**Patient Safety, Quality & Experience Dashboard** Update on the themes and trends identified through complaints related to communication issues to be presented to a future meeting. Update to include the actions being taken to address the position	Assistant Director of Quality & Safety	23 July 20224	**Completed** Update was included in the July iteration of the Quality Dashboard report

7.1	16 May 2024	**Patient Safety, Quality & Experience Dashboard** Update to be presented to a future meeting in relation to progress being made against the improvement plans that had been put into place for Falls and Pressure Damage	Deputy Executive Nurse Director	23 July 2024	**Completed** Report received and discussed at the Quality & Safety Committee held on 23 July 2024

Agenda Item
8.2.2

Quality & Safety Committee

Quality & Safety Committee Annual Cycle of Business

Dyddiad y Cyfarfod / Date of Meeting	18/09/2024
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: Not required
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: Not required
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

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.

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

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	23 July 2024	Aug 2024	18 Sep 2024	Oct 2024	19 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 Agreed at the agenda planning session held on 6 August 2024 that this report would be included on the main agenda from the November 2024 meeting – with a six monthly cycle to be established for main agenda reporting	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									⚑ Defer to Nov 24		⚑	
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 Will be superceded by new Governance Structure within the new Joint Commissioning Committee	Chief Ambulance Services Commissioner	Bi-Annually	⚑						⚑					
DELIVERING OUR IMPROVEMENT PROGRAMMES														

Item of Business	Executive Lead	Reporting period	23 Jan 2024	Feb 2024	14 Mar 2024	April 2024	16 May 2024	June 2024	23 July 2024	Aug 2024	18 Sep 2024	Oct 2024	19 Nov 2024	Dec 2024
Stroke Services Progress Report	Executive Director of Therapies and Health Sciences	Quarterly			⚑				⚑				⚑	
Mental Health In-Patient Improvement Progress Reports Agreed at the agenda planning session held on 6 August 2024 that these reports would move to six monthly (next report due January 2025)	Executive Director of Therapies and Health Sciences	Six monthly	⚑		⚑		⚑		⚑					
CONSENT AGENDA ITEMS – FOR APPROVAL/NOTING														
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						⚑ Defer to Sept 24		⚑ Defer to Nov 24		⚑	
Quality & Safety Committee Annual Self-Assessment	Director of Corporate Governance	Annually							⚑					
Joint Commissioning Committee Quality & Patient Safety Committee Chairs Report	Director of Corporate Governance	Bi-monthly	⚑				⚑				⚑		⚑	
Putting Things Right Annual Report	Director of Corporate Governance	Annually							⚑ Defer to Sept 24		⚑			
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											⚑	

Item of Business	Executive Lead	Reporting period	23 Jan 2024	Feb 2024	14 Mar 2024	April 2024	16 May 2024	June 2024	23 July 2024	Aug 2024	18 Sep 2024	Oct 2024	19 Nov 2024	Dec 2024
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												
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 (Closure report received on 16 May 2024 – no further reports required)	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	**In progress** The Annual Quality Report was presented for endorsing by Board at the July Q&SC and this was endorsed at July Board. Annual Quality work plan to be presented to the **November 2024 meeting**
Request made by Executive Director of Nursing at agenda planning session for this item to be added to the agenda	Additional Item	Nursing & Midwifery Plan	Executive Director of Nursing	Received at the May meeting – check recording if this item needs to come back to future meeting for progress update – agreed at agenda planning that this update could be presented in **November 2024**
Email request received from the Assistant Director of Concerns, Legal Services, Clinical Audit & Informatics	Additional Item	All Wales Learning From Events Organisational Learning Policy	Executive Director of Nursing	Was planned for 23 July 2024 – Now deferred to **18 September 2024** to allow a more sufficient and appropriate amount of time for consultation, review and reflections on comments received – **On agenda**

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 Deputy Chief Operating Officer	Additional Item	Parc Prison Health Care - A Year on Report	Deputy Chief Operating Officer	Planned for 23 July 2024 – Now deferred to 18 September 2024 – **On agenda**
Suggested at the May 2024 meeting that report would be presented to a future meeting on this item	Additional Item	Dental Services	Chief Operating Officer	Agreed at agenda planning this this could be presented to the 18 September 2024 meeting – **On agenda**
Suggested at the May 2024 meeting that report would be presented to a future meeting on this item	Additional Item	CTM Escalation Policy	Chief Operating Officer	Agreed at agenda planning this this could be presented to the 18 September 2024 meeting. Following discussion with the Chief Operating Officers Business Team, this Policy is in the process of being reviewed and updated and will be available for circulation in **early 2025.**
Email request received from the Medical Directors Office for this to be added to the agenda	Additional Item	Assurance Report – HTA Reportable Incidents	Medical Director	Agreed with the Committee Chair that this could be added as an additional item to the agenda for the July 2024 meeting – Request received from the Medical Director to defer this to the 18 September 2024 meeting – **On agenda**
Email request received from the Assistant Director of Governance & Risk following discussion at	Additional Item	Impact and governance around the management of 'Medication shortages	Medical Director	Planned for 18 September 2024 – **On agenda**

Operational Management Board				
Teams message request from Head of Assets, Governance and Technical Services	Additional Items	Estates Policies for Approval: • Energy Policy • High Voltage Electricity Policy	Executive Director of Finance	Planned for 18 September 2024 – **On agenda**
Email request received from the Assistant Director of Nursing and People's Experience	Additional Item	Ward Accreditation	Executive Director of Nursing	Planned for 18 September 2024 – **On agenda**
Executive Director of Nursing requested that this items was added to the agenda	Additional Item	Coroners Cases/Inquests which identifies the plan for reporting moving forwards in relation to Lessons Learnt and Themes and Trends.	Assistant Director of Concerns, Legal Services, Clinical Audit & Informatics	Was planned for 18 September 2024. This will now be presented the **19th November** meeting as part of the Public Services Ombudsman for Wales Annual Report update

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 Executive Medical Director	Additional Item	Body Store Recommendations from Welsh Government	Executive Medical Director	**Completed** Received at the meeting held on 23 July 2024
Suggestion made at the meeting held on 16 May 2024 that this item would require detailed discussion at a future meeting	Additional Item	Boarding of Patients	Executive Director of Nursing	**Completed** Received at the meeting held on 23 July 2024
Email request received from the Assistant Director of Governance & Risk	Additional Item	Annual Report for Quality – to be endorsed for Board approval	Executive Director of Nursing/Deputy CEO	**Completed** Received at the meeting held on 23 July 2024
Email Request received from the Senior Nurse Community Children's Nursing Services	Additional Item	Was Not Brought Policy – For Approval	Director of Nursing	**Completed – No longer applicable** This policy will now be taken through the Operational Management Board for approval as per Clinical Policies process
Email Request received from the Head of Safeguarding	Additional Item	Deprivation of Liberty Protection Safeguards Policy	Director of Nursing	**Completed** Patient Care & Safety Team have advised that this Policy has been approved via the Operational Management Board on the 7 August 2024 and can therefore be removed from the Quality & Safety Committee Forward Work Programme

Agenda Item
8.2.4

Quality & Safety Committee

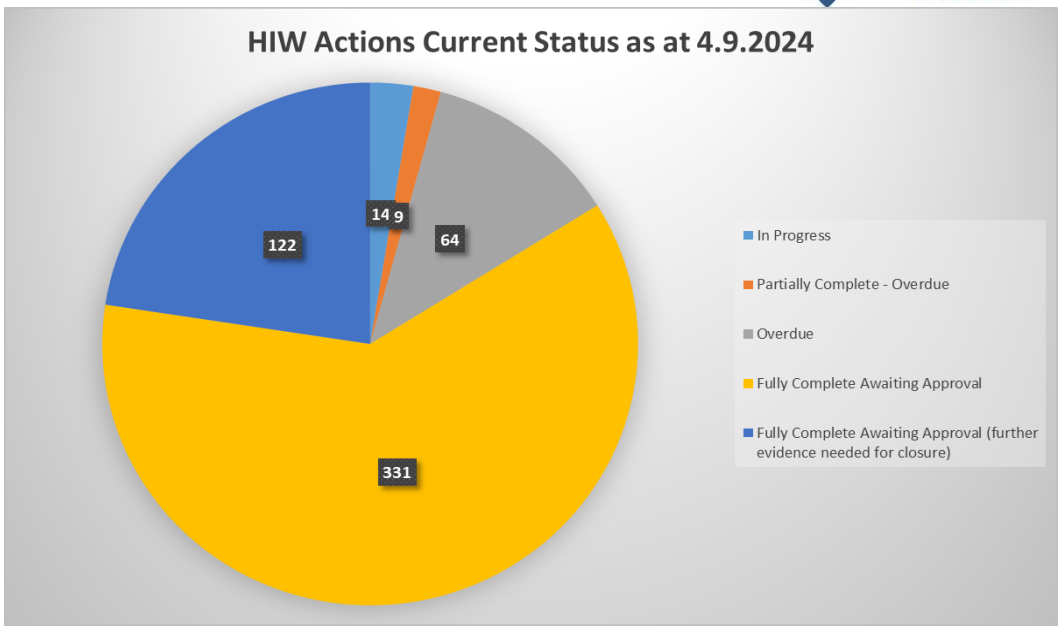
HEALTHCARE INSPECTORATE WALES IMPROVEMENT PLAN TRACKER REPORT September 2024

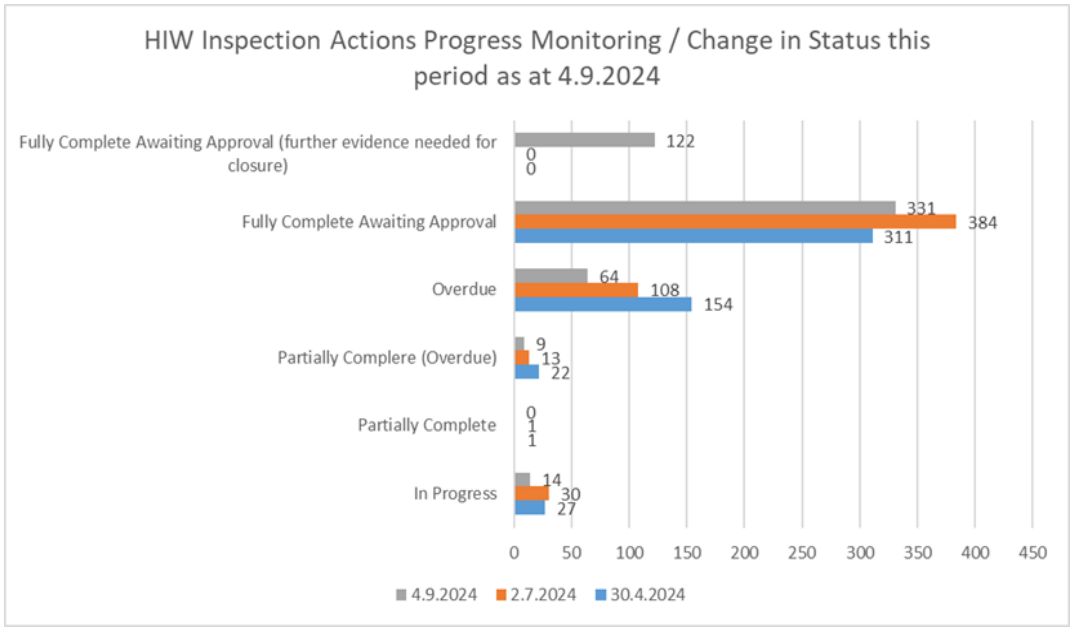
Dyddiad y Cyfarfod / Date of Meeting	18th September 2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Cally Hamblyn, Assistant Director of Governance & Risk
Cyflwynydd yr Adroddiad / Report Presenter	Gregory Padmore-Dix, Deputy Chief Executive / 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**
Executive Leadership Group	9th September 2024	Approved for Submission

Acronyms / Glossary of Terms	
HIW	Healthcare Inspectorate Wales
AMaT	Audit Management and Tracking





There were no new HIW Inspections and/or actions added this period.

1. Situation /Background

1.1 The purpose of this report is to update the Quality & Safety Committee on progress against the open actions held on the Healthcare Inspectorate Wales (HIW) tracker of the accepted improvement plan(s) submitted to HIW following their Inspection(s) across the organisation for the timeframe from July to the 4th September 2024.

1.2 All open and live HIW inspection improvement plans are now recorded on AMaT however due to areas requiring further development within the system there is still a significant element of manual inputting of Data in order to present this report. The request for system changes to support the use of AMaT to track and manage improvement plans for HIW have been submitted to the AMaT team and are in the process of being developed. Work is needed in terms of system development and also in collaboration with each Care Group to cleanse the data contained within the Tracker.

1.3 The Assistant Director of Governance & Risk has met with each Care Groups during August and it has been agreed that Care Groups will transition to using the AMaT system for reporting following the September submission.

2. Specific Matters for Consideration

2.1 The HIW tracker continues to be a live document and each iteration evolves as actions are completed or the date surpasses as well as following the submission and acceptance by HIW of new inspection improvement plans. Therefore, members will note some changes and progress on the actions which remain as open as 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. Reminders are sent out in advance of reporting deadlines to encourage and request further updates from Care Groups. There has been a notable improvement in the updates received during this period as evident in the dashboards on page 2.

2.3 A data cleanse has commenced of the inspections and actions in an attempt to remove completed historic actions as well as review actions that may again be historic but not measurable or attainable. There are a number of "Fully Completed Awaiting Approval" status's identified in purple in the report at Appendix 1, which indicates that further information is required prior to full closure.

2.5 A breakdown of the status position with regards to all actions up to the 4th September 2024 is detailed below.

- A total of **540 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.

2.6 **New Inspections / Actions**

- There were no new Improvement Plans and/or actions added this period.

2.9 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. Cleanse of the trackers will continue in order to update and remove historic actions and complete out of date actions.

3.3 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.

3.5 Ongoing AMaT system developments have continued to be requested in order to deliver a system and process that is required for improved governance. Some small system changes have been completed by the developers which is allowing the team to further adapt the way we capture and analyse the data, however further engagement is required from Care Groups to cleanse the current and historic Inspection actions to make analysis more meaningful. The current list of developments is captured at Appendix 2.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Living Well
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-acten.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Whole-systems Perspective
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Effective
	If more than one applies please list below: Efficient, Equitable, Safe, Timely
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

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

Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? / **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Outcome:	If no, please include rationale below: N.A
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

5.1 The Quality & Safety Committee are asked to **NOTE** the contents of this report and the activity underway to progress the actions outstanding and ongoing within the improvement plans across the Health Board following HIW Inspections.

6. Next Steps

6.1 The Head of Quality Assurance and Compliance will continue to work with Care Group Leads in order to cleanse and update the tracker and streamline the process. This will allow members the opportunity to analyse and understand the progress being made toward the Inspection Actions and objectives.

Code	Title	Care Group & DoN Lead
Healthcare Inspectorate Wales (HIW)/2017/141	National review of Ophthalmology Services - report published 2017 - 1st update submitted 2019-follow up update submitted December 2022	**Planned Care** Sharon O'Brien, Nurse Director
Healthcare Inspectorate Wales (HIW)/2020/136	Quality Check Summary Clinical Decisions Unit, Prince Charles Hospital [Prince Charles Hospital - Clinical Decisions Unit (Ref: 20067)]	**Unscheduled Care** Emma James, Nurse Director
Healthcare Inspectorate Wales (HIW)/2020/139	Quality Check Summary Ysbyty Cwm Rhondda [Ysbyty Cwm Rhondda - Ward A1 (Ref: 20030)]	**Primary Care and Community** Lucie Williams, Nurse Director
Healthcare Inspectorate Wales (HIW)/2021/135	Quality Check Summary Seren Ward, Royal Glamorgan Hospital [Improvement plan - Seren Ward - Royal Glamorgan Hospital (Ref: 20090)]	**Mental Health & Learning Disabilities** Ana Llewelyn, Nurse Director
Healthcare Inspectorate Wales (HIW)/2021/137	National Review of Mental Health Crisis Prevention in the Community	**Mental Health & Learning Disabilities** Ana Llewelyn, Nurse Director
Healthcare Inspectorate Wales (HIW)/2021/138	Quality Check Summary Pinewood House [Pinewood House - Quality Check]	**Mental Health & Learning Disabilities** Ana Llewelyn, Nurse Director
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)]	**Mental Health & Learning Disabilities** Ana Llewelyn, Nurse Director
Healthcare Inspectorate Wales (HIW)/2022/131	Hospital Inspection (Announced) Princess of Wales Hospital – Maternity Services [Appendix C - POW Maternity Unit (Ref: 21233)]	**Children & Families** Suzanne Hardacre, Director of Midwifery
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)]	**Children & Families** Suzanne Hardacre, Director of Midwifery

Healthcare Inspectorate Wales (HIW)/2022/133	Hospital Inspection Report (Unannounced) Emergency Department, Princess of Wales Hospital [Appendix A - Immediate Improvement Plan - Princess of Wales Emergency Department (Ref: 3326)]	**Unscheduled Care** Emma James, Nurse Director
Healthcare Inspectorate Wales (HIW)/2022/36	Hospital Inspection Report (Unannounced) Angelton Clinic, Glanrhyd Hospital [Improvement plan Service Angelton Clinic – Glanrhyd Hospital (Ref: 3171)]	**Mental Health & Learning Disabilities** Ana Llewelyn, Nurse Director
Healthcare Inspectorate Wales (HIW)/2023/130	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	**Mental Health & Learning Disabilities** Ana Llewelyn, Nurse Director
Healthcare Inspectorate Wales (HIW)/2023/134	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital [Appendix A - Immediate Improvement Plan - PCH, E Dept & C D Unit - 31 July 01 & 02 August 2023 (Ref: 3399)]	**Unscheduled Care** Emma James, Nurse Director
Healthcare Inspectorate Wales (HIW)/2023/140	HMP Parc Prison	**Primary Care and Community** Lucie Williams, Nurse Director
Healthcare Inspectorate Wales (HIW)/2023/154	Paediatric Ward - Princess of Wales Hospital-Appendix A-Immediate Assurance (Ref: 03421)	**Children & Families** Suzanne Hardacre, Director of Midwifery
Healthcare Inspectorate Wales (HIW)/2023/155	National Review of Patient Flow - a journey through the stroke pathway	**Unscheduled Care** Emma James, Nurse Director
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)]	**Children & Families** Suzanne Hardacre, Director of Midwifery
Healthcare Inspectorate Wales (HIW)/2023/157	Appendix C - Improvement Plan: Angelton Clinic, Glanrhyd Hospital (Ref: 03445)	**Mental Health & Learning Disabilities** Ana Llewelyn, Nurse Director

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)	**Mental Health & Learning Disabilities** Ana Llewelyn, Nurse Director
Healthcare Inspectorate Wales (HIW)/2023/159	Appendix C - Improvement Plan: Tirion Birth Centre, Royal Glamorgan Hospital (Ref: 03061)	**Children & Families** Suzanne Hardacre, Director of Midwifery
Healthcare Inspectorate Wales (HIW)/2023/160	Appendix C - Improvement Plan: Ty Llidiard (Ref: 03362)	**Mental Health & Learning Disabilities** Ana Llewelyn, Nurse Director
Healthcare Inspectorate Wales (HIW)/2023/167	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	**Unscheduled Care** Emma James, Nurse Director
Healthcare Inspectorate Wales (HIW)/2024/165	Appendix A Immediate Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	**Children & Families** Suzanne Hardacre, Director of Midwifery
Healthcare Inspectorate Wales (HIW)/2024/166	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	**Children & Families** Suzanne Hardacre, Director of Midwifery
Healthcare Inspectorate Wales (HIW)/2024/184	Appendix A - Ysbyty Cwm Rhondda Ward B2 (Ref: 03467)	**Primary Care and Community** Lucie Williams, Nurse Director
Healthcare Inspectorate Wales (HIW)/2024/185	Appendix C – Improvement Plan: POW IR(ME)R_14 April 2024 (Ref: 03497)	**Diagnostics, Therapies, Pharmacies and Specialities** Sharon O'Brien
Healthcare Inspectorate Wales (HIW)/2024/197	HMP Parc Prison - DIC (Case Reference: CA 09791/CRM0006681)	**Primary Care and Community** Lucie Williams, Nurse Director

Healthcare Inspectorate Wales (HIW)/2024/198	HMP Parc Prison - DIC (Case Reference: RD 06379/CRM0006682)	**Primary Care and Community** Lucie Williams, Nurse Director

HIW Inspections Recommendations Tracker

Actions - Status Key

In progress	**Inspection action is in the process of being completed and has not yet reached the deadline.**
Partially complete	**Inspection action is in progress and some of the recommendations have been completed. The deadline has not yet been reached.**
Partially complete (Overdue)	**Inspection action is in progress and some of the recommendations have been met. The deadline has been reached and is now overdue.**
Overdue	**Inspection action deadline has been reached and no recommendations have been completed.**
Fully complete (Awaiting approval)	**Inspection actions have been fully completed and are waiting to be approved to be closed.**
Fully complete (Approved)	Inspection actions and all recommendations have been fully completed, approved and closed by the Committee. Once approved by the Committee actions will be closed on AMaT.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Original Due Date	Current (Revised) Due Date	Progress Status	UPDATES for Quality & Safety Committee Wednesday 18th September 2024 Please submit all updates no later than close of business on Friday 23rd August 2024 Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Issues relating to patient referral process. All parties (Welsh Government, NWIS, Ophthalmology Planned Care Board and Health Boards) must work together towards the introduction of electronic patient record/referral system from optometrists directly to secondary care.	Roll out of OpenEyes has been delayed nationally. Primary Care have worked with the programme team to provide contact details for all optometrists requiring access/relevant training. Enhanced support has been offered by the HB ICT programme and projects team to implement OpenEyes, the national electronic patient record/referral system for eye care which will support closer and integrated working across care settings. A task and finish group has been established, with the clear objective of implementing the system in glaucoma clinics in the UHB's hospitals by the end of March 2023. The programme plan is to then implement e-communications (including e-referrals) between primary and secondary care as stage 2 and to roll out to the other sub specialities in Ophthalmology as stage 3. These are in the local and national plans to be undertaken in the financial year 2023/24. Programme management support has been provided by WG for the 15 months from Jan 2023 to March 2024.	Planned Care	01.03.2023	01.03.2023	Overdue	August 2024 Update - this is ongoing, due to delays in national EPR/ERS programme. E-referral software under national tender, CTM contributing to DHCW's national working groups to establish necessary minimum standards of ERS. Primary care optometry M365/NHS email rollout progressing (84% live across HB) which will support direct email referral into secondary care (until ERS in place). No recent local progression with EPR rollout beyond glaucoma clinics (no OpenEyes business project manager), await EPR programme updates from DHCW.
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	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	01.04.2024	Fully complete (Awaiting approval)	August 2024 Update - meeting scheduled with Planned Care Care Group leads to seek confirmation as to when this action was completed.
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	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	01.04.2024	Fully complete (Awaiting approval)	August 2024 Update - meeting scheduled with Planned Care Care Group leads to seek confirmation as to when this action was completed.
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	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	01.04.2024	Fully complete (Awaiting approval)	August 2024 Update - meeting scheduled with Planned Care Care Group leads to seek confirmation as to when this action was completed.
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	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	01.04.2024	Fully complete (Awaiting approval)	August 2024 Update - meeting scheduled with Planned Care Care Group leads to seek confirmation as to when this action was completed.
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Lack of feedback provided to optometrists following referral and discharge of patients (Patient Referrals – Communication Following referral) (Discharge patient – Quality of information) 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	01.04.2024	Fully complete (Awaiting approval)	August 2024 Update - meeting scheduled with Planned Care Care Group leads to seek confirmation as to when this action was completed.
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Lack of feedback provided to optometrists following referral and discharge of patients (Patient Referrals – Communication Following referral) (Discharge patient – Quality of information) 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	01.04.2024	Fully complete (Awaiting approval)	August 2024 Update - meeting scheduled with Planned Care Care Group leads to seek confirmation as to when this action was completed.
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Lack of feedback provided to optometrists following referral and discharge of patients (Patient Referrals – Communication Following referral) (Discharge patient – Quality of information) C) Health boards/Welsh government must ensure that systems are introduced to improve the amount of information available to optometrists in relation to patients who have been discharged from secondary care.	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	01.04.2024	Overdue	August 2024 Update - this is ongoing, due to delays in national EPR/ERS programme.
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	CHC reports concerns around lack of information provided within secondary care prior to treatment (Patient Referrals – Communication Following referral) - Health Boards must ensure that patients are provided with adequate information about their condition and proposed care plan prior to any investigation or treatment. This should conform to the principles outlined in GMC guidance on informed consent.	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	01.04.2024	Fully complete (Awaiting approval)	August 2024 Update - meeting scheduled with Planned Care Care Group leads to seek confirmation as to when this action was completed.
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Concerns around set monitoring for follow-up patients (Treatment Timescale – Targets) A) The Welsh Government should ensure that Patient Administration Systems are capable of providing data on clinician recommended follow-up interval and actual follow-up interval by care pathway.	Documents and resource related to FUNB patients are shared between the business Informatics and Directorate Management Team by mean of daily downloads. There are a number of status updates reports to include: Total number waiting Patients past target date Patients with a target date Partial booking PIFU Patients with appointments cancelled	Planned Care	01.04.2024	01.04.2024	Overdue	August 2024 Update - No update received this period.
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Concerns around set monitoring for follow-up patients (Treatment Timescale – Targets) B) Health Boards must ensure that care is provided for those (new or follow-up patients) with the greatest health need first, making most effective use of all skills and resources available.	Patients on the FUNB and New list are all given a HRF and target date. When booking clinics the booking office will filter by target date and HRF ensuring that patients are booked into the most appropriate sub-specialty clinic by priority status. However, we continue to hold significant risk with the FUNB cohort and further resource in terms of validation and capacity is required.	Planned Care	01.04.2024	01.04.2024	Overdue	August 2024 Update - No update received this period.
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Concerns around set monitoring for follow-up patients (Treatment Timescale – Targets) C) Clinical teams must clearly document the follow-up regime selected for each case. This should be applied consistently according to agreed protocols. The patient should be kept informed of any changes to the plan.	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	Planned Care	01.04.2024	01.04.2024	Overdue	August 2024 Update - No update received this period.

HIW Inspections Recommendations Tracker - Request for updates by Friday 23rd August 2024
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Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Lack of incident reporting relating to WG patient harm policy A) Health Boards must ensure that there are mechanisms in place to review incident reports to identify potential patterns providing early warnings to more serious system failures.	A FUNB Standard Operating Procedure has recently been submitted to the Surgical Safety and Quality Governance group for review and approval, this includes: • Identify adults who have not had an ophthalmology follow up appointment(s) booked in a timely manner • Ensure that National Standards for Ophthalmology screening have been met in order to maintain compliance with good clinical practice • To review patient pathway delays and identify the level of harm resulting from avoidable delays. • To identify how much loss of vision represents a loss of function and whether this is as a result of a delay in treatment • To ensure, when harm is established, the application of Putting Things Policy and/or Serious Incident management process. • To ensure there is an appropriate follow up plan of care in place for each patient reviewed. • To ensure actions are implemented to reduce the risk of a reoccurring delay in the patient's pathway. • To encourage continuous improvement by identifying areas for improvement in FUNB incident reporting.	Planned Care	01.04.2024	01.04.2024	Overdue	August 2024 Update - No update received this period.
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Lack of capacity/Fragility of services of services due to over-reliance on consultants. Issues relating to lack of capacity, recruitment and lack of investment in services. (Treatment - Capacity) A) Health Boards must proactively develop workforce plans which set out to address any shortfalls in the current service capacity and available facilities to mitigate the risks to patient care. These plans should seek to maximise capacity by making most effective use of the skills of medical and non-medical staff available, as well as available space/facilities.	a) CTM has a well established optometry department which has a number of experienced, highly skilled and qualified optometrists working across glaucoma, medical retina, DRSS, unscheduled care, paediatric clinics and specialist contact lenses. Recent expansion of the service to include community optometrists on a sessional basis which has increased our capacity across these services whilst additionally improving training to community optometrists to in turn reduce referrals and improve referral quality. Hospital based optometry due to start implementing an optometry laser led pathway to improve SLT and laser capacity in the coming months.	Planned Care	01.04.2024	01.04.2024	Overdue	August 2024 Update - Recruitment in progress for additional permanent non-medical staff to create additional capacity in glaucoma clinics (Band 3 tech, Band 4 tech, Band 8a Optometrist)
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Lack of capacity/Fragility of services of services due to over-reliance on consultants. Issues relating to lack of capacity, recruitment and lack of investment in services. (Treatment - Capacity) B) Health boards must consider ways to work more closely with colleagues from primary care. For example, providing equipment (and training) to optometry practices to allow them to undertake referral refinement and/or assessments on stable patients. This needs to be done in a planned and strategic way under control of the health board.	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	01.04.2024	Overdue	August 2024 Update - AMD referral refinement pathway working well, moving to direct optometrist inter-practice referral 2/9/24 (currently coordinated by hospital team). This will reduce admin burden and shorten turnaround time for patients.
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Health boards should learn from the experiences following progress made in other areas (Treatment – Initiatives to improve Capacity) A) Health Boards must ensure that they fully engage with the Ophthalmology Planned Care Board to aid shared learning from/with staff in other areas.	Weekly performance meeting have been arranged between the Clinical Service Group Manager (CSGM) and Interim Director of Planned Care to discuss key performance measures and any ad hoc issues which arise. CSGM from other sites are in attendance for shared learning purposes. Any risks we have assessed in the service is held on the corporate risk register which we update regularly with mitigations to reduce the risks. We also provide regular updates on the above to the Quality, Safety and Risk Group, as well as to the Planned Care Recovery Finance Group and the Joint Executive Team Meetings.	Planned Care	01.04.2024	01.04.2024	Overdue	August 2024 Update - No update received this period.
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Health Boards should learn from the experiences following progress made in other areas (Treatment - Initiatives to improve Capacity) B) Welsh Government should consider whether there is a need to develop further approaches to encourage shared learning between health boards as well as more integrated methods to address common themes/issues being experienced across Wales. For example, the introduction of non-medical injectors.	WG to answer	Planned Care	01.04.2024	01.04.2024	Overdue	August 2024 Update - August 2024 Update - complete - CTM actively participating in regional CIN work to share/ratify JDs and SOPs where appropriate. Not marked as fully complete as need QSRE sign off.
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	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	01.04.2024	Overdue	August 2024 Update - No further update, complete. Not marked as fully complete as need QSRE sign off.
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	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	01.04.2024	Fully complete (Awaiting approval)	August 2024 Update - meeting scheduled with Planned Care Care Group leads to seek confirmation as to when this action was completed.
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	More clarity required in relation to evolving role of optometrist to enable more effective utilisation of optometrists, Welsh Government must provide clarity to health boards relating to Indemnity, resource & finance arrangements, training/qualifications and communication mechanisms.	This appears to be an action required by WG, though we have answered from a CTM perspective. CTM optometrists are being utilised in multiple areas of ophthalmology such as glaucoma, med retina and corneal specialities and direct WG funding has provided sessional optometrists to work within these areas. Higher level training and qualifications are underway and have been utilised historically and currently. Staff have sourced funding from HEIW in order to gain higher qualifications from The Royal College of Optometrist in order to further develop services (such as the soon to implemented optometry led laser service for glaucoma).	Planned Care	01.04.2024	01.04.2024	Overdue	August 2024 Update - CTM Optometry presented proposal to develop a Welsh Hospital Optometry forum, at CIN June '24 which was well supported. Initial planning meeting to develop national subgroup reporting to CIN 6/9/24. Heads of Service vacancies (Optometry/Orthoptics) still ongoing.
Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	Additional utilisation of optometrists is required to increase capacity (HDHB) example) and reduce the burden on secondary care. (Utilisation of optometrists) Health boards should consider additional utilisation of optometrists to increase available capacity and reduce burden on secondary care. Health Board will need to ensure that issues are clarified around Indemnity, resource & finance arrangements, training and communication, for optometrists.	See points above. CTM already utilising both hospital and primary care based optometrists in a range of sub-specialities. Primary care pathways and schemes include IPOS or unscheduled care, Glaucoma community monitoring scheme, AMD referrals refinement and DRSS.	Planned Care	01.04.2024	01.04.2024	Overdue	August 2024 Update - Additional 8a optometrist for glaucoma services in recruitment.

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Healthcare Inspectorate Wales (HIW)/2017/141	30.01.2017	National review of Ophthalmology Services	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	01.04.2024	Fully complete (Awaiting approval)	August 2024 Update - meeting scheduled with Planned Care Care Group leads to seek confirmation as to when this action was completed.
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, Eclipse (incidents and patient feedback/complaints/compliments)	Unscheduled Care	01.03.2021	01.03.2021	Fully complete (Awaiting approval)	August 2024 Update - Completed in February 2024. Signed off by DoN for USC. Formal closure will be confirmed once received at the Quality & Safety Committee on the 18th September 2024. 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.
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 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	01.03.2021	Fully complete (Awaiting approval)	August 2024 Update - Completed in February 2024. Signed off by DoN for USC. Formal closure will be confirmed once received at the Quality & Safety Committee on the 18th September 2024. 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.
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 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	01.03.2021	Fully complete (Awaiting approval)	August 2024 Update - Completed in February 2024. Signed off by DoN for USC. Formal closure will be confirmed once received at the Quality & Safety Committee on the 18th September 2024. 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.	Primary Care & Community	01.12.2020	01.12.2020	Fully complete (Awaiting approval)	August 2024 Update - Action Complete. Strategic review of Infection, Prevention & Control (IP&C) undertaken resulting in an IP&C Strategy 2024-2026. Review outcome received at the Quality & Safety Committee in May 2024. IPC Strategy received at the May 2024 Quality and Safety Committee (QSC) and approved by Board in May 2024.
Healthcare Inspectorate Wales (HIW)/2020/139	08.09.2020	Quality Check Summary Ysbyty Cwm Rhondda [Ysbyty Cwm Rhondda - Ward A1 (Ref: 20030)]	The Health Board should ensure that the escalation procedure is reviewed.	A revised Emergency Pressures Escalation Plan has been drafted (9th September 2020) and submitted to the Executive Director of Operations. Once approved, this will be made available on the CTM intranet site.	Primary Care & Community	01.10.2020	01.10.2020	Overdue	August 2024 Update - The Emergency Preparedness Resilience and Response Manager is following up with Operational colleagues on the development of the Emergency Pressures Escalation Procedure. Draft version is developed and confirmation of approval is being sought. Once confirmed this action will be marked as closed.
Healthcare Inspectorate Wales (HIW)/2021/135	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 & Learning Disabilities	10.08.2021	10.07.2021	Partially complete (Overdue)	August 2024 - Ongoing monitoring via the MHLD Care Group in relation to compliance
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. CTM continue to audit crisis contingency plans developed under Part 2 to ensure they are co-produced and support the individual to recognise and respond to crisis. This is fed through the CTP Monitoring group.	Mental Health & Learning Disabilities	01.10.2022	01.10.2022	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.
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.	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 & Learning Disabilities	01.06.2022	01.06.2022	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.

HIW Inspections Recommendations Tracker - Request for updates by Friday 23rd August 2024
Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Original Due Date	Current (Revised) Due Date	Progress Status	UPDATES for Quality & Safety Committee Wednesday 18th September 2024 Please submit all updates no later than close of business on Friday 23rd August 2024 Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT
Healthcare Inspectorate Wales (HIW)/2021/137	30.06.2021	National Review of Mental Health Crisis Prevention in the Community	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 & Learning Disabilities	01.10.2022	01.10.2022	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.
Healthcare Inspectorate Wales (HIW)/2021/137	30.06.2021	National Review of Mental Health Crisis Prevention in the Community	Health boards must ensure that clear processes are in place to ensure that physical health assessments and monitoring is undertaken for relevant patients under the Mental Health (Wales) Measure 2010.	Working group to be established between Primary Care and mental Health to ensure clear understanding of responsibilities for delivery of Physical Health checks with agreed process	Mental Health & Learning Disabilities	01.11.2024	01.11.2024	Partially complete (Overdue)	August 2024 - MHLD has one outstanding action to be discussed at next QRSE in September 2024.
Healthcare Inspectorate Wales (HIW)/2021/137	30.06.2021	National Review of Mental Health Crisis Prevention in the Community	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 & Learning Disabilities	01.10.2022	01.10.2022	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.
Healthcare Inspectorate Wales (HIW)/2021/137	30.06.2021	National Review of Mental Health Crisis Prevention in the Community	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 & Learning Disabilities	01.10.2022	01.10.2022	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.
Healthcare Inspectorate Wales (HIW)/2021/137	30.06.2021	National Review of Mental Health Crisis Prevention in the Community	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 & Learning Disabilities	01.10.2022	01.10.2022	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.
Healthcare Inspectorate Wales (HIW)/2021/137	30.06.2021	National Review of Mental Health Crisis Prevention in the Community	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 & Learning Disabilities	01.10.2022	01.10.2022	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.
Healthcare Inspectorate Wales (HIW)/2021/137	30.06.2021	National Review of Mental Health Crisis Prevention in the Community	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 & Learning Disabilities	01.10.2022	01.10.2022	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.
Healthcare Inspectorate Wales (HIW)/2021/137	30.06.2021	National Review of Mental Health Crisis Prevention in the Community	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 & Learning Disabilities	31.10.2022	31.10.2022	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.
Healthcare Inspectorate Wales (HIW)/2021/137	30.06.2021	National Review of Mental Health Crisis Prevention in the Community	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 & Learning Disabilities	01.10.2022	01.10.2022	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.
Healthcare Inspectorate Wales (HIW)/2021/137	30.06.2021	National Review of Mental Health Crisis Prevention in the Community	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 & Learning Disabilities	01.10.2022	01.10.2022	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Original Due Date	Current (Revised) Due Date	Progress Status	UPDATES for Quality & Safety Committee Wednesday 18th September 2024 Please submit all updates no later than close of business on Friday 23rd August 2024 Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT
Healthcare Inspectorate Wales (HIW)/2021/137	30.06.2021	National Review of Mental Health Crisis Prevention in the Community	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 & Learning Disabilities	31.10.2022	31.10.2022	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.
Healthcare Inspectorate Wales (HIW)/2021/137	30.06.2021	National Review of Mental Health Crisis Prevention in the Community	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 & Learning Disabilities	01.10.2022	01.10.2022	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.
Healthcare Inspectorate Wales (HIW)/2021/137	30.06.2021	National Review of Mental Health Crisis Prevention in the Community	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 & Learning Disabilities	01.10.2022	01.10.2022	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.
Healthcare Inspectorate Wales (HIW)/2021/137	30.06.2021	National Review of Mental Health Crisis Prevention in the Community	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 & Learning Disabilities	01.10.2022	01.10.2022	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.
Healthcare Inspectorate Wales (HIW)/2021/137	30.06.2021	National Review of Mental Health Crisis Prevention in the Community	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 & Learning Disabilities	01.03.2023	01.03.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.
Healthcare Inspectorate Wales (HIW)/2021/137	30.06.2021	National Review of Mental Health Crisis Prevention in the Community	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 & Learning Disabilities	01.12.2022	01.12.2022	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.
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 & Learning Disabilities	30.11.2021	30.11.2021	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting.
Healthcare Inspectorate Wales (HIW)/2021/138	20.07.2021	Quality Check Summary Pinewood House [Pinewood House - Quality Check]	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 & Learning Disabilities	30.11.2021	30.11.2021	Overdue	August 2024 Update - Remains overdue
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 & Learning Disabilities	28.04.2023	28.04.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting.
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.	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 (Ability and Paliperidone). For all other depot medication staff who order these medication will audit at the same time.	Mental Health & Learning Disabilities	28.04.2023	28.04.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting.
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 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 & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting.
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 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 & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting.
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 and local authority should reflect on comments from staff relating to access to care documents and systems	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 & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting.
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 ensure that medical staff complete all safeguarding related refresher training in a timely manner	All medical staff to attend 'Safeguarding People' Day	Mental Health & Learning Disabilities	28.04.2023	28.04.2023	Overdue	August 2024 Update - remains overdue
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 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 & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting.
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 ensure that Community Treatment Order (CTO) documentation contains all of the required detail	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 & Learning Disabilities	28.04.2023	28.04.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting.
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 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 & Learning Disabilities	21.02.2023	21.02.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Original Due Date	Current (Revised) Due Date	Progress Status	UPDATES for Quality & Safety Committee Wednesday 18th September 2024 Please submit all updates no later than close of business on Friday 23rd August 2024 Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT
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 and local authority should reflect on the staff feedback comments provided in this report	The inspection findings will also form part of our local QSRE meetings standard agenda to maintain monitoring of the review	Mental Health & Learning Disabilities	28.04.2023	28.04.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 31/01/2025	Overdue	August 2024 Update - Business Case currently on hold as from early September, there will be a temporary closure of the maternity and neonatal units at Princess of Wales Hospital (PoW) to allow for essential maintenance works on both units. This action will be revisited in January 2025.
Healthcare Inspectorate Wales (HIW)/2022/131	22.03.2022	Hospital Inspection (Announced) Princess of Wales Hospital – Maternity Services [Appendix C - POW Maternity Unit (Ref: 21233)]	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	31.01.2024	Fully complete (Awaiting approval)	August 2024 Update - Complete. This now forms part of the Annual Record Keeping Audit and Spot Checks by Senior Midwifery Team.
Healthcare Inspectorate Wales (HIW)/2022/131	22.03.2022	Hospital Inspection (Announced) Princess of Wales Hospital – Maternity Services [Appendix C - POW Maternity Unit (Ref: 21233)]	The Health Board must ensure that: 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	01.08.2022	Fully complete (Awaiting approval)	August 2024 Update - Complete. Stamps procured and audits routinely undertaken.
Healthcare Inspectorate Wales (HIW)/2022/131	22.03.2022	Hospital Inspection (Announced) Princess of Wales Hospital – Maternity Services [Appendix C - POW Maternity Unit (Ref: 21233)]	Risk assessments are undertaken and recorded in patient records. Medical discussion and decisions are accurately recorded in patient records.	The specific areas of risk assessment, medical discussions and decisions will be added to the record keeping audit and all service medical staff to participate in this annual audit to drive multi professional improvement in this area.	Children & Families	01.08.2022	01.08.2022	Overdue	August 2024 Update - Update requested from the Medical Director in the Children and Family Care Group.
Healthcare Inspectorate Wales (HIW)/2022/131	22.03.2022	Hospital Inspection (Announced) Princess of Wales Hospital – Maternity Services [Appendix C - POW Maternity Unit (Ref: 21233)]	The Health Board must ensure that: 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	31.01.2024	Fully complete (Awaiting approval)	August 2024 Update - Complete and new system in place.
Healthcare Inspectorate Wales (HIW)/2022/131	22.03.2022	Hospital Inspection (Announced) Princess of Wales Hospital – Maternity Services [Appendix C - POW Maternity Unit (Ref: 21233)]	The Health Board must ensure that: Additional welfare support is available for KIT staff.	Workforce team asked for specific resources for KIT staff going forward.	Children & Families	01.06.2022	01.10.2023	Overdue	August 2024 Update - KIT update to be taken to next Care Group Workforce meeting on the 28th August and the Local Partnership Forum.
Healthcare Inspectorate Wales (HIW)/2022/131	22.03.2022	Hospital Inspection (Announced) Princess of Wales Hospital – Maternity Services [Appendix C - POW Maternity Unit (Ref: 21233)]	The Health Board must ensure that: The backlog of incidents are cleared and consideration of further funding should continue.	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	August 2024 Update - Children & Family Care Group just completing a review of the governance arrangements in line with the new incident management framework. Outcome of will be presented to the Maternity and Neonatal Safety Board in September 2024 with an implementation plan. The new arrangements will ensure proportionate review and learning.
Healthcare Inspectorate Wales (HIW)/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 QI 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	30.04.2024	Fully complete (Awaiting approval)	August 2024 Update - BFI Compliant in Bridgend and working towards re-accreditation in 2025.
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 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	31.01.2024	01.02.2023	Fully complete (Awaiting approval)	August 2024 - Complete and now forms part of the record keeping audit.
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)]	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	31.01.2024	01.02.2023	Fully complete (Awaiting approval)	August 2024 - Complete - fully funded and recruiting to birthrate plus compliance and recommendations. Nurse Director met with Finance Team to review and agree set budgeted establishment in July 2024.
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	01.02.2023	Overdue	August 2024 Update - The USC Care Group are finalising the last AMaT audit for the three Emergency Department's, this will be achieved by Oct 2024 as needs to go through existing governance process' for sign off prior to use.
Healthcare Inspectorate Wales (HIW)/2022/133	17.10.2022	Hospital Inspection Report (Unannounced) Emergency Department, Princess of Wales Hospital [Appendix A - Immediate Improvement Plan - Princess of Wales Emergency Department (Ref: 3326)]	The Health Board must ensure that checks are completed and logged at all times, and that there are robust mechanisms in place to identify and rectify when checks are not completed or logged.	Work with Care Group Directors of Nursing and Midwifery and Heads of Nursing across the three acute sites and community hospital sites in establishing a consistent model of surveillance and checking practice.	Unscheduled Care	01.12.2023	01.12.2023	Overdue	August 2024 Update - The USC Care Group are finalising the last AMaT audit for the three Emergency Department's, this will be achieved by Oct 2024 as needs to go through existing governance process' for sign off prior to use.
Healthcare Inspectorate Wales (HIW)/2022/36	14.11.2022	Hospital Inspection Report (Unannounced) Angelton Clinic, Glanrhyd Hospital [Appendix C 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 & Learning Disabilities	28.04.2023	28.04.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.
Healthcare Inspectorate Wales (HIW)/2022/36	14.11.2022	Hospital Inspection Report (Unannounced) Angelton Clinic, Glanrhyd Hospital [Appendix C Improvement plan Service Angelton Clinic – Glanrhyd Hospital (Ref: 3171)]	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 & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
Healthcare Inspectorate Wales (HIW)/2022/36	14.11.2022	Hospital Inspection Report (Unannounced) Angelton Clinic, Glanrhyd Hospital [Appendix C Improvement plan Service Angelton Clinic – Glanrhyd Hospital (Ref: 3171)]	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 & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
Healthcare Inspectorate Wales (HIW)/2022/36	14.11.2022	Hospital Inspection Report (Unannounced) Angelton Clinic, Glanrhyd Hospital [Appendix C Improvement plan Service Angelton Clinic – Glanrhyd Hospital (Ref: 3171)]	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 & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
Healthcare Inspectorate Wales (HIW)/2022/36	14.11.2022	Hospital Inspection Report (Unannounced) Angelton Clinic, Glanrhyd Hospital [Appendix C Improvement plan Service Angelton Clinic – Glanrhyd Hospital (Ref: 3171)]	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 & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.
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.	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 & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.
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.	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 & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.

HIW Inspections Recommendations Tracker - Request for updates by Friday 23rd August 2024
Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Original Due Date	Current (Revised) Due Date	Progress Status	UPDATES for Quality & Safety Committee Wednesday 18th September 2024 Please submit all updates no later than close of business on Friday 23rd August 2024 Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT
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.	Completion of mental health and physical health checks will be added to the Admission Pathway for all inpatient wards.	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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.	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 & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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.	Audit data will be reported/escalated through Care Group Governance Framework	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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 & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.
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 2 The health board must ensure that when staff complete patient risk assessments, the method should reflect the requirements set out within national guidance.	All staff who are expected to complete clinical risk assessment will receive training in WARRN (nationally recognised) risk assessment and formulation.	Mental Health & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 2 The health board must ensure that when staff complete patient risk assessments, the method should reflect the requirements set out within national guidance.	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 & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.
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 2 The health board must ensure that when staff complete patient risk assessments, the method should reflect the requirements set out within national guidance.	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 & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 2 The health board must ensure that when staff complete patient risk assessments, the method should reflect the requirements set out within national guidance.	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 & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 2 The health board must ensure that when staff complete patient risk assessments, the method should reflect the requirements set out within national guidance.	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 & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 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 & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.
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 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 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 & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 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.	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 & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 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.	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 & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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.	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 & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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.	Staff will learn from audit results when shared with staff teams through the Quality/Audit/learning agenda points in formal team meetings	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 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.	Audit data will be reported/escalated through Care Group Governance Framework	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 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.	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 & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 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 & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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.	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 & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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.	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 & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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.	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 & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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.	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 & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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.	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 & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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.	Staff will learn from audit results when shared with staff teams through the Quality/Audit/learning agenda points in formal team meetings	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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.	Audit data will be reported/escalated through Care Group Governance Framework.	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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.	Audit information will also be will be communicated to all staff through Ward training boards, daily safety briefing etc.	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024

HIW Inspections Recommendations Tracker - Request for updates by Friday 23rd August 2024
Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Original Due Date	Current (Revised) Due Date	Progress Status	UPDATES for Quality & Safety Committee Wednesday 18th September 2024 Please submit all updates no later than close of business on Friday 23rd August 2024 Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT
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 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 & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 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.	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 & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 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.	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 & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 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.	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 & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 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.	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 & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 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 & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 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.	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 & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 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.	An audit tool for the monitoring of these standards will be developed and included as part of the Health Board Electronic System.	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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.	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 & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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.	Staff will learn from audit results when shared with staff teams through the Quality/Audit/learning agenda points in formal team meetings	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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.	Audit data will be reported/escalated through Care Group Governance Framework.	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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 & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 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.	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 & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 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 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 & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 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.	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 & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.
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 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.	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 & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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.	Staff will learn from audit results when shared with staff teams through the Quality/Audit/learning agenda points in formal team meetings.	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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.	Audit data will be reported/escalated through Care Group Governance Framework.	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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 & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 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.	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 & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 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.	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 & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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.	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 & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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.	Care and Treatment Planning	Mental Health & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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.	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 & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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.	This will also enable reporting of training compliance through monthly Integrated Performance meeting chaired by the Care group Service Director.	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.

HIW Inspections Recommendations Tracker - Request for updates by Friday 23rd August 2024
Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Original Due Date	Current (Revised) Due Date	Progress Status	UPDATES for Quality & Safety Committee Wednesday 18th September 2024 Please submit all updates no later than close of business on Friday 23rd August 2024 Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT
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 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.	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 & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 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.	Additional bespoke training will be developed in response to the TNA the completion of the work of the Safe Discharge Workstream.	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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 & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 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.	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 & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 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.	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	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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.	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 & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 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.	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 & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 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.	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 & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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.	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 & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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.	Staff will learn from audit results when shared with staff teams through the Quality/Audit/learning agenda points in formal team meetings	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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.	Audit data will be reported/escalated through Care Group Governance Framework.	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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 & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 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.	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	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 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.	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 & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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.	Audit tool for the monitoring of these standards will be developed and included as part of the Health Board electronic audit system.	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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.	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 & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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.	Staff will learn from audit results when shared with staff teams through the Quality/Audit/learning agenda points in formal team meetings.	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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.	Audit data will be reported/escalated through Care Group Governance Framework	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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.	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 & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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.	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 & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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.	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 & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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 & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 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.	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 & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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.	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 & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Original Due Date	Current (Revised) Due Date	Progress Status	UPDATES for Quality & Safety Committee Wednesday 18th September 2024 Please submit all updates no later than close of business on Friday 23rd August 2024 Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT
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 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.	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 & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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.	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 & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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.	Staff will learn from audit results when shared with staff teams through the Quality/Audit/learning agenda points in formal team meetings.	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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.	Audit data will be reported/escalated through Care Group Governance Framework.	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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 & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 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 care group will audit all cases who are considered to have been subject to "expedited discharge" using standards agreed within the procedure.	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 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.	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 & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 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.	Audit results will be shared with staff teams through the Quality/Audit/learning agenda points in formal team meetings.	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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.	Audit data will be reported/escalated through Care Group Governance Framework.	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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 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 & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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 & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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 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 & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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 & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 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 & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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 & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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 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 & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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	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 & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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 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 & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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	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 & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Original Due Date	Current (Revised) Due Date	Progress Status	UPDATES for Quality & Safety Committee Wednesday 18th September 2024 Please submit all updates no later than close of business on Friday 23rd August 2024 Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 19 The health board must continue to provide HIW with updates on the plans to implement the unified patient clinical records system. This must also include consideration for its inpatient and community services for Child and Adolescent Mental Health Services across the health board.	The Executive and Board are committed to the implementation of a unified electronic record system for the Mental Health and Learning Disabilities Care Group, which includes Child and Adolescent Mental Health Services.	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Overdue	August 2024 Update - this remains on going
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 19 The health board must continue to provide HIW with updates on the plans to implement the unified patient clinical records system. This must also include consideration for its inpatient and community services for Child and Adolescent Mental Health Services across the health board.	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	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 19 The health board must continue to provide HIW with updates on the plans to implement the unified patient clinical records system. This must also include consideration for its inpatient and community services for Child and Adolescent Mental Health Services across the health board.	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 & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting.
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 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 & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting.
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 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.	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 & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting.
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 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 & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting.
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 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	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 & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting.
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 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	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	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting.
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 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	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 & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting.
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 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	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 & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting.
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 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	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 & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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	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 & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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	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 & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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	Staff will learn from audit results when shared with staff teams through the Quality/Audit/learning agenda points in formal team meetings.	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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	Audit data will be reported/escalated through Care Group Governance Framework	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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 & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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 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 & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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.	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 & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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 procedures will be shared with all staff through Communication and Learning Framework (Recommendation 40)	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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.	Audit of the process will be fed back to teams and any remedial action will reinforce compliance	Mental Health & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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.	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 & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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 & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting.
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 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 & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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.	This standard is explicit within the Health Board Discharge Procedure (MH40) standards.	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting.
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 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.	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 & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Original Due Date	Current (Revised) Due Date	Progress Status	UPDATES for Quality & Safety Committee Wednesday 18th September 2024 Please submit all updates no later than close of business on Friday 23rd August 2024 Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT
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 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 High Quality Clinical Records Workstream will provide solutions for the monitoring of discharge follow up by community teams using different record systems.	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 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 & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting. To close following QSC 18th September 2024
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 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 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 & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 25 The health board must take action to manage the risks of insufficient staff numbers and temporary staffing needs on inpatient mental health wards.	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 & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 25 The health board must take action to manage the risks of insufficient staff numbers and temporary staffing needs on inpatient mental health wards.	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 & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 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 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 & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 25 The health board must take action to manage the risks of insufficient staff numbers and temporary staffing needs on inpatient mental health wards.	Workforce issues such as vacancies and sickness are reported , by clinical service group at monthly Integrated performance meeting	Mental Health & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 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 & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 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 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 & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 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 & Learning Disabilities	30.09.2023	30.09.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.
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 27 The health board must provide an update on the status of the Merthyr Cynon CRHT assessment facilities within PCH.	Crisis and Liaison Staff risk assess the patient and depending on need will remain with them in the room at all times.	Mental Health & Learning Disabilities	30.09.2023	30.09.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.
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 27 The health board must provide an update on the status of the Merthyr Cynon CRHT assessment facilities within PCH.	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 & Learning Disabilities	30.09.2023	30.09.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 27 The health board must provide an update on the status of the Merthyr Cynon CRHT assessment facilities within PCH.	Hand held panic alarms have been ordered and will be delivered to Crisis Team w/c 12th June 23	Mental Health & Learning Disabilities	30.09.2023	30.09.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 27 The health board must provide an update on the status of the Merthyr Cynon CRHT assessment facilities within PCH.	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 & Learning Disabilities	30.09.2023	30.09.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 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 & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 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.	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 & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 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.	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 & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 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.	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 & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 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.	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 & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 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 & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.

HIW Inspections Recommendations Tracker - Request for updates by Friday 23rd August 2024
Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Original Due Date	Current (Revised) Due Date	Progress Status	UPDATES for Quality & Safety Committee Wednesday 18th September 2024 Please submit all updates no later than close of business on Friday 23rd August 2024 Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT
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 29 The health board must take action to ensure there is sufficient medical capacity across all mental health teams.	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 & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting.
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 29 The health board must take action to ensure there is sufficient medical capacity across all mental health teams.	"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 & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting.
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 29 The health board must take action to ensure there is sufficient medical capacity across all mental health teams.	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:	Mental Health & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.
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 29 The health board must take action to ensure there is sufficient medical capacity across all mental health teams.	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 & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting.
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 29 The health board must take action to ensure there is sufficient medical capacity across all mental health teams.	Workforce issues such as vacancies and sickness are reported , by clinical service group at monthly Integrated performance meeting	Mental Health & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting.
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 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 & Learning Disabilities	30.09.2023	30.09.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting.
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 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.	"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	Mental Health & Learning Disabilities	30.09.2023	30.09.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
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 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 & Learning Disabilities	31.03.2024	31.03.2024	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting.
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 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.	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	Mental Health & Learning Disabilities	31.03.2024	31.03.2024	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.
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 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 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 & Learning Disabilities	31.03.2024	31.03.2024	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting.
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 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.	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 & Learning Disabilities	31.03.2024	31.03.2024	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting.
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 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.	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 & Learning Disabilities	31.03.2024	31.03.2024	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
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 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.	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 & Learning Disabilities	31.03.2024	31.03.2024	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting.
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 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 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 & Learning Disabilities	31.03.2024	31.03.2024	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting.
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 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.	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 & Learning Disabilities	31.03.2024	31.03.2024	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting.
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 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.	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 & Learning Disabilities	31.03.2024	31.03.2024	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting.
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 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 & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
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 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.	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 & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting.
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 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 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 & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
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 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.	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 & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting.
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 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 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 & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.

HIW Inspections Recommendations Tracker - Request for updates by Friday 23rd August 2024
Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Original Due Date	Current (Revised) Due Date	Progress Status	UPDATES for Quality & Safety Committee Wednesday 18th September 2024 Please submit all updates no later than close of business on Friday 23rd August 2024 Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT
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 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 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 & Learning Disabilities	31.08.2023	31.05.2024	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting.
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 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 & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
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 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 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 & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting.
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 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 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 & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting.
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 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 & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.
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 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 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 & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
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 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 & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
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 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.	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 & Learning Disabilities	31.07.2023	31.07.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 36 The health board must provide HIW with an update on the progress of the ongoing work to review and update the mental health service policies and procedures, and when the health board wide documents will be implemented. This must include how this will be shared with all staff across the mental health services as a whole.	The oversight of this recommendation will be via the Policies Group. The newly established Policy Review group will have an operational scope to: •Review & RAG of all existing MH Policies to establish priorities rating •Develop a policies plan with trajectories for addressing the backlog •To progress for sign off at Care Group level •Maintenance of a register of policies for review Following agreement of ToR at April 2023 Care Group Quality Safety Risk and Experience Group.	Mental Health & Learning Disabilities	01.06.2024	01.06.2024	Overdue	August 2024 Update - •21 policies in date (up from 16 in July). •6 pending ratification, awaiting comments by 2nd Sept, I will then progress. •36 under review (17 have slipped completion dates from June/July to Sept/Oct/Nov 24) as below:
Healthcare Inspectorate Wales (HIW)/2023/130	07.03.2023	Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (Ref: 2023061)	Recommendation 36 The health board must provide HIW with an update on the progress of the ongoing work to review and update the mental health service policies and procedures, and when the health board wide documents will be implemented. This must include how this will be shared with all staff across the mental health services as a whole.	Mental health policies will follow the agreed organisational process for ratification. All NH specific policies were reviewed by 1 June 2023 and of the 49 MH specific policies - Review underway 4 In date and approved 13 Expired 32. With an agreement that those that require updating will be completed by 1st June 2024. The 32 expired policies have been prioritised with consideration of patient safety, present best practice and clinical impact and a review schedule has been developed with this in mind. The Mental Health Policy group will monitor this review schedule at each meeting through an agenda item. In the interim the Mental Health Policy group has directed the clinical teams to work with the most current version each Clinical policy. On completion agreed policies will be communicated to all Nursing and Medical staff across all Mental Health services using the care Group "Communication and Learning Framework" (recommendation All current and ratified policies will be live on the Mental Health Policies page on the staff internet site SharePoint.	Mental Health & Learning Disabilities	01.06.2024	01.06.2024	Overdue	August 2024 Update - 21 policies in date (up from 16 in July). •6 pending ratification, awaiting comments by 2nd Sept, I will then progress. •36 under review (17 have slipped completion dates from June/July to Sept/Oct/Nov 24) as below:
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 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 & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting.
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 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 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 governance arrangements. The Head of Quality and Safety will lead on operational care group governance meeting to monitor compliance with	Mental Health & Learning Disabilities	30.11.2024	30.11.2024	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting.
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 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.	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 & Learning Disabilities	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
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 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 & Learning Disabilities	30.06.2023	31.10.2024	In progress	August 2024 Update - No update received this period.
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 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 & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting.
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 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 agenda 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 & Learning Disabilities	30.06.2023	30.06.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confirmation of the closure sign off at the relevant QSRE meeting.

HIW Inspections Recommendations Tracker - Request for updates by Friday 23rd August 2024
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Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Original Due Date	Current (Revised) Due Date	Progress Status	UPDATES for Quality & Safety Committee Wednesday 18th September 2024 Please submit all updates no later than close of business on Friday 23rd August 2024 Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT
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	01.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Completed in February 2024. Signed off by DoN for USC. Formal closure will be confirmed once received at the Quality & Safety Committee on the 18th September 2024. June 2024 Update - Complete. AMaT audit in place for assurance completed by Senior Nurses.
Healthcare Inspectorate Wales (HIW)/2023/134	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix A - Immediate Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken: • to improve mandatory staff training compliance in respect of resuscitation training • to promote patient safety in the interim until compliance has improved	Cwm Taf University Health Board acknowledges that compliance for mandatory resuscitation training is not where we want it to be in order that Patient Care and Safety can be assured in the event of a patient collapse - Current Training Compliance:- ED •Registered Nurse ILS compliance is currently 38.24% and HCSW BLS is 2.78% as demonstrated in attached training needs analysis. •An 8a Senior Nurse for Professional Education has been appointed (July 2022) as part of the new ED Workforce Model agreed following the HIW review in September 2021. •A Training Needs Analysis has been undertaken and a Study Plan has been developed for all Registered Nurses and HCSWs Registered Nurses-the Resuscitation Team have agreed to undertake bespoke ILS and PILS training monthly with 12 spaces being allocated monthly HCSWs - the Resuscitation Team have agreed to undertake bespoke BLS training monthly for ED -8 spaces As an interim measure to ensure patient safety until compliance has improved the senior nurse for ED will have oversight of the roster to provide assurance that each area has an ILS trained nurse on shift. CDU - Registered Nurse ILS currently 70.6% this should also translate to BLS being achieved at 70.6% which was a data entry error to be immediately rectified by the resuscitation team via ESR. There are only 5 further nurses requiring training in order to meet 100%. Training is in line with the PDR process "Have your Conversation"; training compliance is aligned to the Agenda for Change process.	Unscheduled Care	01.11.2023	30.06.2024	Partially complete (Overdue)	August 2024 Update - CDU BLS - 94%, ILS 40%. ED BLS - 80% ALS 65% (CDU- Clinical Decisions Unit- (BLS) Basic Life support (ILS) Immediate Life Support (ED) Emergency Department (BLS) Basic Life support (ALS) Advanced Life Support.)
Healthcare Inspectorate Wales (HIW)/2023/140	16.05.2023	HMP Parc 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	Primary Care & Community	31.05.2023	31.05.2023	Fully complete (Awaiting approval)	August 2024 Update - Completed in December 2023, updated action plan emailed to the Corporate Team following approval from the Director of Nursing for Primary Care and Community. Formal closure will be confirmed once received at the Quality & Safety Committee on the 18th September 2024. Detailed Action Plan available upon request.
Healthcare Inspectorate Wales (HIW)/2023/140	16.05.2023	HMP Parc Prison	HMP Parc Prison should ensure that there is a robust mechanism to ensure that drug monitoring bloods are organised in a timely fashion especially for immunosuppressant drugs.	A review of the current GP management process to be undertaken . To implement a robust process ensuring that bloods required due to drug monitoring are undertaken in a timely manner and results are reviewed appropriately.	Primary Care & Community	31.08.2023	31.08.2023	Overdue	August 2024 Update - ongoing with Pharmacy lead and GP in HMP parc
Healthcare Inspectorate Wales (HIW)/2023/140	16.05.2023	HMP Parc Prison	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.	Primary Care & Community	31.08.2023	31.08.2023	Fully complete (Awaiting approval)	August 2024 Update - Completed in December 2023, updated action plan emailed to the Corporate Team following approval from the Director of Nursing for Primary Care and Community. Formal closure will be confirmed once received at the Quality & Safety Committee on the 18th September 2024. Detailed Action Plan available upon request.
Healthcare Inspectorate Wales (HIW)/2023/140	16.05.2023	HMP Parc Prison	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.	Primary Care & Community	30.09.2023	30.09.2023	Fully complete (Awaiting approval)	August 2024 Update - Completed in December 2023, updated action plan emailed to the Corporate Team following approval from the Director of Nursing for Primary Care and Community. Formal closure will be confirmed once received at the Quality & Safety Committee on the 18th September 2024. Detailed Action Plan available upon request.
Healthcare Inspectorate Wales (HIW)/2023/140	16.05.2023	HMP Parc Prison	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.	Primary Care & Community	31.10.2023	31.10.2023	Fully complete (Awaiting approval)	August 2024 Update - Completed in December 2023, updated action plan emailed to the Corporate Team following approval from the Director of Nursing for Primary Care and Community. Formal closure will be confirmed once received at the Quality & Safety Committee on the 18th September 2024. Detailed Action Plan available upon request.
Healthcare Inspectorate Wales (HIW)/2023/140	16.05.2023	HMP Parc Prison	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.	Primary Care & Community	30.11.2023	30.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Completed in December 2023, updated action plan emailed to the Corporate Team following approval from the Director of Nursing for Primary Care and Community. Formal closure will be confirmed once received at the Quality & Safety Committee on the 18th September 2024. Detailed Action Plan available upon request.
Healthcare Inspectorate Wales (HIW)/2023/140	16.05.2023	HMP Parc Prison	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.	Primary Care & Community	31.08.2023	31.08.2023	Overdue	August 2024 Update - Ongoing with Pharmacy lead and GP in HMP parc.
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	30.11.2023	Fully complete (Awaiting approval)	August 2024 - Complete - QR Systems in place and working well.
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.	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	31.10.2023	Fully complete (Awaiting approval)	August 2024 - Complete - 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.
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 continues to work in partnership with Cardiff and Vale UHB in the Regional Network for stroke services and have collaborated on cross-health board workshops to share and learn from good practice for service development, including patient education. The Health Board will continue to engage in the national network for stroke to ensure that we work together with other Health Boards across Wales to develop and share good practice and learning for the benefit of our patients and teams. Work continues in our GP Practices to target patients at increased risk of stroke and we continue to build on this as part of CTM2030 and our Acute Clinical Services Plan. Governance and reporting have been refreshed and strengthened, with learning fed back through the CTM UHB Stroke Operational Group and Stroke Performance Board into the Stroke Strategy Group for implementation across the Health Board area.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	August 2024 Update - This work is ongoing and forms part of long term engagement and partnership working via the stroke programme board.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Public Health Wales should consider the development and promotion of a national campaign to raise stroke awareness and its prevention in Wales alongside its Act FAST campaign. This should include raising awareness of stroke prevention within black and minority ethnic communities and the impact of health inequalities and socio-economic deprivation.	This action is led by PHW however, CTM UHB will continue to engage with PHW, the Stroke Association, and other Health Boards through the national network in order to support the development and implementation of a campaign by PHW. Updates will feed through to the CTM UHB Stroke Strategy Group to ensure continued support.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	August 2024 Update - "This action is led by PHW however, CTM UHB will continue to engage with PHW, the Stroke Association, and other Health Boards through the national network in order to support the development and implementation of a campaign by PHW. Updates will feed through to the CTM UHB Stroke Strategy Group to ensure continued support."

HIW Inspections Recommendations Tracker - Request for updates by Friday 23rd August 2024
Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Original Due Date	Current (Revised) Due Date	Progress Status	UPDATES for Quality & Safety Committee Wednesday 18th September 2024 Please submit all updates no later than close of business on Friday 23rd August 2024 Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards and PHW should work closely with Black and minority ethnic communities and people affected by socio-economic deprivation, to understand the specific issues they face with their increased risk of stroke and in accessing preventative care and ensure ongoing engagement with them to support better health outcomes.	CTM UHB will continue to engage with PHW and Health Boards across Wales through the national network to support a co-ordinated approach to effective engagement with Black and minority ethnic communities and people affected by socio-economic deprivation, to understand the specific issues they face. Listening to all our communities and increased engagement is a key part of the CTM UHB Organisational Strategy Action Plan.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	August 2024 Update - "CTM UHB will continue to engage with PHW and Health Boards across Wales through the national network to support a co-ordinated approach to effective engagement with Black and minority ethnic communities and people affected by socio-economic deprivation, to understand the specific issues they face. Listening to all our communities and increased engagement is a key part of the CTM UHB Organisational Strategy Action Plan."
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Welsh Government, health boards and 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	01.04.2024	Fully complete (Awaiting approval)	August 2024 Update - Completed and Signed off by DoN for USC as achieved and ongoing. Formal closure will be confirmed once received at the Quality & Safety Committee on the 18th September 2024.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must communicate with each other to establish the good practices taking in place in some hospitals for the robust management of patient flow. This includes the implementation of effective action plans to manage daily discharges, which remain active throughout the day, and in planning for subsequent days.	Significant work is ongoing to ensure the robust management of patient flow. Each site has a well-established daily Safe2Start meeting which provides assurance around site based escalation, staffing, patient safety and clinical priorities. The meeting allows the identification of clinical priorities, including stroke patients, and time frames for movement to appropriate inpatient beds. All patient flow constraints are discussed and risk is shared across the acute inpatient wards and community sites in order to balance risk within the Emergency Department. This remains an action-focused meeting, with clear ownership and delivery prior to the afternoon meeting. As part of this work, under the 6 Goals national programme, the Safe2Start template has been revised to include SAFER, Red2Green and both internal and external delay metrics. There was a delay in launching the new template due to access required into SAFECARE to display nurse staffing levels, this is being worked through by informatics colleagues with the new template expected to be completed and implemented by November 2024. We have introduced Electronic Whiteboards on every ward that track each stage of discharge and highlights any blockages in the process. This information is an integrated tool across health and social care partners. As part of this work, we have also developed Optimise, a programme of work under the national 6goals programme to focus on value added care for patients, including a multi-professional approach to patient flow and Discharge to Recover then Assess (D2RA) pathways. We continue to share our approach with other Health Boards and bring back learning from good practice gleaned from other areas.	Unscheduled Care	01.11.2023	01.11.2023	Overdue	August 2024 Update - This work is ongoing and forms the central part of the stroke programme board - this is discussed in every other Q&S committee as part of the board update.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must review and consider timelier processes of prescribing take home medication and obtaining this promptly from pharmacy to minimise discharge delays. This should include planning well in advance of the scheduled time for discharge (such as the day before).	CTM UHB is aware that consideration needs to be given to dedicated specialist pharmacist support as part of our review of the Stroke Pathway. The Pharmacy Team are involved in conversations to improve communication regarding estimated dates of discharge and full MDT involvement/use of eWhiteboards, which includes planning the day before for potential discharges. Pharmacy colleagues are also part of the site based Safe2Start meetings, so they are aware of potential discharges across the acute sites early to prevent potential delays.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	August 2024 Update - CTM UHB is aware that consideration needs to be given to dedicated specialist pharmacist support as part of our review of the Stroke Pathway. The Pharmacy Team are involved in conversations to improve communication regarding estimated dates of discharge and full MDT involvement/use of eWhiteboards, which includes planning the day before for potential discharges. Pharmacy colleagues are also part of the site based Safe2Start meetings, so they are aware of potential discharges across the acute sites early to prevent potential delays.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should consider the benefits of dedicated 'discharge phlebotomy slots' for managing the necessary blood tests, to assist with effective and timelier discharge.	Currently, there is variation in the service provided across the CTM UHB footprint. In Princess of Wales Hospital, phlebotomy is provided through an SLA with Swansea Bay UHB. Prince Charles and Royal Glamorgan Hospitals' phlebotomy services are provided through CTM UHB. Further conversations will take place through the Stroke Programme Board/Operational Group to ascertain the feasibility of starting. Robust data would be required to evidence the implementation of this action which as yet we do not have and so this has not yet been progressed.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	August 2024 Update - this action is not being progressed as - Currently, there is variation in the service provided across the CTM UHB footprint. In Princess of Wales Hospital, phlebotomy is provided through an SLA with Swansea Bay UHB. Prince Charles and Royal Glamorgan Hospitals' phlebotomy services are provided through CTM UHB. Further conversations will take place through the Stroke Programme Board/Operational Group to ascertain the feasibility of starting. Robust data would be required to evidence the implementation of this action which as yet we do not have and so this has not yet been progressed.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must consider the benefits of Improvement Cymru's Real Time Demand Capacity methodology, and whether this would have a positive impact to implement (or to pilot) within all hospitals to help manage timelier patient flow.	Within Prince Charles Hospital there was a trial of the RTDC model with some positive effect supported by Improvement Cymru. There is a national move towards the North Bristol Trust model of continuous flow, which has been explored by the USC Group as an option which may have a positive impact on patient flow. We are currently collaborating with NHS Exec colleagues on the roll out of this, with the site planned for proof of concept being Royal Glamorgan. In order to undertake this piece of work, we need to understand the breakdown of our speciality demand and so informatics colleagues are supporting this piece of work which will be developed as an improvement project once relevant base line data is available.	Unscheduled Care	01.02.2024	31.12.2024	In progress	August 2024 Update - we remain in collaboration with the NHS exec on this however as an organisation we do not yet have predicted demand modelling available to us which constrains our ability to progress this work.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should reflect on their patient flow processes and consider whether improvements can be made with predictive methodology for demand in each of their hospital sites, such as with medical and surgical admissions.	CTM UHB has significant experience of using predictive methods to enhance patient and system outcomes. In building on this as part of the development of an USC Dashboard, which is now embedded for operational use, and the future development of an ED Electronic Whiteboard/Viewer, there is the ability to start to inform the USC leadership team around their predicted demand. Later developments will allow the breakdown of this into speciality and also to further explore surgical demand data. The Health Board continues to build on its use of data to enhance the provision of business intelligence on offer at all levels of the organisation, in order to scrutinise the demand and flow of patients through the system. These additional developments have been built into the Informatics IMTP proposals for 2024/2025.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	August 2024 Update - CTM UHB has significant experience of using predictive methods to enhance patient and system outcomes. In building on this as part of the development of an USC Dashboard, which is now embedded for operational use, and the future development of an ED Electronic Whiteboard/Viewer, there is the ability to start to inform the USC leadership team around their predicted demand. Later developments will allow the breakdown of this into speciality and also to further explore surgical demand data. The Health Board continues to build on its use of data to enhance the provision of business intelligence on offer at all levels of the organisation, in order to scrutinise the demand and flow of patients through the system. These additional developments have been built into the Informatics IMTP proposals for 2024/2025.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should consider whether a daily senior nursing/ clinical oversight for each directorate could be implemented to facilitate clinical issues with flow. This may help ensure staff are making timely progress to discharge patients, challenge medical staff to undertake key tasks where necessary, and help expedite any outstanding clinical patient needs. In addition, to commence planning for patient discharge on subsequent days.	See also response to Rec 5. Within the USC Group and under the umbrella of the national 6 Goals programme, there is a significant focus on patient flow, aligned to SAFER, Red2Green and right patient, right time, within work stream 3. Part of this work includes the implementation of a standardised process around board and ward rounds, with senior nursing and clinical teams having direct involvement with information relating to internal and external delays as part of this being captured on an electronic whiteboard which feeds into the afternoon Safe2Start site based meeting. This piece of work is Optimise and focuses of value added care. This work is ongoing and is large scale transformation with a detailed project plan and times lines for implementation that are monitored via 6goals Board.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	August 2024 Update - a proposal has been shared with the board for extension of the CNS workforce with Senior nurse oversight. this requires resource allocation.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards and WAST should engage with people to better understand the barriers to them accessing, or choosing, from the range of healthcare services available in Wales. Once the barriers are understood, this in turn, could be used to influence service design.	Listening to our communities and understanding their experiences is a key part of the CTM UHB Organisational Strategy Action Plan. As part of CTM2030 and our Acute Clinical Services Plan there will be multiple opportunities to engage with our communities in order to influence service design.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	August 2024 Update - Listening to our communities and understanding their experiences is a key part of the CTM UHB Organisational Strategy Action Plan. As part of CTM2030 and our Acute Clinical Services Plan there will be multiple opportunities to engage with our communities in order to influence service design.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should seek assurance that their MIUs and ED departments ensure all reception staff have received up to date Act FAST training, and they are competent with this. In addition, that appropriate escalation process is in place if a receptionist is or is not sure a patient may be suffering with a stroke.	Due to significant changes within CTM in relation to a large scale OCP process with multiple changes to staff groups and lines of reporting the review of current training in relation to Act FAST training has not yet taken place. This is scheduled to start in the next month with an aim for completion by September. There is also a national e-triage system being implemented which may prevent the need for this in future, as stroke symptoms are built in as part of 'red flagging' leading to an appropriate clinical triage category for patients who are symptomatic of a stroke.	Unscheduled Care	01.10.2024	01.10.2024	In progress	August 2024 Update - this work remains a focus and is part of ongoing discussions as programme board - Due to significant changes within CTM in relation to a large scale OCP process with multiple changes to staff groups and lines of reporting the review of current training in relation to Act FAST training has not yet taken place. This is scheduled to start in the next month with an aim for completion by September. There is also a national e-triage system being implemented which may prevent the need for this in future, as stroke symptoms are built in as part of 'red flagging' leading to an appropriate clinical triage category for patients who are symptomatic of a stroke.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	WAST and all health boards must work collaboratively to identify a consistent approach to ensure handover of stroke patients is made within the Welsh Government 15-minute target. This is to ensure that time critical investigations and treatment are undertaken promptly.	Collaborative working with WAST continues as part of the CTM UHB Stroke Programme Board/Stroke Operational Group to collaboratively identify and implement a consistent pathway for stroke patients, both confirmed and query arriving at our emergency departments. In addition, we are currently reviewing our nurse specialist provision in order to create capacity to better support the early handover of stroke patients and transfer directly to time critical investigations.	Unscheduled Care	01.10.2024	31.01.2025	In progress	August 2024 Update - collaborative work with WAST in relation to patient pathways is ongoing.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Welsh Government should work collaboratively with WAST, health boards and social care providers to evaluate and strengthen the current processes in place to improve flow through health and care systems, with a concerted focus on the analysis of flow, the bottlenecks impeding flow and the issues with achieving timely discharge.	This action remains ongoing as stroke and flow performance indicators continue to form part of regular performance meetings with Welsh Government, resulting in scrutiny and discussion. In addition, CTM UHB is working with the NHS Wales Executive Performance and Assurance Directorate regarding stroke performance and the nation review of self-presenters. Recently reviewed data (as per below *table removed for AMaT purposes*), shows a decrease in patients self-presenting to CTM for Stroke, which in theory should enable a more efficient stroke pathway across PoW and PCH where we have stroke provision.	Unscheduled Care	01.10.2024	01.10.2024	In progress	August 2024 Update - this remain ongoing - This action remains ongoing as stroke and flow performance indicators continue to form part of regular performance meetings with Welsh Government, resulting in scrutiny and discussion. In addition, CTM UHB is working with the NHS Wales Executive Performance and Assurance Directorate regarding stroke performance and the nation review of self-presenters. Recently reviewed data (as per below *table removed for AMaT purposes*), shows a decrease in patients self-presenting to CTM for Stroke, which in theory should enable a more efficient stroke pathway across PoW and PCH where we have stroke provision.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that ED staff undertake the triage of patients within the 15-minute target time. Where this has not been possible, it should be clearly documented 'why not' within the patient's clinical record.	Triage within 15 minutes is a national tier one target and quality metric that we always strive to achieve. If not possible, additional resource is allocated to mitigate where possible. Any delays in triage is captured via ED huddles and site management patient safety reports, which are escalated to the Flow Manager of the day and the Exec on call to explore mitigations and actions to reduce any delays. Implementation of e-triage will minimise delays as patients will self-triage and be clinically prioritised following this. If triage times are starting to escalate then additional nursing resource is allocated to support.	Unscheduled Care	01.10.2024	01.10.2024	In progress	August 2024 Update - Triage within 15 minutes is a national tier one target and quality metric that we always strive to achieve. If not possible, additional resource is allocated to mitigate where possible. Any delays in triage is captured via ED huddles and site management patient safety reports, which are escalated to the Flow Manager of the day and the Exec on call to explore mitigations and actions to reduce any delays. Implementation of e-triage will minimise delays as patients will self-triage and be clinically prioritised following this. If triage times are starting to escalate then additional nursing resource is allocated to support.

HIW Inspections Recommendations Tracker - Request for updates by Friday 23rd August 2024
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Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Original Due Date	Current (Revised) Due Date	Progress Status	UPDATES for Quality & Safety Committee Wednesday 18th September 2024 Please submit all updates no later than close of business on Friday 23rd August 2024 Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that medical staff who carry the bleep for stroke alerts recognise the urgency of both thrombolysis and non-thrombolysis stroke calls. A patient may still be symptomatic whilst out of the thrombolysis window but may still be within the thrombectomy time frame. This is particularly important if a referral tertiary centre is relatively close to the ED.	Significant work is ongoing within CTM UHB to review the clinical workforce required to review stroke patients within the ED. Work continues to ensure we have the right workforce with the right skills and attributes to support early recognition and treatment of stroke. Patients eligible for thrombectomy are described in the thrombectomy pathway, which forms part of teaching given to junior doctors and the stroke CNS team who carry the bleep for stroke alerts. The Unscheduled Care Group have developed a case for change to create additional ACP capacity to support urgent stroke alerts and more timely progress through the stroke pathway.	Unscheduled Care	01.01.2025	01.01.2025	In progress	August 2024 Update - Case submitted to Board in January 2024 and rejected - Significant work is ongoing within CTM UHB to review the clinical workforce required to review stroke patients within the ED. Work continues to ensure we have the right workforce with the right skills and attributes to support early recognition and treatment of stroke. Patients eligible for thrombectomy are described in the thrombectomy pathway, which forms part of teaching given to junior doctors and the stroke CNS team who carry the bleep for stroke alerts. The Unscheduled Care Group have developed a case for change to create additional ACP capacity to support urgent stroke alerts and more timely progress through the stroke pathway.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should review the provision of the CNS or ANP stroke specialist service at each acute site and consider how they can maximise their availability throughout the stroke service.	Within CTM, a review of the CNS Stroke workforce has been undertaken with recommendations made to significantly increase the workforce but it is recognised that this requires significant additional resource. This paper has been refreshed to develop an ACP workforce over extended hours to support early recognition and treatment of stroke patients. Ongoing workforce modernisation is underway to ensure we have the right workforce with the right skills and attributes looking after our patients.	Unscheduled Care	01.01.2025	01.01.2025	In progress	August 2024 Update - case submitted to board in January 2024 - Within CTM, a review of the CNS Stroke workforce has been undertaken with recommendations made to significantly increase the workforce but it is recognised that this requires significant additional resource. This paper has been refreshed to develop an ACP workforce over extended hours to support early recognition and treatment of stroke patients. Ongoing workforce modernisation is underway to ensure we have the right workforce with the right skills and attributes looking after our patients.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should ensure that EDs track and monitor all patients arriving at hospital with a suspected stroke (by ambulance and self-presenting), to drive improvement on assessment times, so people can commence on the stroke pathway in a timely manner.	Work is underway to develop a patient alert system embedded in the Electronic White Board that will allow stroke wards to track and monitor suspected stroke patients from the Emergency Department. This is in an early development phase and development and progress is monitored via the 6 Goals Programme Board.	Unscheduled Care	01.01.2025	01.01.2025	In progress	August 2024 Update - remains ongoing with digital team - Work is underway to develop a patient alert system embedded in the Electronic White Board that will allow stroke wards to track and monitor suspected stroke patients from the Emergency Department. This is in an early development phase and development and progress is monitored via the 6 Goals Programme Board.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that all relevant staff within EDs are trained and are competent to use the ROSIER assessment tool. In addition, that staff are consistently using a validated tool, such as ROSIER, to enable prompt differentiation with strokes or stroke mimics, such as TIA.	Work is ongoing within the USC Group to streamline processes and ensure the domains of quality are met across the organisation, with a focus on equity of treatment and patient outcomes. There is a comprehensive stroke pathway that are working to replicate on other sites working in collaboration with stroke teams and other relevant stakeholders to support standardisation where possible to ensure compliance with the ROSIER assessment tool.	Unscheduled Care	01.10.2024	31.01.2025	In progress	August 2024 Update - this remain a priority - Work is ongoing within the USC Group to streamline processes and ensure the domains of quality are met across the organisation, with a focus on equity of treatment and patient outcomes. There is a comprehensive stroke pathway that are working to replicate on other sites working in collaboration with stroke teams and other relevant stakeholders to support standardisation where possible to ensure compliance with the ROSIER assessment tool.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that ED staff fully and clearly complete the clinical diagnostic assessment tool for stroke	As part of ongoing work within the USC Group, actions are being developed to streamline processes and ensure the domains of quality are consistently met, with a focus on equity of treatment and patient outcomes. There is a comprehensive stroke pathway in place that we are working to replicate across all sites. This work is being done in collaboration with stroke teams and other relevant stakeholders to support the standardisation wherever possible and appropriate. This will ensure compliance with completing the clinical diagnostic tool for stroke.	Unscheduled Care	01.10.2024	31.01.2025	In progress	August 2024 Update - USC Care Group continue to work towards equity across our sites and this forms part of stroke programme board discussions.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	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.	Brainomix has been implemented within CTM UHB across all acute sites. This allows the stroke consultant on call to view CTs and CT angiograms from home on a mobile device and so reduce the delays in decisions on thrombolysis and thrombectomy.	Unscheduled Care	01.01.2024	01.01.2024	Fully complete (Awaiting approval)	August 2024 Update - Completed in June 2024. Signed off by DoN for USC. Formal closure will be confirmed once received at the Quality & Safety Committee on the 18th September 2024.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that the reason for delayed brain imaging is monitored and analysed for possible stroke patients to ensure scans are completed in a timely manner in line with NICE guidance.	The work of the CTM UHB Stroke Operational Group is ongoing in its analysis of the stroke pathway through from arrival at hospital front door to discharge. All breaches are reviewed to identify learning and any associated actions. The work of the group will include implementation of processes to monitor delays in the pathway for scans and actions to address.	Unscheduled Care	01.01.2024	01.01.2024	Overdue	August 2024 Update - this work is continuous - The work of the CTM UHB Stroke Operational Group is ongoing in its analysis of the stroke pathway through from arrival at hospital front door to discharge. All breaches are reviewed to identify learning and any associated actions. The work of the group will include implementation of processes to monitor delays in the pathway for scans and actions to address.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	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.	Due to the National Clinical Guideline changing again this will be refreshed and 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	31.10.2024	Fully complete (Awaiting approval)	August 2024 Update - closed - updated guidance in wide use, Closure agreed by USC DoN.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that 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	01.10.2024	Fully complete (Awaiting approval)	August 2024 Update - Completed in June 2024. Signed off by DoN for USC. Formal closure will be confirmed once received at the Quality & Safety Committee on the 18th September 2024.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that all possible stroke patients who are clinically appropriate for thrombolysis, receive treatment in a timely manner.	Within CTM UHB stroke pathway, all patients presenting inside of the thrombolysis window (Code 1 stroke) are to be reviewed by the medical registrar, Stroke CNS and Stroke Consultant on arrival. In hours, the target is to administer thrombolysis within the 45 minute guideline. There are delays out of hours due to waiting for Everlight to report CT scans. Work is ongoing to develop a more robust stroke Consultant rota with other Health Board colleagues and discussions are ongoing around resuming the regional Stroke Consultant rota. This would enable us to avoid Everlight delays by stat reporting by the stroke Consultants.	Unscheduled Care	01.10.2024	01.10.2024	In progress	August 2024 Update - USC Care Group continue to explore regional solutions however this remains multifaceted and complex - Within CTM UHB stroke pathway, all patients presenting inside of the thrombolysis window (Code 1 stroke) are to be reviewed by the medical registrar, Stroke CNS and Stroke Consultant on arrival. In hours, the target is to administer thrombolysis within the 45 minute guideline. There are delays out of hours due to waiting for Everlight to report CT scans. Work is ongoing to develop a more robust stroke Consultant rota with other Health Board colleagues and discussions are ongoing around resuming the regional Stroke Consultant rota. This would enable us to avoid Everlight delays by stat reporting by the stroke Consultants.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	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	01.04.2024	Fully complete (Awaiting approval)	August 2024 Update - Completed in June 2024. Signed off by DoN for USC. Formal closure will be confirmed once received at the Quality & Safety Committee on the 18th September 2024.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	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	01.04.2024	Fully complete (Awaiting approval)	August 2024 Update - closed - USC DoN advised closure as this is always documented.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must explore the options available to improve the process for prioritising stroke patient admissions to acute stroke wards within the four-hour target, to help maximise their clinical outcome.	As part of the Stroke Programme Board/Stroke Operational Group, there is ongoing transformation work around patient flow and prioritisation of stroke patients to meet the 4 hour target. This is a key improvement metric within CTM UHB and work will continue around exploring more extensive ring fencing of beds, early identification, and pull of patients from the Emergency Department. This work needs to be supported by workforce modernisation, digital enablers and resource allocation. A task and finish group has delivered a single pathway for patients self-presenting at RGH to transfer to the Stroke unit at PCH this in continuously monitored and re/evaluated as required.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	August 2024 Update - this work is ongoing as was a focus as part of the recent 'reset fortnight' - As part of the Stroke Programme Board/Stroke Operational Group, there is ongoing transformation work around patient flow and prioritisation of stroke patients to meet the 4 hour target. This is a key improvement metric within CTM UHB and work will continue around exploring more extensive ring fencing of beds, early identification, and pull of patients from the Emergency Department. This work needs to be supported by workforce modernisation, digital enablers and resource allocation. A task and finish group has delivered a single pathway for patients self-presenting at RGH to transfer to the Stroke unit at PCH this in continuously monitored and re/evaluated as required.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Ring fenced stroke beds are frequently used for non-stroke patients, which may impact on a new stroke admission to ED. Therefore, health boards must explore how a ring fenced stroke bed can be maintained, to help ensure the best outcome for a stroke patient following their arrival at ED.	As above, this continues to be a priority for CTM UHB, with non-stroke patients identified via a ward/board round, inputted into the electronic white board, and moved to the appropriate inpatient area. Ring-fenced capacity is identified at the twice daily cross site bed meetings and forms part of the out of hours and weekend planning cycle of the HB. Work is underway to better understand the risks/benefits of more extensive ring-fencing of stroke beds.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	August 2024 Update - this continues to be a priority - As above, this continues to be a priority for CTM UHB, with non-stroke patients identified via a ward/board round, inputted into the electronic white board, and moved to the appropriate inpatient area. Ring-fenced capacity is identified at the twice daily cross site bed meetings and forms part of the out of hours and weekend planning cycle of the HB. Work is underway to better understand the risks/benefits of more extensive ring-fencing of stroke beds.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards 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.	The ESD service is well established working out of Prince Charles Hospital. The expansion of ESD across the whole of CTM UHB has recently been implemented following HB investment. This service is reviewed in relation to capacity and patient outcomes via the stroke programme board structure.	Unscheduled Care	01.12.2023	01.12.2023	Fully complete (Awaiting approval)	August 2024 Update - Completed in June 2024. Signed off by DoN for USC. Formal closure will be confirmed once received at the Quality & Safety Committee on the 18th September 2024.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must review their therapies staffing models to ensure there are sufficient resources and staff in place to adequately manage the rehabilitation and recovery of stroke patients in line with NICE guidance.	Current therapies workforce data is being captured, with a review of therapy workforce provision to explore the best models for therapy provision. This is linked to recommendation 38 regarding need for funded 7 day service. In order to achieved this, a case for resource to expand ESD is being developed.	Unscheduled Care	01.01.2024	01.01.2024	Overdue	August 2024 Update - Current therapies workforce data is being captured, with a review of therapy workforce provision to explore the best models for therapy provision. This is linked to recommendation 38 regarding need for funded 7 day service. In order to achieved this, a case for resource to expand ESD is being developed.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must consider the need for psychological support for people with stroke, and that adequately trained staff can provide this support to help effectively manage patient recovery.	This service is fragile in CTM UHB and historical funding was for the north of the CTM footprint only, excluding Bridgend. The national withdrawal of the funding for the Community Neurorehabilitation service combined with maternity leave for a senior psychologist has led to the temporary cessation of the neuropsychology service to ESD patients within CTM. The Health Board remains committed to the ongoing development of the stroke pathway and consideration will be given to this aspect of the service as part of any redesign/investment opportunities.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	August 2024 Update - this remains ongoing - This service is fragile in CTM UHB and historical funding was for the north of the CTM footprint only, excluding Bridgend. The national withdrawal of the funding for the Community Neurorehabilitation service combined with maternity leave for a senior psychologist has led to the temporary cessation of the neuropsychology service to ESD patients within CTM. The Health Board remains committed to the ongoing development of the stroke pathway and consideration will be given to this aspect of the service as part of any redesign/investment opportunities.

HIW Inspections Recommendations Tracker - Request for updates by Friday 23rd August 2024
Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Original Due Date	Current (Revised) Due Date	Progress Status	UPDATES for Quality & Safety Committee Wednesday 18th September 2024 Please submit all updates no later than close of business on Friday 23rd August 2024 Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must consider introducing the provision of sufficient seven-day therapies services to comply with NICE guidance, to help improve patient flow by supporting a seven-day discharge for patients, and to help meet targets as highlighted within SSNAP.	CTM UHB currently offers a 5 day clinical model. A 7 day clinical model remains the ambition for the health board but requires identification of significant financial resource. This is linked to the response to recommendation 36. The Health Board remains committed to the ongoing development of the stroke pathway and consideration will be given to this aspect of the service as part of any redesign/investment opportunities.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	August 2024 Update - this remains ongoing - CTM UHB currently offers a 5 day clinical model. A 7 day clinical model remains the ambition for the health board but requires identification of significant financial resource. This is linked to the response to recommendation 36. The Health Board remains committed to the ongoing development of the stroke pathway and consideration will be given to this aspect of the service as part of any redesign/investment opportunities.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must ensure that stroke rehabilitation environments are appropriate and are adequate to meet the needs of patients.	Risk assessments have been submitted as part of the Health Board stroke action plan. Current rehabilitation space is sub-optimal and review of the stroke pathway includes detailed consideration of the environment and we are actively exploring options to address this. This action has been recognised as a risk and is regularly reviewed.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	August 2024 Update - we continue to review this as a risk -Risk assessments have been submitted as part of the Health Board stroke action plan. Current rehabilitation space is sub-optimal and review of the stroke pathway includes detailed consideration of the environment and we are actively exploring options to address this. This action has been recognised as a risk and is regularly reviewed.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must 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 are 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 integrated discharge delivery board, linking directly to oversight and improvement actions associated with pathway of care delays. The Red2Green and SAFER principles are being embedded into all board rounds pan-CTM to support timely patient review, planning and discharge when clinically optimised. This work is ongoing under the Optimise project and will be achieved on both stroke wards as per the project plan.	Unscheduled Care	01.11.2024	01.11.2024	Fully complete (Awaiting approval)	August 2024 Update - this can be closed - "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 are 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 integrated discharge delivery board, linking directly to oversight and improvement actions associated with pathway of care delays. The Red2Green and SAFER principles are being embedded into all board rounds pan-CTM to support timely patient review, planning and discharge when clinically optimised. This work is ongoing under the Optimise project and will be achieved on both stroke wards as per the project plan."
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards should ensure that staff are utilising the SAFER Patient Flow principles, to promote safe and timely discharge and help improve patient flow.	As previously stated, work is underway as part of the 6 Goals national programme for improvement to ensure early identification of any internal or external delays. Reflecting these on the electronic white board allows us to perform thematic analysis in order to positively impact delay issues themes. The Red2Green and SAFER principles are being embedded into all board rounds pan-CTM to support timely patient review, planning and discharge when clinically optimised.	Unscheduled Care	01.11.2024	01.11.2024	Fully complete (Awaiting approval)	August 2024 Update - this can be closed - As previously stated, work is underway as part of the 6 Goals national programme for improvement to ensure early identification of any internal or external delays. Reflecting these on the electronic white board allows us to perform thematic analysis in order to positively impact delay issues themes. The Red2Green and SAFER principles are being embedded into all board rounds pan-CTM to support timely patient review, planning and discharge when clinically optimised.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	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 Discharge to Recover then Assess pathways (D2RA), overseen by the integrated discharge delivery board. A referral and trusted assessor 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. An Integrated Discharge Policy and Procedure was agreed in April 2024 by sovereign agencies and the Regional Partnership Board. The policy was written collaboratively and based on Welsh Government Guidance: Hospital Discharge Guidance December 2023, All-Wales Optimal Hospital Patient Flow Framework, D2RA Principles and Standards and Trusted Assessor Role Guidance. A comprehensive integrated training and roll out plan is in place which includes quality audits to ensure compliance and effectiveness.	Unscheduled Care	01.03.2024	01.03.2024	Fully complete (Awaiting approval)	August 2024 Update - Completed in June 2024. Signed off by DoN for USC. Formal closure will be confirmed once received at the Quality & Safety Committee on the 18th September 2024.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health Boards must work collaboratively with social 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 the implementation of D2RA, a supported discharge notification (SDN) has been created to identify patients who require support from a social worker. These cases are triaged in the discharge hub. Proportionate assessment in an acute setting is promoted through the use of the trusted assessor model. 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. Trusted Assessors are being trained to screen SDNs to ensure that SW allocation is appropriate to patient needs and supports a straight OT service model through the integrated proportionate assessment.	Unscheduled Care	01.12.2023	01.12.2023	Fully complete (Awaiting approval)	August 2024 Update - Completed in June 2024. Signed off by DoN for USC. Formal closure will be confirmed once received at the Quality & Safety Committee on the 18th September 2024.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must work collaboratively with social workers and social care providers to ensure that delays in arranging or holding Best Interest Meetings are minimised, to ensure timely and effective hospital discharge for patients to improve flow.	As part of the D2RA improvement programme, a task and finish group was set up to improve delays in the overall Mental Capacity Act process, including Best Interest meetings and associated Court of Protection proceedings. A training programme has been rolled out across social care and the Health Board. Delays are monitored though EWB and escalated as previously outlined. Timescales have been collaboratively agreed across health and social care of a 21 day maximum assessment period for Pathway 3 patients, which include MCA processes.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	August 2024 Update - significant work ongoing under the optimise project to address MCA challenges with supported intervention from Head of nursing ot maintain training and standards on their sites.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must develop and strengthen Home First services across Wales to benefit the people who need this across Wales, and to help manage the issues with patient flow through health and social care systems.	Implementation of D2RA in CTM UHB has widely promoted the increase of Home First pathways. Awareness and engagement sessions have been held with nearly 500 staff. Key questions to increase update for Pathway 1 are included on board round guidance as well as guidance on selection of pathway. We continue to monitor the volume of home first pathways, with a balance to bed based pathways with the trend shown below (*table removed for AMaT purposes).	Unscheduled Care	01.04.2024	01.04.2024	Overdue	August 2024 Update - this is ongoing - Implementation of D2RA in CTM UHB has widely promoted the increase of Home First pathways. Awareness and engagement sessions have been held with nearly 500 staff. Key questions to increase update for Pathway 1 are included on board round guidance as well as guidance on selection of pathway. We continue to monitor the volume of home first pathways, with a balance to bed based pathways with the trend shown below (*table removed for AMaT purposes).
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Welsh Government, health boards and local authorities must work collaboratively to consider the options of improving the accessibility to care in the community, such as domiciliary care.	A targeted improvement plan has been created through the Integrated Discharge Delivery Board that also reports directly in the 6GUEC board, the Integrated Adults and then into the Regional Partnership Board. Specific improvement has been identified for accessibility for intermediate care, domiciliary care and care homes. This action plan escalates activity highlighted through the market stability statement published by the region. A PoCD action plan addressing community delays has been collaboratively agreed with all partners. A work programme in line with WG guidance for Enhanced Community Care has been set up under an Integrated Director.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	August 2024 Update - this is ongoing but being prioritised - "A targeted improvement plan has been created through the Integrated Discharge Delivery Board that also reports directly in the 6GUEC board, the Integrated Adults and then into the Regional Partnership Board. Specific improvement has been identified for accessibility for intermediate care, domiciliary care and care homes. This action plan escalates activity highlighted through the market stability statement published by the region. A PoCD action plan addressing community delays has been collaboratively agreed with all partners. A work programme in line with WG guidance for Enhanced Community Care has been set up under an Integrated Director."
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must consider their discharge lounge services and whether they are utilised efficiently and effectively to support timely discharge to improve patient flow.	The USC group continue to review inpatient bed base and patient flow to better understand the requirement for discharge lounges. Planned/predicted discharges are identified through the cross site bed meetings, in addition they form part of the out of hours and weekend planning cycle. There is a discharge lounge in place in POW and we are exploring the feasibility of further discharge lounges on the other two sites, recognising that capital and revenue investment would be required.	Unscheduled Care	01.01.2024	01.01.2024	Overdue	August 2024 Update - this remains ongoing and requires capital funds - The USC group continue to review inpatient bed base and patient flow to better understand the requirement for discharge lounges. Planned/predicted discharges are identified through the cross site bed meetings, in addition they form part of the out of hours and weekend planning cycle. There is a discharge lounge in place in POW and we are exploring the feasibility of further discharge lounges on the other two sites, recognising that capital and revenue investment would be required.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health board must identify the hospital sites that do not have a discharge lounge service and should consider the benefits of implementing this service on improving patient flow.	As above, the USC group continue to review inpatient bed base and patient flow to better understand the requirement for discharge lounges across our sites. Planned/predicted discharges are identified through the cross site bed meetings and form part of the out of hours and weekend planning cycle. There is a discharge lounge in place in POW and we are exploring the feasibility of further discharge lounges on the other two sites, recognising that capital and revenue investment would be required.	Unscheduled Care	01.01.2024	01.01.2024	Overdue	August 2024 Update -As above, the USC group continue to review inpatient bed base and patient flow to better understand the requirement for discharge lounges across our sites. Planned/predicted discharges are identified through the cross site bed meetings and form part of the out of hours and weekend planning cycle. There is a discharge lounge in place in POW and we are exploring the feasibility of further discharge lounges on the other two sites, recognising that capital and revenue investment would be required.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	Health boards must assure themselves that ward staff are promptly declaring a fully completed patient discharge within the electronic patient systems once they have left the ward. This is to enable patient flow managers to see that a bed as become available, to help manage timely patient flow.	The electronic Whiteboard developed under the 6 Goals programme allows the site management team to see when a discharge has completed. As part of ongoing improvement to the system, there is an ambition for future versions to include a 'push report' that would notify the site team that a patient has been discharged.	Unscheduled Care	01.10.2024	01.10.2024	In progress	August 2024 Update - this work is ongoing with digital colleagues - The electronic Whiteboard developed under the 6 Goals programme allows the site management team to see when a discharge has completed. As part of ongoing improvement to the system, there is an ambition for future versions to include a 'push report' that would notify the site team that a patient has been discharged.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	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	01.04.2024	Fully complete (Awaiting approval)	August 2024 Update - Signed off by DoN for USC. Formal closure will be confirmed once received at the Quality & Safety Committee on the 18th September 2024.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	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	01.04.2024	Fully complete (Awaiting approval)	August 2024 Update - Signed off by DoN for USC. Formal closure will be confirmed once received at the Quality & Safety Committee on the 18th September 2024.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	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	01.04.2024	Fully complete (Awaiting approval)	August 2024 Update - Signed off by DoN for USC. Formal closure will be confirmed once received at the Quality & Safety Committee on the 18th September 2024.

HIW Inspections Recommendations Tracker - Request for updates by Friday 23rd August 2024
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Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Original Due Date	Current (Revised) Due Date	Progress Status	UPDATES for Quality & Safety Committee Wednesday 18th September 2024 Please submit all updates no later than close of business on Friday 23rd August 2024 Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	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	01.04.2024	Fully complete (Awaiting approval)	August 2024 Update - Signed off by DoN for USC. Formal closure will be confirmed once received at the Quality & Safety Committee on the 18th September 2024.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	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	01.04.2024	Fully complete (Awaiting approval)	August 2024 Update - Signed off by DoN for USC. Formal closure will be confirmed once received at the Quality & Safety Committee on the 18th September 2024.
Healthcare Inspectorate Wales (HIW)/2023/155	07.09.2023	National Review of Patient Flow - a journey through the stroke pathway	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	01.04.2024	Fully complete (Awaiting approval)	August 2024 Update - Signed off by DoN for USC. Formal closure will be confirmed once received at the Quality & Safety Committee on the 18th September 2024.
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	31.12.2023	Fully complete (Awaiting approval)	August 2024 - Complete - Process established.
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)]	The health board should display information on healthy eating and smoking cessation.	Health promotion board on display on Childrens ward. Healthy diet and smoking risks, with signposting for additional advice and support will be added to the health promotion board.	Children & Families	31.12.2023	31.08.2024	Overdue	August 2024 Update - refurbishment of area now complete. Awaiting display boards and once in situ this action will be completed.
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 & Learning Disabilities	01.04.2024	01.04.2024	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angelton Clinic, Glanrhyd Hospital (Ref: 03445)	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 & Learning Disabilities	28.12.2023	28.12.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angelton Clinic, Glanrhyd Hospital (Ref: 03445)	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 & Learning Disabilities	28.12.2023	28.12.2023	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angelton Clinic, Glanrhyd Hospital (Ref: 03445)	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 & Learning Disabilities	01.01.2024	01.01.2024	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angelton Clinic, Glanrhyd Hospital (Ref: 03445)	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 & Learning Disabilities	28.12.2023	28.12.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angelton Clinic, Glanrhyd Hospital (Ref: 03445)	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 & Learning Disabilities	28.12.2023	28.12.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angelton Clinic, Glanrhyd Hospital (Ref: 03445)	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 & Learning Disabilities	28.12.2023	28.12.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angelton Clinic, Glanrhyd Hospital (Ref: 03445)	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 & Learning Disabilities	28.12.2023	28.12.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angelton Clinic, Glanrhyd Hospital (Ref: 03445)	•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 & Learning Disabilities	28.12.2023	28.12.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angelton Clinic, Glanrhyd Hospital (Ref: 03445)	•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 & Learning Disabilities	01.01.2024	01.01.2024	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angelton Clinic, Glanrhyd Hospital (Ref: 03445)	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 & Learning Disabilities	28.12.2023	28.12.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angelton Clinic, Glanrhyd Hospital (Ref: 03445)	•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 & Learning Disabilities	28.12.2023	28.12.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angelton Clinic, Glanrhyd Hospital (Ref: 03445)	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 & Learning Disabilities	28.12.2023	28.12.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Original Due Date	Current (Revised) Due Date	Progress Status	UPDATES for Quality & Safety Committee Wednesday 18th September 2024 Please submit all updates no later than close of business on Friday 23rd August 2024 Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angelton Clinic, Glanrhyd Hospital (Ref: 03445)	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 & Learning Disabilities	28.12.2023	28.12.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angelton Clinic, Glanrhyd Hospital (Ref: 03445)	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 & Learning Disabilities	28.12.2023	28.12.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angelton Clinic, Glanrhyd Hospital (Ref: 03445)	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 & Learning Disabilities	28.12.2023	28.12.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angelton Clinic, Glanrhyd Hospital (Ref: 03445)	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 & Learning Disabilities	28.12.2023	28.12.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angelton Clinic, Glanrhyd Hospital (Ref: 03445)	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 & Learning Disabilities	28.12.2023	28.12.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angelton Clinic, Glanrhyd Hospital (Ref: 03445)	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 & Learning Disabilities	28.12.2023	28.12.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angelton Clinic, Glanrhyd Hospital (Ref: 03445)	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 & Learning Disabilities	28.12.2023	28.12.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angelton Clinic, Glanrhyd Hospital (Ref: 03445)	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 & Learning Disabilities	28.12.2023	28.12.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angelton Clinic, Glanrhyd Hospital (Ref: 03445)	The health board must ensure that 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 & Learning Disabilities	28.12.2023	28.12.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angelton Clinic, Glanrhyd Hospital (Ref: 03445)	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 & Learning Disabilities	28.12.2023	28.12.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angelton Clinic, Glanrhyd Hospital (Ref: 03445)	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 & Learning Disabilities	28.12.2023	28.12.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angelton Clinic, Glanrhyd Hospital (Ref: 03445)	The health board must ensure that hospital systems and processes can be suitably filtered to extract ward specific data to support effective supervision, governance oversight and shared learning.	The incident management system Datix Cloud IQ can be filtered down to show specific data relating to areas, incident type and severity. The Head of Nursing is working with the Patient Care and Safety Business Intelligence officer to ensure all Lead Nurse, Senior Nurse and ward Managers have access to and training on Datix dashboards.	Mental Health & Learning Disabilities	31.01.2024	10.07.2024	Overdue	August 2024 Update - The HoN is working with the Business Intelligence Manager in the Patient Care and Safety team on the development of a Quality Dashboard, the mapping of the new Care Group structure is complete and we are awaiting implementation.
Healthcare Inspectorate Wales (HIW)/2023/157	13.11.2023	Appendix C - Improvement Plan: Angelton Clinic, Glanrhyd Hospital (Ref: 03445)	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.	Mental Health & Learning Disabilities	28.12.2023	28.12.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
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 & Learning Disabilities	09.01.2024	09.01.2024	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 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	Mental Health & Learning Disabilities	09.01.2024	09.01.2024	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Original Due Date	Current (Revised) Due Date	Progress Status	UPDATES for Quality & Safety Committee Wednesday 18th September 2024 Please submit all updates no later than close of business on Friday 23rd August 2024 Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT
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 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.	Mental Health & Learning Disabilities	09.01.2024	09.01.2024	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 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 insigniad 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	Mental Health & Learning Disabilities	28.02.2024	28.02.2024	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.
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 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 & Learning Disabilities	30.06.2024	30.06.2024	Overdue	August 2024 - MHLD to update in readiness for next report.
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 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	Mental Health & Learning Disabilities	09.01.2024	09.01.2024	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 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 & Learning Disabilities	09.01.2024	09.01.2024	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 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	Mental Health & Learning Disabilities	09.01.2024	09.01.2024	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 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	Mental Health & Learning Disabilities	09.01.2024	09.01.2024	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 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 & Learning Disabilities	09.01.2024	09.01.2024	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.

HIW Inspections Recommendations Tracker - Request for updates by Friday 23rd August 2024
Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Original Due Date	Current (Revised) Due Date	Progress Status	UPDATES for Quality & Safety Committee Wednesday 18th September 2024 Please submit all updates no later than close of business on Friday 23rd August 2024 Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT
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 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 & Learning Disabilities	30.04.2024	30.04.2024	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.
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 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.	Mental Health & Learning Disabilities	09.01.2024	09.01.2024	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 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 & Learning Disabilities	01.06.2024	01.06.2024	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in August 2024.
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 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 & Learning Disabilities	31.03.2024	31.03.2024	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in August 2024.
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 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	Mental Health & Learning Disabilities	09.01.2024	09.01.2024	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 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	Mental Health & Learning Disabilities	09.01.2024	09.01.2024	Fully complete (Awaiting approval)	The completion of this action was pre care group reconfiguration and the MHLD are providing confimration of the closure sign off at the relevant QSRE meeting.
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 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 & Learning Disabilities	31.03.2024	31.03.2024	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in May 2024
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 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.	Mental Health & Learning Disabilities	31.01.2024	31.01.2024	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in August 2024.
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 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.	Mental Health & Learning Disabilities	28.02.2024	28.02.2024	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.
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	28.12.2023	Fully complete (Awaiting approval)	August 2024 - Complete - HIW have confirmed in a letter to the Health Board on the 25th July 2024 that they have evaluated the updated Improvement Plan and concluded that it provides sufficient assurance. All actions relating to the Tirion Birth Centre are now closed.
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.	Finance secured and replacement blinds ordered.	Children & Families	01.02.2024	01.02.2024	Fully complete (Awaiting approval)	August 2024 - Complete - HIW have confirmed in a letter to the Health Board on the 25th July 2024 that they have evaluated the updated Improvement Plan and concluded that it provides sufficient assurance. All actions relating to the Tirion Birth Centre are now closed.
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.	AMAT environmental audit undertaken monthly.	Children & Families	28.12.2023	28.12.2023	Fully complete (Awaiting approval)	August 2024 - Complete - HIW have confirmed in a letter to the Health Board on the 25th July 2024 that they have evaluated the updated Improvement Plan and concluded that it provides sufficient assurance. All actions relating to the Tirion Birth Centre are now closed.

HIW Inspections Recommendations Tracker - Request for updates by Friday 23rd August 2024
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Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Original Due Date	Current (Revised) Due Date	Progress Status	UPDATES for Quality & Safety Committee Wednesday 18th September 2024 Please submit all updates no later than close of business on Friday 23rd August 2024 Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT
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.	Tirion to be added to the RGH site rolling maintenance programme for paintwork.	Children & Families	28.12.2023	28.12.2023	Fully complete (Awaiting approval)	August 2024 - Complete - HIW have confirmed in a letter to the Health Board on the 25th July 2024 that they have evaluated the updated Improvement Plan and concluded that it provides sufficient assurance. All actions relating to the Tirion Birth Centre are now closed.
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.	Environment included within rolling programme of Purposeful Visiting annually.	Children & Families	28.12.2023	28.12.2023	Fully complete (Awaiting approval)	August 2024 - Complete - HIW have confirmed in a letter to the Health Board on the 25th July 2024 that they have evaluated the updated Improvement Plan and concluded that it provides sufficient assurance. All actions relating to the Tirion Birth Centre are now closed.
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 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	01.12.2023	Fully complete (Awaiting approval)	August 2024 - Complete - HIW have confirmed in a letter to the Health Board on the 25th July 2024 that they have evaluated the updated Improvement Plan and concluded that it provides sufficient assurance. All actions relating to the Tirion Birth Centre are now closed.
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 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.	Identify all welsh speaking members of Tirion staff to ensure appropriate uniform with iaith gwaith logo.	Children & Families	01.02.2024	01.02.2024	Fully complete (Awaiting approval)	August 2024 - Complete - HIW have confirmed in a letter to the Health Board on the 25th July 2024 that they have evaluated the updated Improvement Plan and concluded that it provides sufficient assurance. All actions relating to the Tirion Birth Centre are now closed.
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 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.	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	28.12.2023	Fully complete (Awaiting approval)	August 2024 - Complete - HIW have confirmed in a letter to the Health Board on the 25th July 2024 that they have evaluated the updated Improvement Plan and concluded that it provides sufficient assurance. All actions relating to the Tirion Birth Centre are now closed.
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 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.	Implement use of an iPad to support translation and interpreting services for non-English speakers.	Children & Families	28.12.2023	28.12.2023	Fully complete (Awaiting approval)	August 2024 - Complete - HIW have confirmed in a letter to the Health Board on the 25th July 2024 that they have evaluated the updated Improvement Plan and concluded that it provides sufficient assurance. All actions relating to the Tirion Birth Centre are now closed.
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 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.	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	01.03.2024	Fully complete (Awaiting approval)	August 2024 - Complete - HIW have confirmed in a letter to the Health Board on the 25th July 2024 that they have evaluated the updated Improvement Plan and concluded that it provides sufficient assurance. All actions relating to the Tirion Birth Centre are now closed.
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 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.	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	28.12.2023	Fully complete (Awaiting approval)	August 2024 - Complete - HIW have confirmed in a letter to the Health Board on the 25th July 2024 that they have evaluated the updated Improvement Plan and concluded that it provides sufficient assurance. All actions relating to the Tirion Birth Centre are now closed.
Healthcare Inspectorate Wales (HIW)/2023/159	19.10.2023	Appendix C - Improvement Plan: Tirion Birth Centre, Royal Glamorgan Hospital (Ref: 03061)	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	30.09.2024	Fully complete (Awaiting approval)	August 2024 - Complete - HIW have confirmed in a letter to the Health Board on the 25th July 2024 that they have evaluated the updated Improvement Plan and concluded that it provides sufficient assurance. All actions relating to the Tirion Birth Centre are now closed.
Healthcare Inspectorate Wales (HIW)/2023/159	19.10.2023	Appendix C - Improvement Plan: Tirion Birth Centre, Royal Glamorgan Hospital (Ref: 03061)	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.	Baby Abduction drill planned: Table-top baby abduction drill & local baby abduction drill.	Children & Families	01.12.2024	01.12.2024	Fully complete (Awaiting approval)	August 2024 - Complete - HIW have confirmed in a letter to the Health Board on the 25th July 2024 that they have evaluated the updated Improvement Plan and concluded that it provides sufficient assurance. All actions relating to the Tirion Birth Centre are now closed.
Healthcare Inspectorate Wales (HIW)/2023/159	19.10.2023	Appendix C - Improvement Plan: Tirion Birth Centre, Royal Glamorgan Hospital (Ref: 03061)	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.	Baby Abduction drill planned: Full baby abduction drill	Children & Families	01.01.2024	01.01.2024	Fully complete (Awaiting approval)	August 2024 - Complete - HIW have confirmed in a letter to the Health Board on the 25th July 2024 that they have evaluated the updated Improvement Plan and concluded that it provides sufficient assurance. All actions relating to the Tirion Birth Centre are now closed.
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 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	28.12.2023	Fully complete (Awaiting approval)	August 2024 - Complete - HIW have confirmed in a letter to the Health Board on the 25th July 2024 that they have evaluated the updated Improvement Plan and concluded that it provides sufficient assurance. All actions relating to the Tirion Birth Centre are now closed.
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 raise awareness of facilities, outcomes and satisfaction levels of women that have used Tirion Birth Centre with wider colleagues from across the health board.	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	28.12.2023	Fully complete (Awaiting approval)	August 2024 - Complete - HIW have confirmed in a letter to the Health Board on the 25th July 2024 that they have evaluated the updated Improvement Plan and concluded that it provides sufficient assurance. All actions relating to the Tirion Birth Centre are now closed.
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 raise awareness of facilities, outcomes and satisfaction levels of women that have used Tirion Birth Centre with wider colleagues from across the health board.	Family stories shared at departmental meetings/forums.	Children & Families	28.12.2023	28.12.2023	Fully complete (Awaiting approval)	August 2024 - Complete - HIW have confirmed in a letter to the Health Board on the 25th July 2024 that they have evaluated the updated Improvement Plan and concluded that it provides sufficient assurance. All actions relating to the Tirion Birth Centre are now closed.
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 raise awareness of facilities, outcomes and satisfaction levels of women that have used Tirion Birth Centre with wider colleagues from across the health board.	Tirion 'marketing' video developed and shares family's experiences of using Tirion.	Children & Families	28.12.2023	28.12.2023	Fully complete (Awaiting approval)	August 2024 - Complete - HIW have confirmed in a letter to the Health Board on the 25th July 2024 that they have evaluated the updated Improvement Plan and concluded that it provides sufficient assurance. All actions relating to the Tirion Birth Centre are now closed.
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 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	28.12.2023	Fully complete (Awaiting approval)	August 2024 - Complete - HIW have confirmed in a letter to the Health Board on the 25th July 2024 that they have evaluated the updated Improvement Plan and concluded that it provides sufficient assurance. All actions relating to the Tirion Birth Centre are now closed.
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 audit, update and share guidelines and policies related maternity care.	Guideline Service Group produces an annual plan of work to ensure timely review of guidelines.	Children & Families	01.01.2024	01.01.2024	Fully complete (Awaiting approval)	August 2024 - Complete - HIW have confirmed in a letter to the Health Board on the 25th July 2024 that they have evaluated the updated Improvement Plan and concluded that it provides sufficient assurance. All actions relating to the Tirion Birth Centre are now closed.
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 audit, update and share guidelines and policies related maternity care.	Staff updated via email and staff social media Comms to ensure awareness of extension of these guidelines.	Children & Families	01.01.2024	01.01.2024	Fully complete (Awaiting approval)	August 2024 - Complete - HIW have confirmed in a letter to the Health Board on the 25th July 2024 that they have evaluated the updated Improvement Plan and concluded that it provides sufficient assurance. All actions relating to the Tirion Birth Centre are now closed.
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 audit, update and share guidelines and policies related maternity care.	There is a maternity/ gynaecology/ISH guideline group which monitors guidelines which are coming out of date.	Children & Families	28.12.2023	28.12.2023	Fully complete (Awaiting approval)	August 2024 - Complete - HIW have confirmed in a letter to the Health Board on the 25th July 2024 that they have evaluated the updated Improvement Plan and concluded that it provides sufficient assurance. All actions relating to the Tirion Birth Centre are now closed.
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 & Learning Disabilities	13.11.2023	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (Ref: 03362)	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 & Learning Disabilities	13.11.2023	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (Ref: 03362)	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.	Mental Health & Learning Disabilities	13.11.2023	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.

HIW Inspections Recommendations Tracker - Request for updates by Friday 23rd August 2024
Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Original Due Date	Current (Revised) Due Date	Progress Status	UPDATES for Quality & Safety Committee Wednesday 18th September 2024 Please submit all updates no later than close of business on Friday 23rd August 2024 Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (Ref: 03362)	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 & Learning Disabilities	01.05.2024	01.05.2024	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (Ref: 03362)	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 & Learning Disabilities	13.11.2023	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (Ref: 03362)	The health board must ensure any required repairs and maintenance are undertaken in a timely manner.	Operational procedure in place to guide staff members on the reporting system for environmental maintenance.	Mental Health & Learning Disabilities	13.11.2023	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (Ref: 03362)	The health board must ensure any required repairs and maintenance are undertaken in a timely manner.	Facilities log maintained to reflect reports and required actions.	Mental Health & Learning Disabilities	13.11.2023	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (Ref: 03362)	The health board must ensure any required repairs and maintenance are undertaken in a timely manner.	Senior Nurse to escalate environmental maintenance concerns via Quality Safety Risk and Experience report	Mental Health & Learning Disabilities	13.11.2023	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (Ref: 03362)	The health board must ensure any required repairs and maintenance are undertaken in a timely manner.	Locality manager can escalate any issues via Health and Safety meeting	Mental Health & Learning Disabilities	13.11.2023	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (Ref: 03362)	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 & Learning Disabilities	13.11.2023	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (Ref: 03362)	The health board must provide clarity and guidance on staff responsibilities to ensure effective cleaning of the outside areas and staff toilets.	Cleaning schedule of the staff toilets was increased to twice daily on 06/11/2023	Mental Health & Learning Disabilities	13.11.2023	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (Ref: 03362)	The health board must provide clarity and guidance on staff responsibilities to ensure effective cleaning of the outside areas and staff toilets.	IPC added to the nurse meeting agenda.	Mental Health & Learning Disabilities	13.11.2023	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (Ref: 03362)	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 & Learning Disabilities	13.11.2023	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (Ref: 03362)	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 & Learning Disabilities	13.11.2023	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (Ref: 03362)	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 & Learning Disabilities	13.11.2023	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (Ref: 03362)	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 & Learning Disabilities	01.05.2024	01.05.2024	Fully complete (Awaiting approval)	August 2024 Update - approved for closure by the QSRE in August.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (Ref: 03362)	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 & Learning Disabilities	13.11.2023	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (Ref: 03362)	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 & Learning Disabilities	13.11.2023	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (Ref: 03362)	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 & Learning Disabilities	13.11.2023	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (Ref: 03362)	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.	Mental Health & Learning Disabilities	13.11.2023	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (Ref: 03362)	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 & Learning Disabilities	13.11.2023	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (Ref: 03362)	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 & Learning Disabilities	13.11.2023	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (Ref: 03362)	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.	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 & Learning Disabilities	13.11.2023	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (Ref: 03362)	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 & Learning Disabilities	01.05.2024	01.05.2024	Fully complete (Awaiting approval)	August 2024 - MHLD Care Group confirmed action completed at their QSRE meeting in June 2024.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (Ref: 03362)	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 & Learning Disabilities	13.11.2023	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (Ref: 03362)	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 & Learning Disabilities	13.11.2023	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (Ref: 03362)	The health board must discuss the issues raised in relation to staffing levels with staff to fully understand their concerns.	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 & Learning Disabilities	13.11.2023	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.

HIW Inspections Recommendations Tracker - Request for updates by Friday 23rd August 2024
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Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Original Due Date	Current (Revised) Due Date	Progress Status	UPDATES for Quality & Safety Committee Wednesday 18th September 2024 Please submit all updates no later than close of business on Friday 23rd August 2024 Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (Ref: 03362)	The health board must discuss the issues raised in relation to staffing levels with staff to fully understand their concerns.	Weekly acuity is assessed using Levels of Care. This supports the reporting of patient acuity within the unit.	Mental Health & Learning Disabilities	13.11.2023	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (Ref: 03362)	The health board must discuss the issues raised in relation to staffing levels with staff to fully understand their concerns.	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 & Learning Disabilities	13.11.2023	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (Ref: 03362)	The health board must discuss the issues raised in relation to staffing levels with staff to fully understand their concerns.	Any concerns about staffing levels can be escalated through the senior nurse Quality Safety Risk and Experience report.	Mental Health & Learning Disabilities	13.11.2023	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (Ref: 03362)	The health board must discuss the issues raised in relation to staffing levels with staff to fully understand their concerns.	The Head of Nursing holds weekly drop in sessions where staff can raise issues or concerns, including those related to staffing.	Mental Health & Learning Disabilities	13.11.2023	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
Healthcare Inspectorate Wales (HIW)/2023/160	11.09.2023	Appendix C - Improvement Plan: Ty Llidiard (Ref: 03362)	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 & Learning Disabilities	13.11.2023	13.11.2023	Fully complete (Awaiting approval)	August 2024 Update - Action approved for completion at QSRE. Action will move to fully complete awaiting approval following the QSC on the 18th September.
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	30.04.2024	Fully complete (Awaiting approval)	August 2024 Update - this can be closed. GPAU corridor has now closed, SDEC is open and patients are flowing via this area and reducing the pressure on the ambulatory care area.
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.	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	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed SOP and huddles in place.
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.	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	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed - GPAU now closed and SDEC open to support ambulatory flows.
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.	PCH is currently in the process of major construction works to remove and as part of this further applications for Welsh Government funding are being explored to support significant changes to the EU footprint. This will facilitate improved patient clinical areas allowing for improved patient and staff experience.	Unscheduled Care	01.06.2024	31.12.2024	In progress	August 2024 Update - capital work ongoing - PCH is currently in the process of major construction works to remove and as part of this further applications for Welsh Government funding are being explored to support significant changes to the EU footprint. This will facilitate improved patient clinical areas allowing for improved patient and staff experience.
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.	CTM has implemented a pre-emptive transfer and boarding process to support patient flow, sharing the risk across inpatient areas allowing the de-escalation of risk held in ambulatory care. This reinforces that patient flow is a team approach across the site.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	August 2024 Update - work ongoing
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.	We are awaiting capital works to progress to take down a wall partially of the large non-clinical area with the Ambulatory Care Area-this will facilitate improved observation of patients within the area to ensure patient care and safety.	Unscheduled Care	01.09.2023	01.09.2023	Overdue	August 2024 Update - part of ongoing capital plans - We are awaiting capital works to progress to take down a wall partially of the large non-clinical area with the Ambulatory Care Area-this will facilitate improved observation of patients within the area to ensure patient care and safety.
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	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	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to 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	Unscheduled Care	01.12.2023	01.12.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to 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.	Unscheduled Care	01.09.2023	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed

HIW Inspections Recommendations Tracker - Request for updates by Friday 23rd August 2024
Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Original Due Date	Current (Revised) Due Date	Progress Status	UPDATES for Quality & Safety Committee Wednesday 18th September 2024 Please submit all updates no later than close of business on Friday 23rd August 2024 Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to 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	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to improve 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	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised this action can be closed - updated signage in place.
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with an update on the systems in place to improve patient flow through the EU.	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	Unscheduled Care	01.03.2024	01.03.2024	Overdue	August 2024 Update - this work is ongoing - This work continues to progress via the Optimise Project which formally reports into 6 goals programme board and onto NHS Executive colleagues.
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to 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	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to 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	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to 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	Unscheduled Care	01.09.2023	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to 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	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to 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	Unscheduled Care	01.09.2023	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to 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	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to 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	Unscheduled Care	01.09.2023	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to 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	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to improve staff compliance with 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	Unscheduled Care	01.09.2023	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to 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	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed
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 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	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to 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	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to 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	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to: •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	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update -USC DoN advised this can be closed - as of April - 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."
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to 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	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to 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	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed

HIW Inspections Recommendations Tracker - Request for updates by Friday 23rd August 2024
Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Original Due Date	Current (Revised) Due Date	Progress Status	UPDATES for Quality & Safety Committee Wednesday 18th September 2024 Please submit all updates no later than close of business on Friday 23rd August 2024 Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to 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	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to improve staff compliance with Departmental Fire Safety (EU) and Mental Capacity and DoLS (CDU) training.	The Senior Nurse for Professional Education is key to progressing this agenda in EU and maintaining a database of training compliance and has developed a training needs analysis template. A plethora of study days, and protected study time for the inclusion of mandatory training and recovery of face to face study time has been provided. Ongoing training dates are in place with an improving picture which is monitored by the Nurse Director at bi-monthly workforce meeting. The Fire Officer has been undertaking bespoke training sessions for the PCH site weekly to improve compliance as part of the resetting post Covid-19 pandemic where training was unavailable as of Aug'23 fire training for staff is as follows:- ED-RN 72.85% HCSW 84% CDU-RN 97.50% HCSW 58.33%	Unscheduled Care	01.04.2024	01.04.2024	Overdue	August 2024 Update - 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. ED MCA now 77% and fire 85%
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with assurance Violence and Aggression, Mental Capacity and DoLS training compliance is effectively tracked for the EU.	Monthly mandatory training study days and reports now include V & A, DoLs, medications management, safeguarding and MCA training and compliance. Mandatory training compliance is monitored during the 6 weekly Workforce and Business meetings; trends are monitored for improvements, where there is deterioration-action plans are required. V&A compliance is recorded on the Mandatory Training database held by the Senior Nurse for professional Education.	Unscheduled Care	01.04.2024	01.04.2024	Overdue	August 2024 Update - 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. CDU fire is 100%
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to 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-	Unscheduled Care	01.09.2023	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to 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	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to 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	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed
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 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	Unscheduled Care	01.09.2023	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed
Healthcare Inspectorate Wales (HIW)/2023/167	31.07.2023	Hospital Inspection Report (Unannounced) Emergency Unit and Clinical Decisions Unit, Prince Charles Hospital Appendix C - Improvement Plan_31 July 01 & 02 August 2023 (Ref: 3399)	The health board is required to provide HIW with details of the action taken to 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	Unscheduled Care	01.09.2023	01.09.2023	Fully complete (Awaiting approval)	August 2024 Update - USC DoN advised that this can be closed
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	12.01.2024	Fully complete (Awaiting approval)	August 2024 - Complete - monitored carefully though daily acuity. Rotation of specialist staff providing extra shifts. Started using Bank Agency. 17 new midwives starting in September 2024.
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.	b)Access to electronic roster has been restricted to ensure appropriate oversight of changes to off duty.	Children & Families	12.01.2024	12.01.2024	Fully complete (Awaiting approval)	August 2024 - Complete - restricted access achieved immediately in response to recommendation.
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.	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	01.02.2024	Fully complete (Awaiting approval)	August 2024 - Complete - No international midwifes to recruit to at this stage.
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.	d)Review of all Flexible Working arrangements within the department to ensure that this support is proportionate and appropriate.	Children & Families	31.03.2024	31.03.2024	Fully complete (Awaiting approval)	August 2024 Update - Complete - flexible working arrangements reviewed and completed to ensure fairness and that the needs of the service are met.
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.	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	12.01.2024	Fully complete (Awaiting approval)	August 2024 Update - Complete - Care Group are working closely with the Care Group People Business Partners to ensure staff are supported through the attendance at work policy.
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.	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	01.02.2024	Fully complete (Awaiting approval)	August 2024 Update - Complete - work will continue in relation to embedding the new principles of safe care through workforce meetings. Plans are established to evaluate and this action is now embedded as business as usual practice.
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.	g)Working with finance colleagues to develop a new model for obstetric theatre nursing (releasing midwifery time).	Children & Families	01.02.2024	01.02.2024	Partially complete (Overdue)	August 2024 Update - activity underway with finance colleagues but pace of progress has been impacted by the temporary closure of the maternity and neonatal units at Princess of Wales Hospital (PoW)
Healthcare Inspectorate Wales (HIW)/2024/165	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.	h)The Service is moving from the Birthrate + 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	01.03.2024	Fully complete (Awaiting approval)	August 2024 Update - Complete - "Safe Care" acuity system implemented.
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.	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	31.01.2024	Partially complete (Overdue)	August 2024 Update - need to be reviewed at Care Group Workforce Meeting on the 28th August to monitor implementation.
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.	j)Work with the Corporate Communications department to develop a Comms Recruitment strategy to demonstrate the benefits to attract staff to work in CTM UHB.	Children & Families	29.02.2024	29.02.2024	Partially complete (Overdue)	August 2024 Update - Work underway in conjunction with the recruitment and retention lead including developing a short video as part of an attraction campaign. There will be a focus on the PCH site.
Healthcare Inspectorate Wales (HIW)/2024/165	09.01.2024	Appendix 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.	k)Rolling advert to continue to appoint band 6 midwives, closed and continuous advert for bank midwife.	Children & Families	12.01.2024	12.01.2024	Fully complete (Awaiting approval)	August 2024 Update - Complete. There is a rolling advert that is used should any vacancies arise. Proactive approach to advertise as soon as additional midwives are needed.
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.	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	12.01.2024	Fully complete (Awaiting approval)	August 2024 - complete and considered in conjunction with birthrate plus and the needs of the service for the future.
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.	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	12.01.2024	Fully complete (Awaiting approval)	August 2024 - Complete. System and process in place and working well.
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.	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	13.01.2024	Fully complete (Awaiting approval)	August 2024. Complete - Workforce meetings now established.
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.	o)Nursing (and Midwifery) productivity workforce meetings held within the Care Group Structure.	Children & Families	12.01.2024	12.01.2024	Fully complete (Awaiting approval)	August 2024. Complete - Workforce meetings now established.

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Original Due Date	Current (Revised) Due Date	Progress Status	UPDATES for Quality & Safety Committee Wednesday 18th September 2024 Please submit all updates no later than close of business on Friday 23rd August 2024 Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT
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.	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	30.01.2024	Fully complete (Awaiting approval)	August 2024 Update -Complete - dashboard developed and captures identified metrics.
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.	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	12.01.2024	Partially complete (Overdue)	August 2024 - included in 'safe to start' meetings and working with the corporate team to ensure the mat neo template is fit for purpose.
Healthcare Inspectorate Wales (HIW)/2024/165	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.	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	31.01.2024	Fully complete (Awaiting approval)	August 2024 - complete and ward manager now based on ward 21 so regular huddles held during the day to ensure acuity and workforce needs align.
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.	s)Temporary cease midwifery rotation to other areas.	Children & Families	13.01.2024	13.01.2024	Fully complete (Awaiting approval)	August 2024 - completed and held until staffing situation improved.
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.	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	31.01.2024	Fully complete (Awaiting approval)	August 2024 - Complete - Monitoring in Place at ward and directorate level and reported via WESSEE and SWAG forums
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.	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	11.01.2024	Fully complete (Awaiting approval)	August 2024 - Complete - CTMUHB are represented at the Perinatal Steering Group.
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.	v)Review night time rosters to determine whether any cultural concerns which may impact attendance at work.	Children & Families	31.01.2024	31.01.2024	Fully complete (Awaiting approval)	August 2024 Update - Complete - monitored via Head of Midwifery, Wellbeing support and workforce colleagues. Also captured via Datix. No further concerns identified.
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.	w)Bank & Overtime Hours offered to midwives.	Children & Families	17.01.2024	17.01.2024	Fully complete (Awaiting approval)	August 2024 -Complete. Bank and overtime hours offered to staff.
Healthcare Inspectorate Wales (HIW)/2024/165	09.01.2024	Appendix A Immediate Improvement Plan_PCH Maternity Unit_9-11 January 2024 (Ref: 03600)	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	12.01.2024	Fully complete (Awaiting approval)	August 2024 - Closed as completed and locks in place.
Healthcare Inspectorate Wales (HIW)/2024/165	09.01.2024	Appendix A Immediate Improvement Plan_PCH Maternity Unit_9-11 January 2024 (Ref: 03600)	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.	b)1 x Lock ordered for further cupboard awaiting delivery.	Children & Families	19.01.2024	19.01.2024	Fully complete (Awaiting approval)	August 2024 - Closed as completed and locks in place.
Healthcare Inspectorate Wales (HIW)/2024/165	09.01.2024	Appendix A Immediate Improvement Plan_PCH Maternity Unit_9-11 January 2024 (Ref: 03600)	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.	c)Domestic Supervisors have shared a safety briefing with her team, to ensure they are aware of the requirement.	Children & Families	12.01.2024	12.01.2024	Fully complete (Awaiting approval)	August 2024 - Completed and in place.
Healthcare Inspectorate Wales (HIW)/2024/165	09.01.2024	Appendix A Immediate Improvement Plan_PCH Maternity Unit_9-11 January 2024 (Ref: 03600)	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.	d)Continued oversight though monitoring through the AMaT ward audit schedule.	Children & Families	12.01.2024	12.01.2024	Fully complete (Awaiting approval)	August 2024 - Completed and 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	04.03.2024	Fully complete (Awaiting approval)	August 2024 Update - Complete - reviewed visiting times and extended visiting hours for partners.
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	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. Mythbusting – 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	01.03.2024	Fully complete (Awaiting approval)	August 2024 Update - Complete -all mechanisms in place to monitor. This activity will be under continual review.
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	UNICEF Baby Friendly Initiative The health board must work to achieve the UNICEF Baby Friendly Initiative reaccreditation.	There are dedicated infant feeding co-ordinators in place across the perinatal services who are working together toward BFI reaccreditation. The service is currently undertaking a number of audits in readiness for re-assessment which is planned for April 2024. Recent PREM data shows that infant feeding experience is positive. The service has implemented a feeding voice partnership.	Children & Families	01.05.2024	01.05.2024	Overdue	August 2024 Update - In response to a recent positive inspection audit there are a few actions underway. Accreditation being sought in the next couple of months.
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	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	31.03.2024	Fully complete (Awaiting approval)	August 2024 Update - Complete. Will continue to be monitored through supervision and audited through NICE Safe Midwifery Staffing standards as a red maternity flag if there is a delayed medication.
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	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	12.01.2024	Fully complete (Awaiting approval)	August 2024 Update - reviewed and action considered to be complete.
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	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 Birthrights 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.	Children & Families	01.07.2024	01.07.2024	Fully complete (Awaiting approval)	August 2024 Update - Complete - Annual Prem Report presented. No actions outstanding.
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	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	01.07.2024	Fully complete (Awaiting approval)	August 2024 Update - Complete and the Care Group are continuing to work to achieve cultural competence. Training with diverse cymru. Led by Consultant Midwife for Population Health. Developed a transgender guideline. Training compliance will continue to be monitored.

HIW Inspections Recommendations Tracker - Request for updates by Friday 23rd August 2024
Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Original Due Date	Current (Revised) Due Date	Progress Status	UPDATES for Quality & Safety Committee Wednesday 18th September 2024 Please submit all updates no later than close of business on Friday 23rd August 2024 Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	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	12.01.2024	Fully complete (Awaiting approval)	August 2024 Update - Completed as an immediate action.
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	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	01.05.2024	Fully complete (Awaiting approval)	August 2024 Update - Supervisors just completed annual records keeping assessment and outcomes and any learning shared.
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	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	16.01.2024	12.01.2024	Fully complete (Awaiting approval)	August 2024 Update - reviewed and action considered to be complete.
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Access to electronic roster has been restricted to ensure appropriate oversight of changes to off duty.	Children & Families	15.01.2024	12.01.2024	Fully complete (Awaiting approval)	August 2024 Update - reviewed and action considered to be complete.
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Review of all Flexible Working arrangements within the department to ensure that this support is proportionate and appropriate.	Children & Families	31.03.2024	31.03.2024	Fully complete (Awaiting approval)	August 2024 Update - Complete - flexible working arrangements reviewed and completed to ensure fairness and that the needs of the service are met.
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	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	12.01.2024	Fully complete (Awaiting approval)	August 2024 Update - Complete - Care Group are working closely with the Care Group People Business Partners to ensure staff are supported through the attendance at work policy.
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	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	12.01.2024	Fully complete (Awaiting approval)	August 2024 Update - Complete - work will continue in relation to embedding the new principles of safe care through workforce meetings. Plans are established to evaluate and this action is now embedded as business as usual practice.
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Working with finance colleagues to develop a new model for obstetric theatre nursing (releasing midwifery time).	Children & Families	01.03.2024	01.03.2024	Overdue	August 2024 Update - activity underway with finance colleagues but pace of progress has been impacted by the temporary closure of the maternity and neonatal units at Princess of Wales Hospital (PoW)
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	The Service is moving from the Birthrate + 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	01.03.2024	Fully complete (Awaiting approval)	August 2024 Update - August 2024 Update - Complete - "Safe Care" acuity system implemented.
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Review safe care tool to ensure that red flags according to NICE safe staffing 2015 are included in the tool	Children & Families	31.01.2024	31.01.2024	Overdue	August 2024 Update - need to be reviewed at Care Group Workforce Meeting on the 28th August to monitor implementation.
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Work with the Corporate Communications department to develop a Comms Recruitment strategy to demonstrate the benefits to attract staff to work in CTM UHB.	Children & Families	29.02.2024	29.02.2024	Overdue	August 2024 Update - August 2024 Update - Work underway in conjunction with the recruitment and retention lead including developing a short video as part of an attraction campaign. There will be a focus on the PCH site.
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Rolling advert to continue to appoint band 6 midwives, closed and continuous advert for bank midwife.	Children & Families	12.01.2024	12.01.2024	Fully complete (Awaiting approval)	August 2024 Update - Complete. There is a rolling advert that is used should any vacancies arise. Proactive approach to advertise as soon as additional midwives are needed.
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	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	12.01.2024	Fully complete (Awaiting approval)	August 2024 - complete and considered in conjunction with birthrate plus and the needs of the service for the future.
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	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	22.01.2024	12.01.2024	Fully complete (Awaiting approval)	August 2024 - Complete. System and process in place and working well.
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	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	13.01.2024	Fully complete (Awaiting approval)	August 2024. Complete - Workforce meetings now established.
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Nursing (and Midwifery) productivity workforce meetings held within the Care Group Structure.	Children & Families	12.01.2024	12.01.2024	Fully complete (Awaiting approval)	August 2024. Complete - Workforce meetings now established.
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	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	30.01.2024	Fully complete (Awaiting approval)	August 2024 Update -Complete - dashboard developed and captures identified metrics.
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	The team are working with the wider Health Board initiative to ensure maternity services are included as part of 'Safe to Start'.	Children & Families	12.01.2024	12.01.2024	Partially complete (Overdue)	August 2024 - included in 'safe to start' meetings and working with the corporate team to ensure the mat neo template is fit for purpose.

HIW Inspections Recommendations Tracker - Request for updates by Friday 23rd August 2024
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Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Original Due Date	Current (Revised) Due Date	Progress Status	UPDATES for Quality & Safety Committee Wednesday 18th September 2024 Please submit all updates no later than close of business on Friday 23rd August 2024 Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	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	12.01.2024	Fully complete (Awaiting approval)	August 2024 - complete and ward manager now based on ward 21 so regular huddles held during the day to ensure acuity and workforce needs align.
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Temporary cease midwifery rotation to other areas	Children & Families	31.01.2024	31.01.2024	Fully complete (Awaiting approval)	August 2024 - completed and held until staffing situation improved.
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	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	31.01.2024	Fully complete (Awaiting approval)	August 2024 - Complete - Monitoring in Place at ward and directorate level and reported via WESSEE and SWAG forums
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	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	11.01.2024	Fully complete (Awaiting approval)	August 2024 - Complete - CTMUHB are represented at the Perinatal Steering Group.
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Review night time rosters to determine whether any cultural concerns which may impact attendance at work.	Children & Families	31.01.2024	31.01.2024	Fully complete (Awaiting approval)	August 2024 Update - Complete - monitored via Head of Midwifery, Wellbeing support and workforce colleagues. Also captured via Datix. No further concerns identified.
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Bank & Overtime Hours offered to midwives.	Children & Families	17.01.2024	17.01.2024	Fully complete (Awaiting approval)	August 2024 -Complete. Bank and overtime hours offered to staff.
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Staffing (also detailed in Appendix B) The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Agency midwifery introduced to support.	Children & Families	01.03.2024	01.03.2024	Overdue	August 2024 - Complete - monitored carefully though daily acuity. Rotation of specialist staff providing extra shifts. Started using Bank Agency. 17 new midwives starting in September 2024.
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	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	01.03.2024	Overdue	August 2024 Update - Update requested from Children and Family Care Group.
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	Datix reporting The health board should undertake a review of the processes for reviewing incidents. The reviewing team should include clinicians and practitioners with the appropriate experience and expertise.	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	Children & Families	01.04.2024	01.04.2024	Overdue	August 2024 Update - Children & Family Care Group just completing a review of the governance arrangements in line with the new incident management framework. Outcome of will be presented to the Maternity and Neonatal Safety Board in September 2024 with an implementation plan. The new arrangements will ensure proportionate review and learning.
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	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	12.01.2024	Fully complete (Awaiting approval)	August 2024 - Complete
Healthcare Inspectorate Wales (HIW)/2024/166	09.01.2024	Appendix C Improvement Plan_PCH Maternity Unit_9-11 January 2024 (ref: 03600)	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	12.01.2024	Fully complete (Awaiting approval)	August 2024 - Complete.
Healthcare Inspectorate Wales (HIW)/2024/184	11.04.2024	Appendix A Immediate Improvement Plan_Ysbyty Cwm Rhondda Ward B2_11-12 April 2024 (Ref: 03467)	Provide HIW with details of the action taken to ensure a call bell system is put in place as soon as possible.	Discussion with operational estates manager who has confirmed funding has been agreed to replace the system and a plan is in place to replace.	Primary Care & Community	30.06.2024	30.06.2024	Overdue	August 2024 Update - installation date agreed for 27th August.
Healthcare Inspectorate Wales (HIW)/2024/184	11.04.2024	Appendix A Immediate Improvement Plan_Ysbyty Cwm Rhondda Ward B2_11-12 April 2024 (Ref: 03467)	In the interim, provide HIW with details of a robust system where patients are checked regularly to ensure they are safe, and their needs are met.	Risk assessment in place to provide assurance on reducing the risk of patient needs not being met.	Primary Care & Community	30.06.2024	30.06.2024	Partially complete (Overdue)	August 2024 Update - partially completed. ongoing monitoring of actions implemented until new call bell system is in place.
Healthcare Inspectorate Wales (HIW)/2024/184	11.04.2024	Appendix A Immediate Improvement Plan_Ysbyty Cwm Rhondda Ward B2_11-12 April 2024 (Ref: 03467)	Provide HIW with details of a robust system where nurses can alert other staff in the event of an emergency.	Staff members are to be provided with personal safety alarms. These alarms will ensure that during an emergency event on the ward they would be able to alert all staff in the ward area.	Primary Care & Community	26.04.2024	26.04.2024	Fully complete (Awaiting approval)	August 2024 Update - completed and all staff have personal safety alarms for use. Updated action plan emailed to the Corporate Team following approval from the Director of Nursing for Primary Care and Community. Formal closure will be confirmed once received at the Quality & Safety Committee on the 18th September 2024. Detailed Action Plan available upon request.
Healthcare Inspectorate Wales (HIW)/2024/185	14/4/2024	Appendix C – Improvement Plan: POW IR(ME)R_14 April 2024 (Ref: 03497)	The employer needs to ensure that the relevant employer's procedure and IRPP are reviewed to ensure the process for entitlement is consistent between the two documents and accurate with current practice.	Both of these documents will be reviewed for consistency and current practice. Update EP1 and IRPP	Diagnostics, Therapies, Pharmacies and Specialities	15.08.2024	15.08.2024	Fully complete (Awaiting approval)	August 2024 Update - Complete. DTPS Care Group confirmed that this action has been completed as EP1 and IRPP have been updated 1.7.2024. Following consideration at the Quality & Safety Committee in September 2024 this action will be closed on AMaT.
Healthcare Inspectorate Wales (HIW)/2024/185	14/4/2024	Appendix C – Improvement Plan: POW IR(ME)R_14 April 2024 (Ref: 03497)	The employer needs to review the use of the DAG for the administration of radiopharmaceuticals and update this to reflect the entitlement process for individuals entitled to administer radiopharmaceuticals.	Delegated authorisation guidelines (DAGs) have been reviewed with any terminology changes made during this process	Diagnostics, Therapies, Pharmacies and Specialities	15.08.2024	15.08.2024	Fully complete (Awaiting approval)	August 2024 Update - Complete. DTPS Care Group confirmed that this action has been completed as delegated authorisation guidelines (DAGs) have been reviewed with any terminology changes made during this process: Complete 27/6/24. Following consideration at the Quality & Safety Committee in September 2024 this action will be closed on AMaT.
Healthcare Inspectorate Wales (HIW)/2024/185	14/4/2024	Appendix C – Improvement Plan: POW IR(ME)R_14 April 2024 (Ref: 03497)	The employer must ensure that the: •Employer's procedure for practical training for practitioners and operators is reviewed and includes the relevant nuclear medicine tasks and equipment as appropriate. •The record of staff competency and scope entitlement procedure is reviewed alongside the employer's procedure and includes the correct forms which are used in staff training records.	Employees procedure will be update to provide clarity with a standard approach in all documentation. Training forms removed EP2 updated and NM03 removed	Diagnostics, Therapies, Pharmacies and Specialities	15.08.2024	15.08.2024	Fully complete (Awaiting Approval)	August 2024 Update - Complete. Complete. DTPS Care Group confirmed that this action has been completed training forms removed EP2 updated and NM03 removed Complete 4/7/24. Following consideration at the Quality & Safety Committee in September 2024 this action will be closed on AMaT.
Healthcare Inspectorate Wales (HIW)/2024/185	14/4/2024	Appendix C – Improvement Plan: POW IR(ME)R_14 April 2024 (Ref: 03497)	The employer must ensure that the employer's procedures reflect the use and scope of MARS for recording training records of practitioners.	Employers procedure has been updated to reflect that the use of the Medical Appraisal Revalidation System (MARS) is used for the training records of practitioners. Update EP2	Diagnostics, Therapies, Pharmacies and Specialities	15.08.2024	15.08.2024	Fully complete (Awaiting Approval)	August 2024 Update - Complete. Complete. DTPS Care Group confirmed that this action has been completed as references to MARS added to EP2 Complete 25.6.24. Following consideration at the Quality & Safety Committee in September 2024 this action will be closed on AMaT.

HIW Inspections Recommendations Tracker - Request for updates by Friday 23rd August 2024
Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT

Inspection Code	Date of Inspection	Inspection Title	Recommendation	Action	Care Group	Original Due Date	Current (Revised) Due Date	Progress Status	UPDATES for Quality & Safety Committee Wednesday 18th September 2024 Please submit all updates no later than close of business on Friday 23rd August 2024 Please complete all updates, including any revisions i.e. Revised Due Date in RED text for ease of referencing and transfer to AMaT
Healthcare Inspectorate Wales (HIW)/2024/185	14/4/2024	Appendix C – Improvement Plan: POW IR(ME)R_14 April 2024 (Ref: 03497)	The employer must ensure that the employer's procedure relating to justification and authorisation: •Is reviewed and updated to refer to the duty holders and their scope using appropriate terminology with reference to IR(ME)R and to clarify the lines of responsibility for justification and authorisation. •Reflects the processes used in nuclear medicine.	The Employers Procedures (EP's) are being updated to cover all areas in radiology, including Nuclear Medicine. EP6 updated	Diagnostics, Therapies, Pharmacies and Specialities	15.08.2024	15.08.2024	Fully complete (Awaiting Approval)	August 2024 Update - Complete. Complete. DTPS Care Group confirmed that this action has been completed as EP6 updated Complete 5/7/24. Following consideration at the Quality & Safety Committee in September 2024 this action will be closed on AMaT.
Healthcare Inspectorate Wales (HIW)/2024/185	14/4/2024	Appendix C – Improvement Plan: POW IR(ME)R_14 April 2024 (Ref: 03497)	The employer must ensure that the written employer's procedure and the nuclear medicine procedure for paediatrics are reviewed and updated for accuracy of terminology and to be clear on the age range that it applies to.	The Employers procedure (EP) is being updated to reflect current legislation with the correct age for paediatrics in both proceduresNM34 updated to reflect paediatric age of 18 or below	Diagnostics, Therapies, Pharmacies and Specialities	15.08.2024	15.08.2024	Fully complete (Awaiting Approval)	August 2024 Update - Complete. DTPS Care Group confirmed that this action has been completed as NM34 updated to reflect paediatric age of 18 or below Complete 2/7/24. Following consideration at the Quality & Safety Committee in September 2024 this action will be closed on AMaT.
Healthcare Inspectorate Wales (HIW)/2024/185	14/4/2024/	Appendix C – Improvement Plan: POW IR(ME)R_14 April 2024 (Ref: 03497)	The employer needs to eliminate the duplication between the QA handbook and the other nuclear medicine QA procedures and consolidate these within the QA handbook as appropriate.	There are separate Quality Assurance (QA) books provided by the Medical Physics Expert (MPE) for general radiology and nuclear medicine. This duplication has arisen as the new nuclear medicine camera has a CT element. New updated NM QA introduced.	Diagnostics, Therapies, Pharmacies and Specialities	15.08.2024	15.08.2024	Fully complete (Awaiting Approval)	August 2024 Update - Complete. DTPS Care Group confirmed that this action has been completed as New updated NM QA introduced Complete 2/7/24. Following consideration at the Quality & Safety Committee in September 2024 this action will be closed on AMaT.
Healthcare Inspectorate Wales (HIW)/2024/185	14/4/2024	Appendix C – Improvement Plan: POW IR(ME)R_14 April 2024 (Ref: 03497)	The employer is required to review the referral forms alongside the procedure for the completion of referral forms to ensure that the method for the completion of forms is consistently applied. Ideally the documentation should be standardised to aid completion.	The POW referral form is going to be replaced with the CTMUHB electronic form. We acknowledge that in the meanwhile we will make sure our EPS are followed regardless of the referral form submitted and will be vigilant during the transition period.Email sent to all staff reminding them of the process if insufficient information is on the request form.	Diagnostics, Therapies, Pharmacies and Specialities	15.08.2024	15.08.2024	Fully complete (Awaiting Approval)	August 2024 Update - Complete. DTPS Care Group confirmed that this action has been completed as email sent to all staff reminding them of the process if insufficient information is on the form Complete 5/7/24. Following consideration at the Quality & Safety Committee in September 2024 this action will be closed on AMaT.
Healthcare Inspectorate Wales (HIW)/2024/185	14/4/2024	Appendix C – Improvement Plan: POW IR(ME)R_14 April 2024 (Ref: 03497)	The employer is to ensure that the ionising radiation protection policy, nuclear medicine procedures and radiology employer's procedures are reviewed for consistency, to remove duplication and ensure accuracy. Consideration should be given to having one set of procedures that cover radiology and nuclear medicine.	Discrepancies between the Ionising Radiation Protection Policy (IRPP) and Employers Procedures (EPs) will be addressed and the documents will b	Diagnostics, Therapies, Pharmacies and Specialities	15/8/24	15/8/24	Fully complete (Awaiting Approval)	August 2024 Update - Complete. DTPS Care Group confirmed that this action has been completed as: Remove NM64 and only have updated EP24: Remove NM12 and only have updated EP18: Remove NM24 and only have updated EP22: Remove NM30 and only have updated EP10: EP23 updated: EP7 updated Complete 1/7/24. Following consideration at the Quality & Safety Committee in September 2024 this action will be closed on AMaT.
Healthcare Inspectorate Wales (HIW)/2024/185	14/4/2024	Appendix C – Improvement Plan: POW IR(ME)R_14 April 2024 (Ref: 03497)	The employer is to ensure that the lists of local and national DRL's are combined into a single list with the DRL's used for each procedure for display in the injection room.	A single List of Diagnostic Reference Levels (DRLs) has now been placed in the injection room	Diagnostics, Therapies, Pharmacies and Specialities	15/8/24	15/8/24	Fully complete (Awaiting Approval)	August 2024 Update -Complete. DTPS Care Group confirmed that this action has been completed as a single List of Diagnostic Reference Levels (DRLs) has now been placed in the injection room Complete 15/5/24. Following consideration at the Quality & Safety Committee in September 2024 this action will be closed on AMaT.
Healthcare Inspectorate Wales (HIW)/2024/185	14/4/2024	Appendix C – Improvement Plan: POW IR(ME)R_14 April 2024 (Ref: 03497)	The employer must ensure that the entitlement documentation for all staff includes their scope of practice for all of their duty holder roles.	Entitlement records have been completely overhauled with the introduction of an Entitlement Certificate for each individual which details entitlement for individual IR(ME)R tasks.	Diagnostics, Therapies, Pharmacies and Specialities	15/8/24	15/8/24	Fully complete (Awaiting Approval)	August 2024 Update - Complete. DTPS Care Group confirmed that this action has been completed as entitlement records have been completely overhauled with the introduction of an Entitlement Certificate for each individual which details entitlement for individual IR(ME)R tasks. Complete 27/6/24. Following consideration at the Quality & Safety Committee in September 2024 this action will be closed on AMaT.
Healthcare Inspectorate Wales (HIW)/2024/185	14/4/2024	Appendix C – Improvement Plan: POW IR(ME)R_14 April 2024 (Ref: 03497)	The employer needs to ensure that: 1. Entitlement documentation is completed in full, with appropriate information on entitlement. 2. Training records of the staff should be updated to ensure that staff competencies were assessed by an appropriate individual who has been delegated the task by the employer.	Entitlement records have been completely overhauled with the introduction of an Entitlement Certificate for each individual which details entitlement for individual IR(ME)R tasks. This will remove the additional 'date of entitlement'. Training records have been updated to ensure correct authorisation of training.	Diagnostics, Therapies, Pharmacies and Specialities	30/9/24	30/9/24	Fully complete (Awaiting Approval)	August 2024 Update - Complete. DTPS Care Group confirmed that this action has been completed as entitlement records have been completely overhauled with the introduction of an Entitlement Certificate for each individual which details entitlement for individual IR(ME)R tasks. This will remove the additional 'date of entitlement'. Training records have been updated to ensure correct authorisation of training. Complete 27/6/24. Following consideration at the Quality & Safety Committee in September 2024 this action will be closed on AMaT.
Healthcare Inspectorate Wales (HIW)/2024/185	14/4/2024	Appendix C – Improvement Plan: POW IR(ME)R_14 April 2024 (Ref: 03497)	The employer must ensure that the medical referrers are sent a letter of their entitlement as required by the IRPP.	Letters sent out from Clinical Director to all Clinical Directors in Health board (inc. GP's and Dentists)	Diagnostics, Therapies, Pharmacies and Specialities	15/8/24	15/8/24	Fully complete (Awaiting Approval)	August 2024 Update - Complete. DTPS Care Group confirmed that this action has been completed as Letters sent out from Clinical Director to all Clinical Directors in Health board (inc. GP's and Dentists) Complete 27/6/24.Following consideration at the Quality & Safety Committee in September 2024 this action will be closed on AMaT.
Healthcare Inspectorate Wales (HIW)/2024/185	14/4/2024	Appendix C – Improvement Plan: POW IR(ME)R_14 April 2024 (Ref: 03497)	The employer needs to ensure that: 1. Employers procedures includes instructions on how to evidence patient identification checks have been made where there are multiple exposures or operators involved.2. Completion of referral forms are clear where there are multiple operators and contact points	Employers procedure have been updated to cover this situation. EP7 updated	Diagnostics, Therapies, Pharmacies and Specialities	15/8/24	15/8/24	Fully complete (Awaiting Approval)	August 2024 Update - Complete. DTPS Care Group confirmed that this action has been completed as EP7 Updated Complete 1/7/24. Following consideration at the Quality & Safety Committee in September 2024 this action will be closed on AMaT.
Healthcare Inspectorate Wales (HIW)/2024/185	14/4/2024	Appendix C – Improvement Plan: POW IR(ME)R_14 April 2024 (Ref: 03497)	The employer must ensure that the relevant employer's procedure includes the process for verifying pregnancy and breastfeeding status when the patient is unable to respond and the subsequent agreement of the practitioner	EP8 has been updated to ensure we are working safely. A further review of pregnancy checking and recording of responses and providing risk information is going to be completed across the Health Board.	Diagnostics, Therapies, Pharmacies and Specialities	15/8/24	15.08.2024	Fully complete (Awaiting Approval)	August 2024 Update - Complete. DTPS Care Group confirmed that this action has been completed as EP8 has been updated to ensure we are working safely. A further review of pregnancy checking and recording of responses and providing risk information is going to be completed across the Health Board. Complete 24/7/24. Following consideration at the Quality & Safety Committee in September 2024 this action will be closed on AMaT.
Healthcare Inspectorate Wales (HIW)/2024/185	14/4/2024	Appendix C – Improvement Plan: POW IR(ME)R_14 April 2024 (Ref: 03497)	The employer must review the information in the written employer's procedures and the nuclear medicine procedure for providing written instructions and information to the patient for accuracy and to remove duplication. Consideration should be given to having a single procedure only.	Employers procedures have been updated with any duplication addressed. EP18 amended, NM12 withdrawn.	Diagnostics, Therapies, Pharmacies and Specialities	15/8/24	15/8/24	Fully complete (Awaiting Approval)	August 2024 Update - Complete. DTPS Care Group confirmed that this action has been completed as EP18 amended with medical physics comments. NM12 withdrawn. Complete 1/7/24. Following consideration at the Quality & Safety Committee in September 2024 this action will be closed on AMaT.
Healthcare Inspectorate Wales (HIW)/2024/185	14/4/2024	Appendix C – Improvement Plan: POW IR(ME)R_14 April 2024 (Ref: 03497)	The employer is to ensure that audit reports are updated to include evidence of how practice was changed, actions required, who was responsible for actions and how the completion of actions was verified is always included.	Audit documentation has been updated to include evidence of how practice was changed, along with action taken. The action owner is responsible for sharing the audit outcome via email, CPD workshops and feedback sessions.	Diagnostics, Therapies, Pharmacies and Specialities	15/8/24	15/8/24	Fully complete (Awaiting Approval)	August 2024 Update - Complete. DTPS Care Group confirmed that this action has been completed as Audit documentation has been updated to include evidence of how practice was changed, along with action taken. The action owner is responsible for sharing the audit outcome via email, CPD workshops and feedback sessions. Complete 15/5/24. Following consideration at the Quality & Safety Committee in September 2024 this action will be closed on AMaT.
Healthcare Inspectorate Wales (HIW)/2024/185	14/4/2024	Appendix C – Improvement Plan: POW IR(ME)R_14 April 2024 (Ref: 03497)	The employer is to consider the differences between IR(ME)R audits and clinical audits and ensure that appropriate procedures reflect this difference and ensure that feedback from IR(ME)R audits are communicated with the MPE	Employers procedure has been updated to address this. EP22 updated NM24 removed	Diagnostics, Therapies, Pharmacies and Specialities	15/8/24	15/8/24	Fully complete (Awaiting Approval)	August 2024 Update - Complete. DTPS Care Group confirmed that this action has been completed as EP22 updated NM24 removed Complete 1/7/24. Following consideration at the Quality & Safety Committee in September 2024 this action will be closed on AMaT.
Healthcare Inspectorate Wales (HIW)/2024/185	14/4/2024	Appendix C – Improvement Plan: POW IR(ME)R_14 April 2024 (Ref: 03497)	The employer is to ensure that the employer's procedure for the reporting and investigation of accidental and unintended exposures is updated to include: 1. Delete references which were not relevant to the procedure.2. Update the definition of a significant accidental or unintendedexposure to reference the guidance supported by HIW. 3. Refer to the notification criteria required by HIW.	Employers procedure has been updated to address this issue. EP23 updated	Diagnostics, Therapies, Pharmacies and Specialities	15/8/24	15/8/24	Fully complete (Awaiting Approval)	August 2024 Update - Complete. DTPS Care Group confirmed that this action has been completed as EP23 updated Complete 27/6/24. Following consideration at the Quality & Safety Committee in September 2024 this action will be closed on AMaT.
Healthcare Inspectorate Wales (HIW)/2024/185	14/4/2024	Appendix C – Improvement Plan: POW IR(ME)R_14 April 2024 (Ref: 03497)	The employer should consider the comments of staff and inform HIW of the actions they will take to resolve these.	We have informed all staff that there is an open door policy. If anyone needs to discuss any concerns they are aware of who they can come to. We used the following methods to address this : Section heads meeting; All staff meeting; Email from Radiology Services Manager to all staff. The department aims to support staff and takes all concerns seriously.	Diagnostics, Therapies, Pharmacies and Specialities	15.08.2024	15.08.2024	Fully complete (Awaiting approval)	August 2024 Update - Complete. DTPS Care Group confirmed that this action has been completed as they have informed all staff that there is an open door policy. If anyone needs to discuss any concerns they are aware of who they can come to. DTPS Care Group used the following methods to address this : Section heads meeting; All staff meeting; Email from Radiology Services Manager to all staff. The department aims to support staff and takes all concerns seriously. Complete 15/5/24. Following consideration at the Quality & Safety Committee in September 2024 this action will be closed on AMaT.
Healthcare Inspectorate Wales (HIW)/2024/185	14/4/2024	Appendix C – Improvement Plan: POW IR(ME)R_14 April 2024 (Ref: 03497)	The employer is to ensure that the individual signing the form as referrer is acknowledged as the referrer	The current Employers procedures (EP) are clear regarding who the Referrer is under the Regulations. All forms (paper and electronic) identify the Referrer for the examination and also the Senior Responsible Clinician who will receive the reports following completion of the examination	Diagnostics, Therapies, Pharmacies and Specialities	15.08.2024	15.08.2024	Fully complete (Awaiting approval)	August 2024 Update - Complete. DTPS Care Group confirmed that this action has been completed as the current Employers procedures (EP) are clear regarding who the Referrer is under the Regulations. All forms (paper and electronic) identify the Referrer for the examination and also the Senior Responsible Clinician who will receive the reports following completion of the examination. Following consideration at the Quality & Safety Committee in September 2024 this action will be closed on AMaT.

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

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** July 2024 Update – COMPLETE (PART) (AMaT Release Note Q1 2024/25). Revised due dates captured within action history and data forms part of the Excel report export (original due date, current due date and number of changes). Further enhancement required in relation to rationale. May 2024 Update – DevLog 507 to be presented to AMaT Inspection Workshop July 2024 (email 26/04/2024).
2. Inspection actions to be defined as High Medium or Low in the system.	**COMPLETE**	CTMUHB Clinical Audit Team	**June 2024** May 2024 Update – COMPLETE
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** July 2024 Update – CH ongoing discussions with colleagues at Audit Wales and in Internal Audit in relation to theming. May 2024 Update – Work has been completed in relation to theming wording in line with the Quality Standards within AMaT (email 30/04/2024). **January 2025** July 2024 – Work ongoing with AMaT System/Report Developers. Further enhancements requested, awaiting approval and allocation to DevLog in relation to overall reporting functionality.

Development Required	Action Needed (Local or External)	Lead on Action	Implementation Timescale
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** Complete – All members advised of the process to gain read only access should they require it.
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** This request has been submitted and added to DevLog as at April 2024.
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** This request has been submitted and added to DevLog as at April 2024.

Development Required	Action Needed (Local or External)	Lead on Action	Implementation Timescale
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** July 2024 Update - Enhancement to notifications (AMaT Release Note Q1 2024/25). May 2024 Update – DevLog 262 & 371 to be presented to AMaT Inspection Workshop July 2024 (email 26/04/2024).
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** July 2024 Update – Ongoing. Further enhancements requested, awaiting approval and allocation to DevLog.
9. Internal Audit Reports – Tracker introductory Sheet to include assurance rating	**COMPLETE**	CTMUHB Quality Assurance & Compliance Team	May 2024 Update – COMPLETE. This detail is now included manually into reporting. Link to DevLog 388 for long term process.

Development Required	Action Needed (Local or External)	Lead on Action	Implementation Timescale
10. Overall outcome of Inspection	**External Development led by AMaT. Added to the system Development Log for approval. High priority has been assigned.**	AMaT System developers	**AWATING CONFIRMATION FROM AMAT SYSTEM DEVELOPERS IN RELATION TO ANTICIPCATED TIMESCALE/IMPLEMENTATION DATE** July 2024 Update - Enhancement requested via DevLog 388.
11. New Open and Confidential check boxes	**External Development led by AMaT. Added to the system Development Log for approval. High priority has been assigned.**	AMaT System developers	**AWATING CONFIRMATION FROM AMAT SYSTEM DEVELOPERS IN RELATION TO ANTICIPCATED TIMESCALE/IMPLEMENTATION DATE** July 2024 Update – Enhancement requested, awaiting approval and allocation to DevLog.
12. Full Inspection Action History	**External Development led by AMaT. Added to the system Development Log for approval. High priority has been assigned.**	AMaT System developers	**AWATING CONFIRMATION FROM AMAT SYSTEM DEVELOPERS IN RELATION TO ANTICIPCATED TIMESCALE/IMPLEMENTATION DATE** July 2024 Update - Enhancement requested, awaiting approval and allocation to DevLog.

Development Required	Action Needed (Local or External)	Lead on Action	Implementation Timescale
13. Retaining previous comments/progress updates	**External Development led by AMaT. Added to the system Development Log for approval. High priority has been assigned.**	AMaT System developers	**AWAITING CONFIRMATION FROM AMAT SYSTEM DEVELOPERS IN RELATION TO ANTICIPCATED TIMESCALE/IMPLEMENTATION DATE** July 2024 Update - Enhancement requested, awaiting approval and allocation to DevLog.
14. Executive Lead as a separate Lead on Inspections.	**External Development led by AMaT. Added to the system Development Log for approval. High priority has been assigned.**	AMaT System developers	**AWAITING CONFIRMATION FROM AMAT SYSTEM DEVELOPERS IN RELATION TO ANTICIPCATED TIMESCALE/IMPLEMENTATION DATE** July 2024 Update - Enhancement requested, awaiting approval and allocation to DevLog.

Joint Commissioning Committee
16 July 2024
Agenda Item: 4.1.5

Reporting Committee	**Quality Patient Safety Committee (QPSC)**
Chaired by	**Susan Elsmore**
Lead Executive Director	**Director of Nursing & Quality**
Date of Meeting	**24 June 2024**

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

1. CARDIAC PATIENT SOTRY

Members received an informative patient story about a gentleman who had suffered a sudden cardiac arrest. Members noted the challenges that the patient faced at the outset and how a range of JCC services and the public saved his life. The patient and his family praised the care that they had received throughout this traumatic event. The patient story highlighted the positive impact that the EMRTS service and the cardiac services had made to the patient's quality of life.

2. 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 and a summary of the highest scoring risks was provided.

3. 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.

- **South Wales Plastic Surgery**
  Members noted that this service provided by SBUHB remained at Level 2 of the Escalation process and was the only NWJCC commissioned service where patients were waiting over 104 weeks. The JCC made a choice around not accelerating improvements but within the ICP for 2024/2025 it was agreed to continue with this steady improvements towards the target. However, following approval of the ICP, WG published targets to achieve

104 weeks by March 2025. These were further revised in a letter received from the Deputy General/CEO NHS Wales on 7 May 2024 outlining revised Ministerial targets of no patients waiting over 104 weeks by the end of December 2024. This will require a decision to be made by the NWJCC in July 2024 and the NWJCC is undertaking further work currently with SBUHB to understand the demand, activity and efficiency assumptions in this delivery plan and trajectory, and engaging with Health Boards on the approach to the balance between the financial position and performance.

- **Plastic Surgery Outreach at BCUHB**
  This service was currently within the Welsh Government escalation/ special measures framework for BCUHB as the quality issues concern the operational responsibility of BCUHB for the provision of clinic administration and facilities under a Service Level Agreement between the Health Board and MWL. WG have acknowledged that there was evidence of improvement. Since the last meeting the harms review had been completed and it was presented to BCUHB QPSC Committee in June 2024. The report provides assurance that no evidence of patient harm was found. Despite this being a retrospective review, these issues have been mitigated as the level of service support, administration, quality reporting process, activity and waiting times reporting and ongoing monitoring arrangements have been strengthened. In addition, they have also funded waiting list initiatives to address the backlog and there were fewer patients on the waiting list compared to when the review was started.

3.2 Cardiac

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

- Although the two service providers in South Wales following a Getting it Right First Time (GIRFT) review have been in escalation for some time, they have been on a de-escalation trajectory for most of that time and both services have engaged well with the escalation process. Swansea Bay Cardiac Surgery Service was de-escalated from Level 2 to 0 of the Escalation Framework in May 2024 and was now out of escalation completely. The Cardiff and Vale Cardiac Surgery Service has been de-escalated to Escalation Level 1 pending receipt of an audit report.
- An update was provided on the exercise into any unreported cases of Mycobacterium Chimera. This bacteria is associated with water heater cooling systems used in cardiac surgery. They undertook an extensive piece of work in terms of a look back and this work has concluded with no new cases having been reported within the last 8 years. This extensive work seems to be working as there had been no recent reported cases.

3.3 Neurosciences

Members received an update of the quality issues for services relating to the neurosciences Team Portfolio.

- NWJCC had reallocated funding to address the Neurosurgery risk and agreed additional money within the ICP for 2024-2025.

- There were two service related risks which were being managed in line with the engagement for service change guidance issued by Welsh Government and the NWJCC were keeping in close contact with Llais.

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.

Paediatric Surgery

Members noted the positive progress and good evidence of operational improvement underpinning a reduction in the waiting times and the waiting list in line with the accelerated target over and above the ministerial measures of 52 weeks that the JC agreed last year. The HB was not able to achieve the target by the end of March 2024 due to the industrial action but assurance has been received that the target will be achieved by the end of June 2024. Based on this assurance, the Commissioning Team agreed to de-escalate the service to Level 0 and the service has returned back to normal performance monitoring arrangements. The letter confirming the de-escalation was sent to the provider last week. The JCC ambition for this year was to maintain that 52 week wait.

Wales Fertility Institute

Members noted the positive progress with the Fertility service issues. Due to regulatory issues following an inspection by the HFEA the service was placed in escalation Level 4 with regular reporting through the NWJCC via the Performance Report. A positive inspection report from the HFEA had recently been received and reported through the escalation meeting. There had been good progress in the appointment of a Person responsible (PR) with the intention to appoint more than one person to perform the PR role to ensure sustainability going forward. Following confirmation of the above progress, the Commissioning Team agreed to de-escalate the service to Level 3 and remove the service from the critical escalation Level 4.

Neonatal Care (NICU) and Paediatric Intensive Care (PICU)

Members noted that there was less assurance in relation to Paediatric Intensive Care (PICU) and Neonatal Care and as commissioners it was noted that the same level of progress had not been made within these service areas. A decision was taken to reset the process at executive level and move towards a more outcomes and objectives based escalation. Whilst most of the services have been on a de-escalation trajectory, progress within these two service areas was complicated

due to some underlying themes such as the scarcity of specialist workforce. The NWJCC understood the complexities and this was the reason for the reset approach to try and achieve a better outcome for the population of South Wales.

Members discussed the new approach and questioned how these services would be measured going forward. Members were assured that the NWJCC would be using national benchmarks and metrics and monitoring those together with the Health Board and addressing access to those really highly specialised services to ensure that we are assured on the quality management systems and workforce availability within these two areas.

3.5 Mental Health

Members received an update of the quality issues for services relating to the Mental Health and Vulnerable Groups for the former WHSSC Commissioning Team Portfolio.

Members noted that there had been little change to the commissioning risks since the last report. Funding to address the Neuropsychiatry sustainability risks was approved and was included in the ICP for 2024/2025 with the aim to bring the business case seeking funding release to the Management Group meeting in July 2024.

Members noted the comprehensive summary regarding Gender Development Service (GIDS) for Children and Young People, the Cass review, the new legislation around prescribing puberty supressing hormones and the progress that has been made on Phase one and Phase two of the NHS England transformation programme.

Members were made aware of some issues in relation to a specialist eating disorder provider.

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. Members noted that the Independent Provider Framework Agreement with the independent sector for the provision of home care and parenteral nutrition products ended on 30th June 2024. A procurement process was undertaken by the NHS Wales Shared Services Partnership (NWSSP) to renew the Framework agreement. The three open risks were linked to this issue and will be de-escalated following the renewal of this Framework agreement.

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 Paediatric services in escalation Level 3 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 Quality and Safety Report (Former EASC)

Members received a report providing an update on quality and safety matters for the Emergency Ambulance Services Committee (EASC) commissioned services. Members noted that this report was usually considered under the EASC Management Group before being presented to the EASC Joint Committee.

A range of the measures were presented and discussed. Members provided useful feedback on what information they would find useful for future reports.

4.3 Mental Health and Vulnerable Groups Commissioning Management Team Report

Members received a report providing an update on issues for services relating to the MHVG Commissioning Management Team. Due to the transition of work from the former Quality Assurance Improvement Service into the new NWJCC, the service portfolio reported was focused on the 'National Collaborative Framework for the provision of services for Adult Mental Health Learning Disability / Child and Adolescent Mental Health Hospitals', with a view to presenting a fully integrated MHVG report for the next QPSC meeting.

Members provided useful feedback on what information they would find useful for future reports.

4.4 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 February 2024 to May 2024 was presented to the committee.

4.5 Incident and Concerns Report

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

4.6 Policy Group Report

Members received an update on activity and output from the NWJCC Policy Group during the period 1 January 2024 – 31 March 2024 together with an updated overview of all NWJCC policies and service specifications including those published during the current financial year, together with the rationale for their development.

5. ITEMS FOR INFORMATION

Members received a number of documents for information only:

- Chair's Report and Escalation Summary to Joint Committee April 2024;
- Welsh Health Circular: NHS Wales National Clinical Audit and Outcome review plan: Annual Rolling Programme from 2024/2025; and
- QPSC Distribution List.

6. ANY OTHER BUSINESS

Members provided useful feedback on the quality newsletter.

Key risks and issues/matters of concern and any mitigating actions

Key risks are highlighted in the narrative above and summarised below;

- The general concerns with paediatric services in CVUHB.
- Ensuring future reports are aligned to the new duty of quality.
- Ensuring concerns report contain some trends and themes as well as capturing patient experience/stories.

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	2 September 2024

Executive Director Lead: Nicola Johnson and Carole Bell
Commissioning Lead: Vacancy
Commissioning Team: Women and Children

Date of Escalation Meetings: Most recent - 16/05/24
Date Last Reviewed by Quality & Patient Safety Committee: 19/02/2024

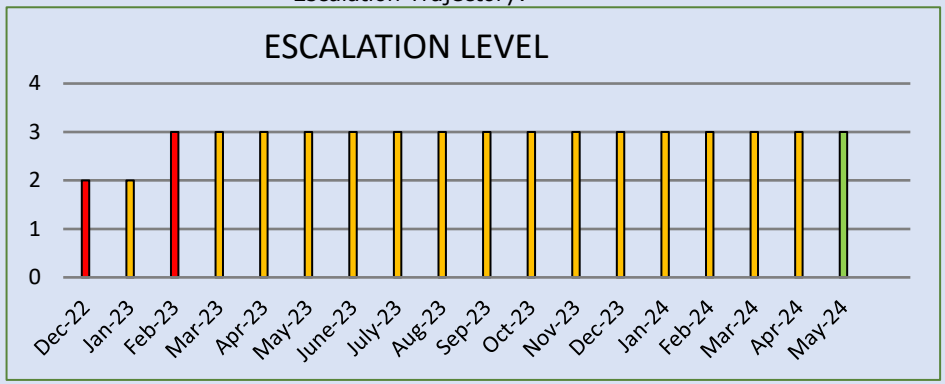
Service in Escalation: Paediatric Surgery

Current Escalation Level 3

Escalation Trend Level

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

Escalation Trajectory:



Escalation History:

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

Rationale for Escalation Status :
As a result of the service failing to engage fully with WHSSC regarding contract delivery and waiting time profiles, it was agreed that the service should be further escalated from Level 1 to Level 3 of the WHSSC Escalation Framework. A target of 52 weeks was set by the WHSSC Joint Committee.

Background Information:

• The WHSSC Joint Committee committed to a target of 52 weeks and to maintaining this in the ICP 2024/25. There has been operational improvement in the service.

WHSSC assurance and confidence level in developments:

High – Action plan developed and positive progress made in delivering service improvements and securing additional capacity. The target was not met by the end of March due to the effects of industrial action but assurance has been given on achieving it by the end of June 2024. This has been reported to Management Group and JCC with acknowledgement that de-escalation is to be considered at the Commissioning Team meeting in June 2024.

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	
Triple escalation meetings established to monitor progress of all three paediatric services in escalation against overarching objectives.	Director of Planning & Performance / Director of Nursing and Quality	16 May 2024	

Issues/Risks:
May 2024 – Escalation status being considered at Commissioning Team meeting in June 2024.

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

Date of Escalation Meetings: 10/10/23, 19/12/23, 16/05/24
Date Last Reviewed by Quality & Patient Safety Committee: 19/02/2024

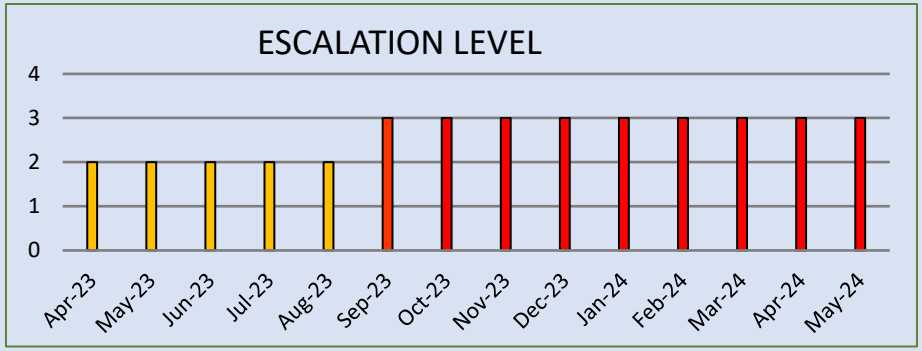
Service in Escalation: Paediatric Intensive Care

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ May 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. Escalation status being discussed at executive level within the JCC.

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	30 June 2024	
Requested sight of the Pressure Sore report presented to the HB Quality and Patients Safety Committee.	Senior Planning Manager	Ongoing	
Triple Escalation meeting to discuss detail and progress against action plan (monthly)	Senior Planning Manager	16/05/24	

Issues/Risks:

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

Date of Escalation Meetings: 10/10/23, 19/12/23, 16/05/24
Date Last Reviewed by Quality & Patient Safety Committee: 19/02/2024

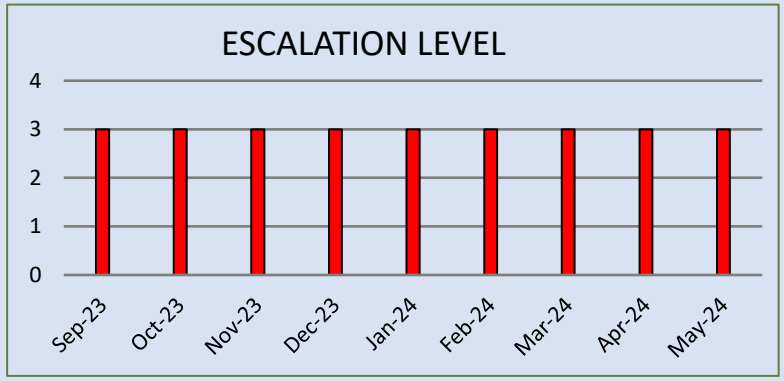
Service in Escalation:
Neonatal Intensive Care Unit

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ May 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. Escalation status being discussed at executive level within the JCC.

Actions:

Action	WHSSC Lead	Action Due Date	Completion Date
Working with C&V UHB executive team to develop a plan to implement new baseline as all other HBs are in a position to go live	Director of Planning	16/05/24	

Issues/Risks:
March 24 - The service have not submitted an action plan despite being in escalation since Sept 23, they are unable to increase their cot numbers based on the new cot configuration and reported that they cannot safely deliver on the cots that they are currently commissioned, no progress made with exec to exec meeting, possibility that outsourcing from the service may be required, the service remains at escalation level 3 but if there are no improvements increasing the escalation will be considered.
May 24 - Through quarterly assurance meetings with all neonatal units in the South & West of Wales it has been reported that there has been increased pressure across the network for cot availability

Executive Director Lead: Iolo Doull
Commissioning Lead:
Commissioning Team: Women and Children

Date of Escalation Meetings: 07/08/23, 19/09/23, 10/10/23, 07/12/23, 15/02/24, 14/03/24, 11/04/24, 08/05/24
Date Last Reviewed by Quality & Patient Safety Committee: 19/02/2024

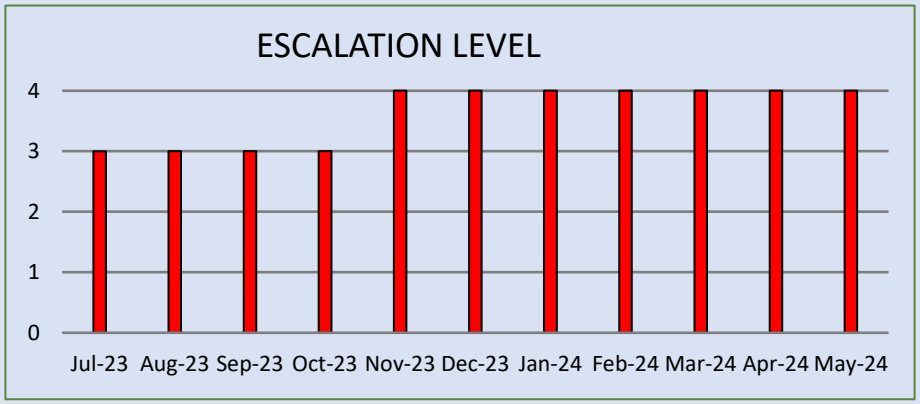
Service in Escalation: Wales Fertility Institute

Current Escalation Level 4

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ May 2024
↔	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.

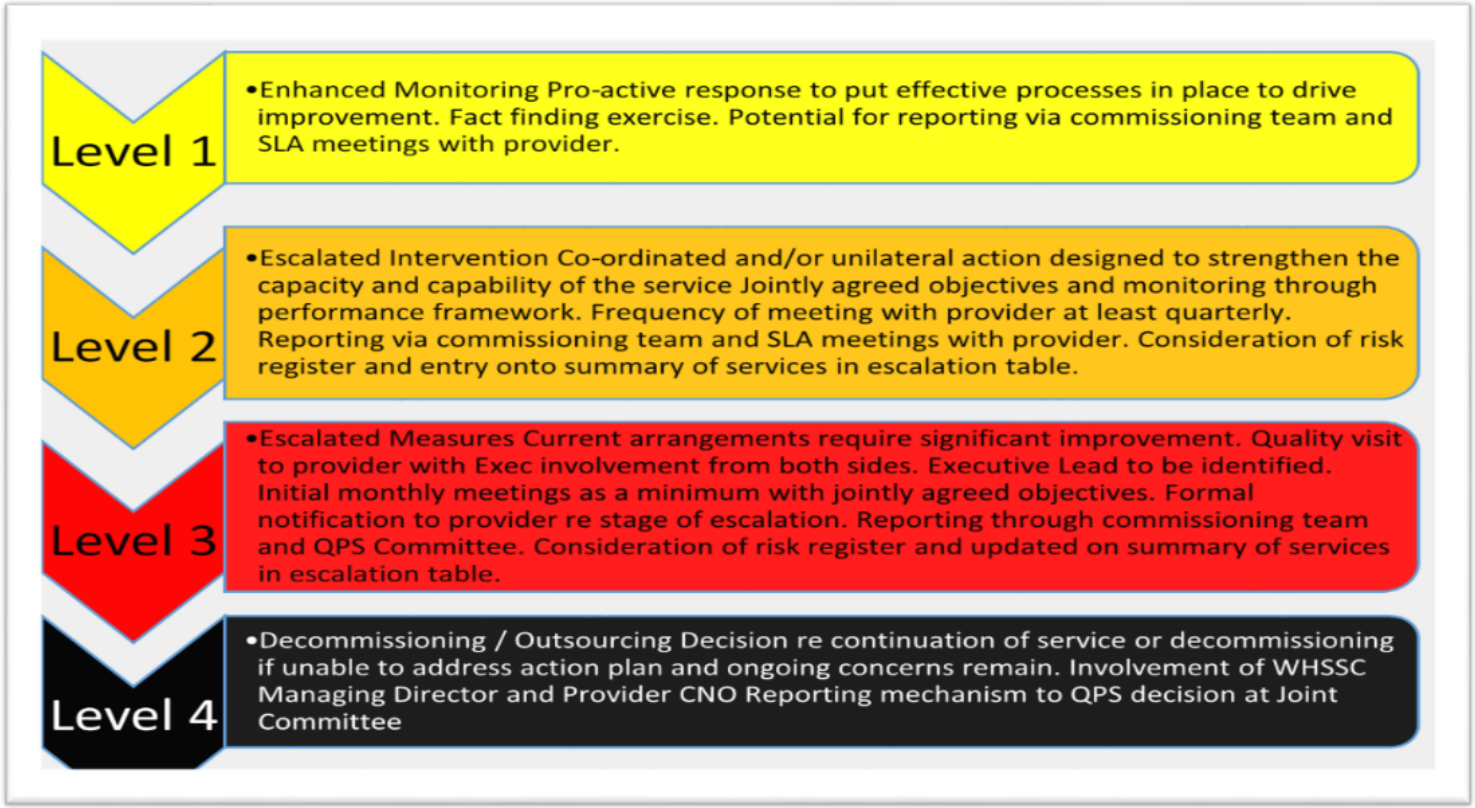
Actions:

Action	Lead	Action Due Date	Completion Date
Monthly escalation meeting to review progress against Action Plan Escalation meeting 19th September 2023 10th October 2023 7th December 2023 15th February 2024 14th March 2024 9th April 2024 8th May 2024	Assistant Specialised Planner	Monthly	13 June 2024

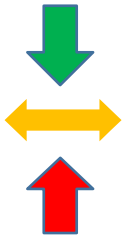
The service submitted an audit of notes to the HFEA at the end of December, they are awaiting feedback from this submission. The service have identified a number of suitable staff members to prepare and take on the role of PR. The intention is for all suitable staff to sit the exam, to ensure sustainability of the service with a PR over Cardiff and a PR over Neath Port Talbot. Cardiff inspection took place in March 2024, following the inspection being considered by the HFEA licensing panel who agreed to changing the licence to a storage only facility. The Neath Port Talbot Inspection took place in May 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. A new clinical service manager took up post at the start of May 2024. The HB have agreed to undertake a comprehensive service review to include, performance, finance, complaints, incidents and risks. It was originally intended for the review to be completed by the end of January 2024 however this has been delayed with the review report due to be shared with the HB Board at the end of May 2024.	SMART Action plan reviewed and agreed	Service Manager	19th September 2023	19th September 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

Agenda Item
8.2.6

Quality & Safety Committee

Infection Prevention & Control Annual Report 2023 – 2024

Dyddiad y Cyfarfod / Date of Meeting	18/09/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Bethan Cradle Head of Infection, Prevention and Control at time of Annual Report
Cyflwynydd yr Adroddiad / Report Presenter	Filipe Leitao, Head of Infection Prevention and Control
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Tabled and noted at Infection, Prevention & Control Committee	16/07/2024	Received and Noted

Acronyms / Glossary of Terms	
AMR	Anti-microbial Resistance
ANTT	Aseptic Non Touch Technique
ARI	Acute respiratory infection
BBE	Bare Below Elbow
CAUTI	Catheter Associated Urinary Tract Infection
HCAI	Health Care Associated Infection
IP&C	Infection, Prevention and Control
LAB	Line Associated Bacteraemia
PPE	Personal protective equipment
PPS	Point Prevalence Study
PII	Period of Increased Incidence

1. Situation /Background

1.1 The Infection, Prevention and Control annual report provides a detailed analysis of the surveillance data, audit, education / training and policies developed to support and direct patient care.

1.2 This report covers the date range of April 2023 to March 2024

2. Specific Matters for Consideration

2.1 **The key achievements are outlined on pages 3 to 4 of the report, they include**:

2.2 All Acute Respiratory Infection (ARI) outbreaks across the UHB have continued to be managed by the IP&C team. Multidisciplinary Period of Increased Incidence (PII) meetings are held to discuss each outbreak and learning is shared widely to influence and inform practice.

2.3 All healthcare associated Clostridium difficile and preventable bacteraemia e.g., Catheter Associated Urinary Tract Infection (CAUTI) and Line Associated Bacteraemia (LAB) have been investigated by the IP&C team, with occasional Patient Care & Safety involvement, to understand whether Duty of Candour has been breached.

2.4 The IP&C team introduced local improvement goals and shared monthly infographic reports to support ownership of local data. The IP&C team are planning to develop Care Group HCAI improvement goals for the upcoming financial year.

2.5 The IP&C team continue to support the mandatory IPC/ANTT training program and have delivered a number of hand hygiene, bare below elbow (BBE) and personal protective equipment (PPE) training sessions.

2.6 The IPC Strategy 2024 - 2027 has been developed and awaiting ratification in the upcoming Q&S Committee meeting.

2.7 The IP&C team achieved reasonable and substantial assurance following an internal decontamination audit performed in July 2024.

2.8 The UHB achieved the Pseudomonas aeruginosa HCAI improvement goal.

2.9 The IP&C team participated in the national HALT-4 Point Prevalence Study (PPS). The survey determined the number of residents in long term facilities receiving antibiotics for an infection. Four care homes within the CTM boundary took part in the survey and results were shared with Public Health Wales colleagues.

2.10 Welsh Government (WG) HCAI/AMR improvement goals – these have remained the same as the previous financial year.

2.11 The Improvement goals for reducing healthcare associated infections includes five key surveillance organisms; Clostridium difficile, Staph aureus bacteraemia (combined target), E.coli bacteraemia, Klebsiella sp. bacteraemia and Pseudomonas aeruginosa bacteraemia.

2.12 The UHB is working towards the goals set out in the UK AMR Strategy, the 5-year ambitions outlined in the UK National Action Plan 2019-2024 and the addendum published in May 2022. The 4-nations are in the process of developing the next 5-year National Action Plan.

2.13 Local improvement goals were agreed for each of the then Integrated Locality Groups (ILG), based on the wider Health Board targets for reducing healthcare associated infections. A monthly infographic demonstrating the local and Health Board position was shared with the relevant stakeholders and discussed at local IPC meetings. Assurance is provided to IPC committee on a quarterly basis

3. Key Risks / Matters for Escalation

3.1 **At the July 2024 Infection Prevention and Control Committee meeting the members resolved to**:

3.2 Note to implement the New IPC Strategy.

3.3 Note the overall poor compliance of the IPC Audits.

3.4 Continue to support the decontamination agenda for both Primary and Secondary Care Services.

3.5 Support refurbishment of Capital Project Schemes including Llantrisant Health Park.

3.6 Deliver a comprehensive surveillance auditing and training programme.

3.7 Continue working on all the improvement works.

4. Assessment

4.1 The Priorities for 2024- 2025 can be found on pages 28 and 29 of the Annual Report, these include:

4.2 The implementation of the IPC Strategy (2024-2027). The IPC team will provide an integrated service across primary, community and secondary care services. More emphasis will be placed on making improvements in primary care to advance patient care and safety and influence a reduction in C. difficile, S. aureus and gram-negative infections.

4.3 The continued support of the decontamination agenda for both primary and secondary care services.

4.4 The support of refurbishment and capital project schemes ongoing across the Organisation, including Llantrisant Health Park.

4.5 The aim to deliver a comprehensive surveillance, audit and training program.

4.6 The support of clinical teams to reduce healthcare associated infections.

4.7 The development of local HCAI improvement goals for the 5 mandatory surveillance organisms in line with the new Care Group model.

4.8 The involvement in national work to standardise IPC practice/procedures/ audit and investigative tools.

4.9 The following improvement work will recommence:

4.10 Develop and introduce a robust root cause analysis process for all HCAI/CAI cases of C. difficile and preventable infections.

4.11 Establish a CAUTI/IV device improvement group to support a reduction in device associated bacteraemia.

4.12 Support improvements in IPC practice.

4.13 Work towards achieving bronze accreditation for ANTT.

4.14 Support maternity services to improve surveillance and reporting of C-section surgical site infections

5. Assessment

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

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality**	Yes: ☐	No: ☒
	Outcome:	This is not required as the report is an Annual Report comprising of factual data,

Have you undertaken a Quality Impact Assessment Screening?		progress and priorities for 2024- 2025
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	This is not required as the report is an Annual Report comprising of data, progress and priorities for 2024- 2025. If copies of the Annual Report in the Welsh language are requested these can be provided.
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.	

6. Recommendation

6.1 The Quality & Safety Committee is asked to **NOTE** this report.

7. Next Steps

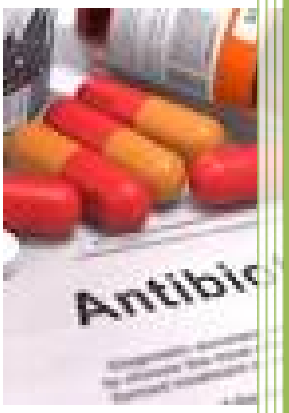
7.1 As detailed in section 4.9 focus will be on recommencing the 5 topics of improvement work.

Enc. 4

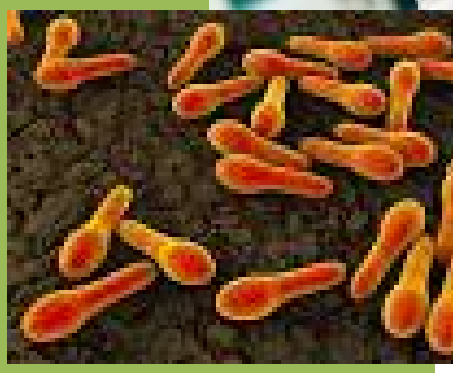
GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Infection Prevention & Control Annual Report 2023-2024









July 2024
Draft V1

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1. Executive Summary

Cwm Taf Morgannwg University Health Board (CTMUHB) strives to deliver safe and effective care, enhanced value across the diverse communities and improved health and wellbeing. Quality and Safety is at the heart of everything we do and the organisational strategy; CTM 2030 'Our Health, Our Future', outlines the significance of service improvement, 2030 and beyond.

Healthcare associated infections (HCAI) remains a key patient safety issue, which results in a significant burden of disease and financial cost to the NHS in Wales. CTMUHB is committed to reducing HCAI and adopts a zero tolerance to all preventable infections. There are effective management arrangements, assurance systems and reporting processes in place to support and drive the infection prevention and control (IP&C) agenda.

Our goal is to be the best in Wales and we are making incremental changes to improve patient safety and deliver the HCAI improvement goals set by Welsh Government.

The Infection Prevention Control Team (IP&CT) cover secondary care services across the UHB but have minimal input in the primary care sector. There is a strategic review planned to determine the direction of IPC across the CTM footprint. The aim is for the IP&CT to provide an integrated service across primary, community and secondary care services. The UHB will not achieve the improvement goals without investment in primary care.

Improving IPC practices will reduce healthcare associated infections and the need for antimicrobials, which in turn will preserve their effectiveness.
We must use the lessons learned from the pandemic to strengthen our focus on the IPC agenda to improve the quality of our health and care services.

The IPC service continues to strengthen across the Health Board which is supported by a comprehensive range of infection prevention and control policies and procedures which act as a resource for clinical staff.

The annual report provides a detailed analysis of the surveillance data, audit, education / training and policies developed to support and direct patient care. The information has been collected and produced by the IP&CT for April 2023 to March 2024.

Key achievements

- The IP&CT have continued to manage Acute Respiratory Infection (ARI) outbreaks across the UHB. Multidisciplinary Period of Increased Incidence (PII) meetings are held to discuss each outbreak and learning is shared widely to influence and inform practice.
- All healthcare associated Clostridium difficile and preventable bacteraemia e.g., Catheter Associated Urinary Tract Infection (CAUTI) and Line Associated Bacteraemia (LAB) have been investigated by the IP&CT, with

occasional Patient Care & Safety involvement, to understand whether Duty of Candour has been breached.

- The IP&CT introduced local improvement goals and shared monthly infographic reports to support ownership of local data. The IP&CT are planning to develop Care Group HCAI improvement goals for the upcoming financial year.
- The IP&CT continue to support the mandatory IPC/ANTT training program and have delivered a number of hand hygiene, bare below elbow (BBE) and personal protective equipment (PPE) training sessions.
- The IPC Strategy 2024 - 2027 has been developed and awaiting ratification in the upcoming Q&S Committee meeting.
- The IP&CT achieved reasonable and substantial assurance following an internal decontamination audit performed in July 2024.
- The UHB achieved the Pseudomonas aeruginosa HCAI improvement goal.
- The IP&CT participated in the national HALT-4 Point Prevalence Study (PPS). The survey determined the number of residents in long term facilities receiving antibiotics for an infection. Four care homes within the CTM boundary took part in the survey and results were shared with Public Health Wales colleagues.

2. Healthcare associated infections (HCAI): statistics and performance

Effective infection prevention and control (IPC) must be everybody's responsibility and central to everyday healthcare practice. Effective IPC practice is based on the best available evidence to reduce preventable infections, improve the quality of care delivered and maximise outcomes for patients.

Welsh Government (WG) HCAI/AMR improvement goals for 2023- 2024

The HCAI and AMR improvement goals for 2023/24 remained the same as the previous financial year. The improvement goals for reducing healthcare associated infections includes five key surveillance organisms; Clostridium difficile, Staph aureus bacteraemia (combined target), E.coli bacteraemia, Klebsiella sp. bacteraemia and Pseudomonas aeruginosa bacteraemia.

The UHB is working towards the goals set out in the UK AMR Strategy, the 5-year ambitions outlined in the UK National Action Plan 2019-2014 and the addendum published in May 2022. The 4-nations are in the process of developing the next 5-year National Action Plan (NAP).

Local improvement goals were agreed for each of the Integrated Locality Groups (ILG), based on the wider Health Board targets for reducing healthcare associated infections. A monthly infographic demonstrating the local and Health Board position was shared with the relevant stakeholders and discussed at local IPC meetings. Assurance is provided to IPC committee on a quarterly basis.

Number and rate of *C. difficile, S.aureus* bacteraemia, *E. coli* bacteraemia, Klebsiella sp. bacteraemia and Pseudomonas aeruginosa bacteraemia per 100,000 population, April 2023 - March 2024.

	C. difficile		MRSA		MSSA		E. coli		Klebsiella sp.		Pseudo aer	
	No. of Cases	Rate	No. of cases	Rate	No. of cases	Rate	No. of cases	Rate	No. of cases	Rate	No. of cases	Rate
CTM	126	28.38	9	2.03	129	29.05	378	85.13	118	26.57	21	4.73
All Wales	1218	38.89	57	1.82	802	25.61	2274	72.61	736	23.50	145	4.63

Data taken from HCAI mandatory surveillance summary, HARP. April 2023 – March 2024.

Lower than the same period of previous FY

Higher than the same period of previous FY

Same as the same period of previous FY

*** The numbers/rates included in the table above have been taken from the HARP database. There are some anomalies compared to the local numbers included in the narrative below due to different cut off dates for collecting information.**

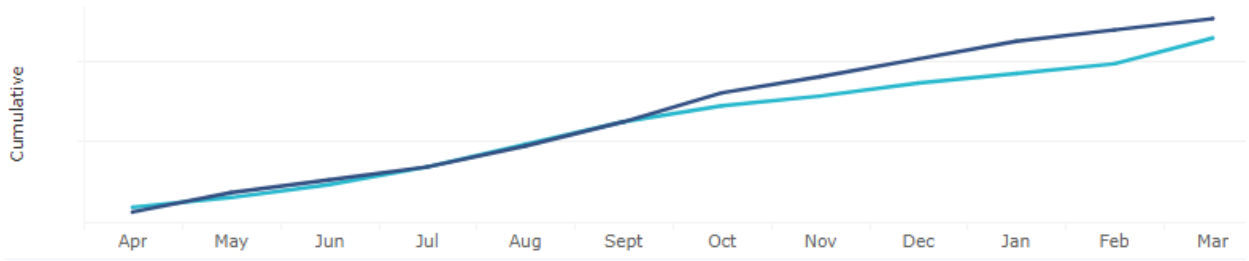
(A) *Clostridium difficile* Infection (CDI):

The reduction expectation for 2023/24 was 25 cases per 100,000 population, which equates to no more than 112 cases per year. CTM exceeded the improvement goal and ended the year with a rate of 28.38 per 100,000 population, which is lower than the all-Wales rate of 38.89.

12 additional cases reported 2023/24 compared to the previous year and CTM achieved the second lowest rate in Wales.

126 cases of C.difficile infection was reported April 2023 – March 2024.

CTMUHB cumulative monthly numbers of C. difficile in April 23 – March 24 against the equivalent period in 2022/23.



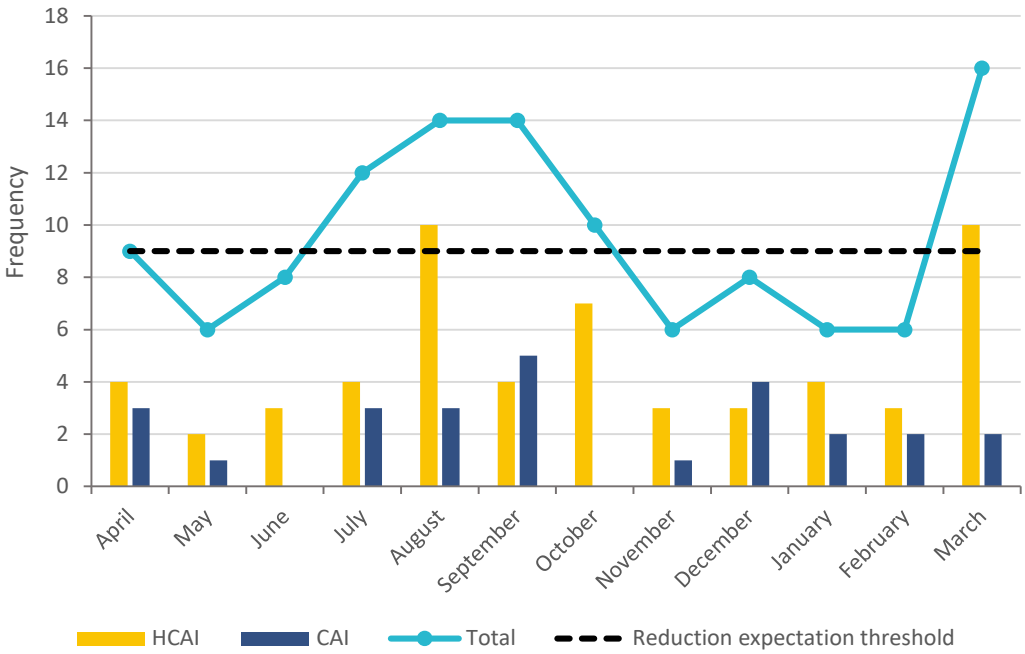


- 44% (56/126) of cases were categorised HCAI, based on sample sent >48 hours post admission to hospital or recent admission within past 4 weeks.
- 29% (36/126) of cases were deemed to be community acquired infections as the sample was either sent within 48 hours of the patients' admission or the patient had no recent admission in the past 4 weeks.
- 49% (34/70) of the total samples were sent from GP practices. Only 3 of the 34 patients had a hospital admission in the past 4 weeks.
- A seasonal increase in cases was reported between August and October 2023.

The RCA process for investigating C.difficile cases must be strengthened across secondary care and re-introduced in primary care. Common risk factors and themes of learning have been identified through the RCA/huddle process. Focused improvement work is required in the upcoming financial year to address the learning points associated with C.difficile infection.

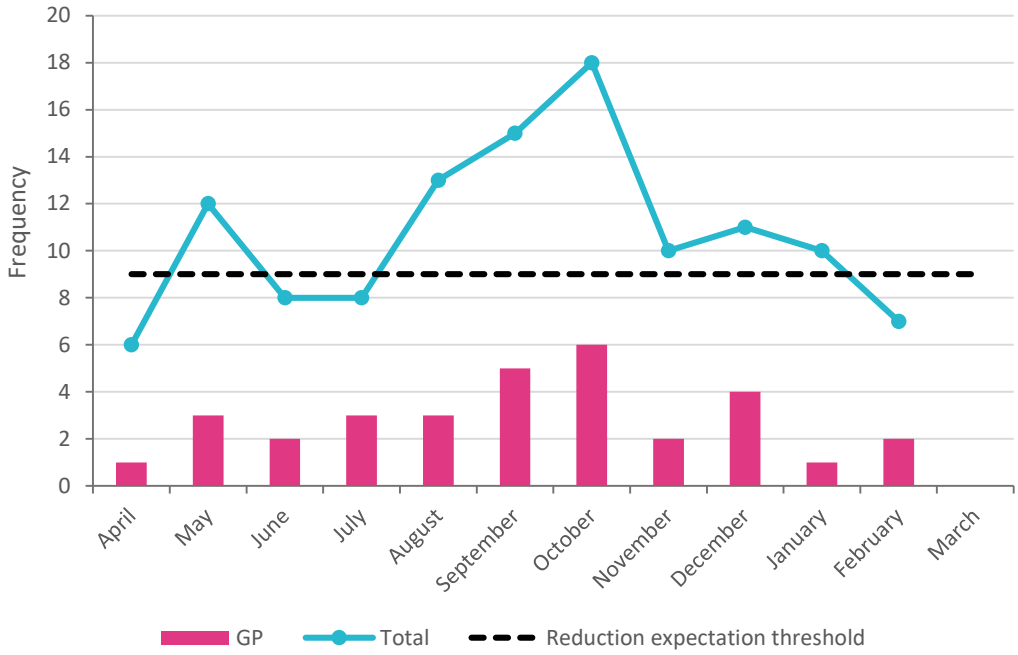
7% of the C.difficile cases were classed as a recurrent infection. The majority of cases were identified in Bridgend. Faecal Microbiota Transplant (FMT) is currently offered to patients in Rhondda Taf Ely and Merthyr Cynon. Further discussion required with key stakeholders to explore the extension of service across the Health Board.

Distribution of *C. difficile* infections (Threshold ≤9 cases/month)



⁺HCAI and CAI infections relate to infections identified in inpatient settings.
*Total includes infections identified in GP practices

Distribution of *C. difficile* infections, specimens from GP practices



*Total includes infections identified in inpatient settings

CDI Mortality Data

An incident form was submitted for all healthcare associated cases of C. difficile infection and updated if C.difficile was included on the death certificate.

Direct attributable cause of death (CDI on any part of death cert.)++

	2020/21	2021/22	2022/23	2023/24
RGH	2	1	0	4
PCH	2	2	2	1
POW	7	5	1	0
Total	11 (10%)	8 (5%)	3 (3%)	5 (4%)

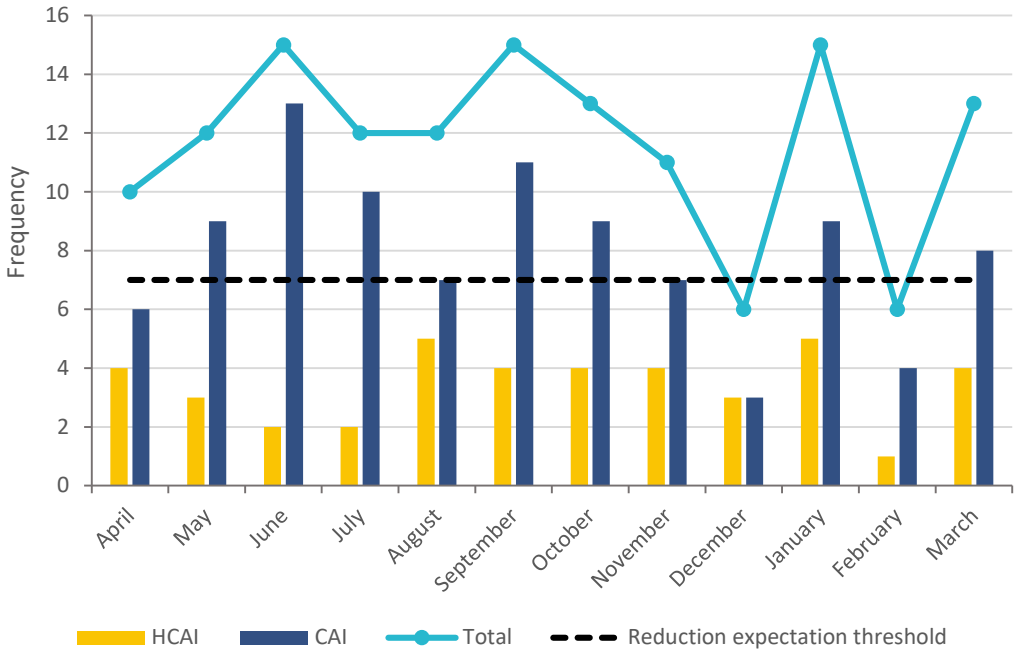
Three of the cases were deemed unavoidable following a multidisciplinary review.

(B) *Staphylococcus aureus* Bacteraemia (MSSA & MRSA)

The reduction expectation for 2023/24 was a combined target (MRSA and methicillin sensitive S.aureus) of 20 per 100,000 population, which equates to no more than 90 cases per year.

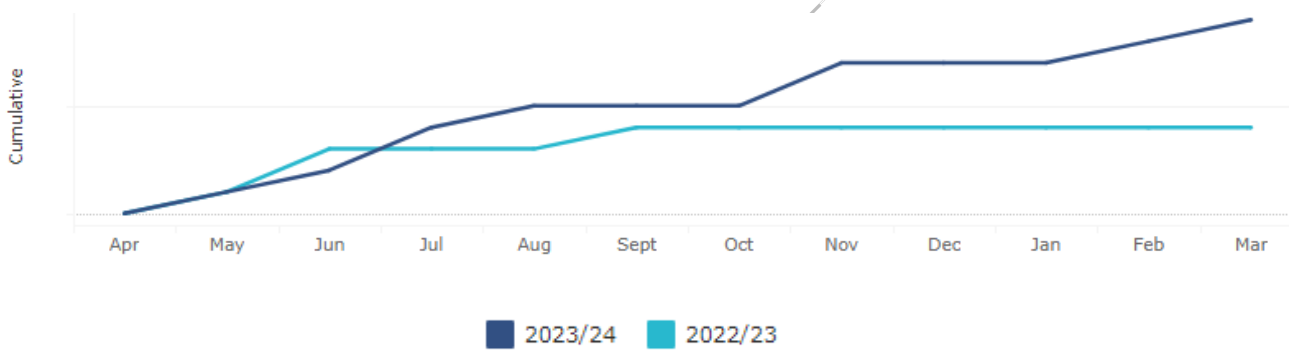
CTM achieved a rate of 31.30 per 100,000 population, which was higher than the All-Wales rate of 27.49.
CTM reported more cases than the set monthly target for a total of 10 months.

Distribution of S.aureus bacteraemia (threshold ≤7 cases/month)



MRSA

CTMUHB cumulative monthly numbers of MRSA bacteraemia April 23 - March 24 in comparison to the equivalent period in 2022/23



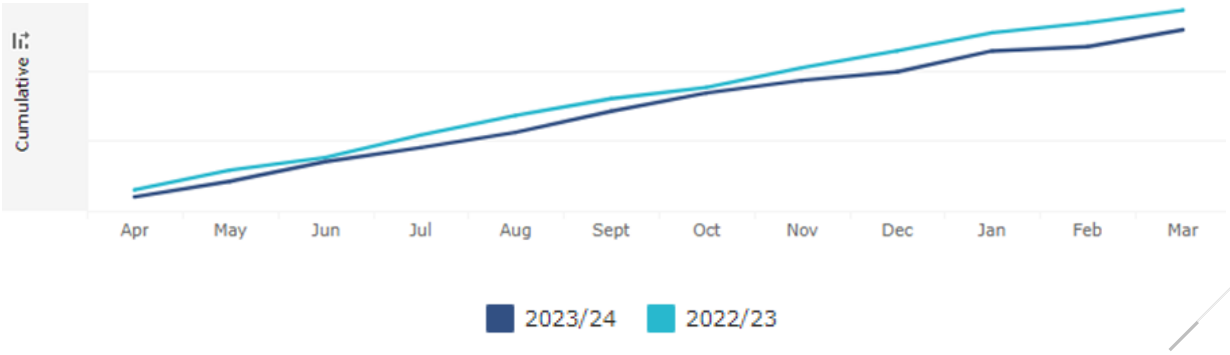
CTM reported 9 cases of MRSA bacteraemia April 2023 – March 2024. This is double the number compared to the previous year. The rate of MRSA bacteraemia was 2.03 per 100,000 population. CTM achieved the third lowest rate of MRSA bacteraemia in Wales.

- 78% of the cases were community acquired infections
- One community acquired case was deemed preventable from an IPC perspective. The bacteraemia was associated with a PICC line and managed by Velindre NHS Trust.

MSSA

130 cases of MSSA reported April 2023 – March 2024. This is approximately 9% less than the previous year. The rate of MSSA bacteraemia was 29.28 per 100,000 population. CTM achieved the third lowest rate of MSSA bacteraemia in Wales.

CTMUHB cumulative monthly numbers of MSSA bacteraemia for April 23 to March 24 against the equivalent period in 2022/23



- 24% (31/130 cases) were healthcare associated infections based on sample sent >48 hours post admission to hospital or recent admission past 4 weeks. Of the 31 cases, 26% (8/31) had a preventable source –
    - 8 IV device associated bacteraemia;
        - 6 linked to a PVC
        - 1 linked to a PICC line
        - 1 linked to a vascath

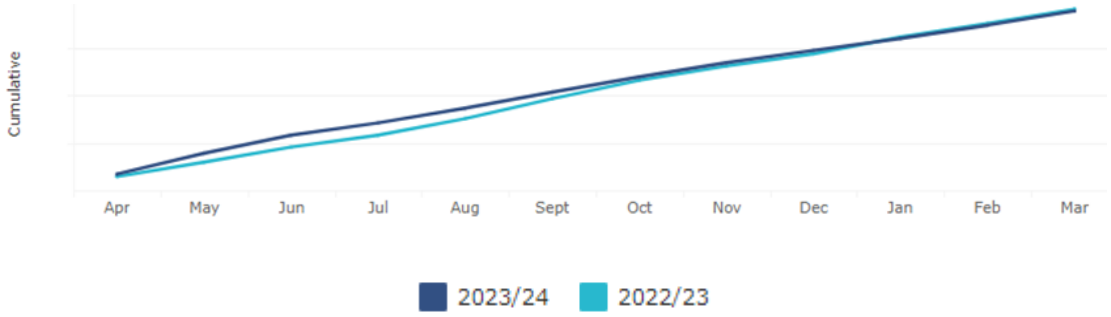
- 76% (99/130 cases) were community acquired infections. Of those cases, 8% (8/99) had a preventable source -
    - 7 IV device associated bacteraemia;
        - 6 linked to a Permacath
        - 1 linked to a central line
    - 1 case associated with a urinary catheter

The IPC Team investigate all preventable bacteraemia and work with clinical teams to share learning from incidents to influence and improve patient care.

Preventable MSSA bacteraemia is now considered a moderate risk. The Patient Care and Safety team arrange a rapid review to discuss the preventable infection and determine whether duties of candour and quality have been breached.

(C) E. coli bacteraemia

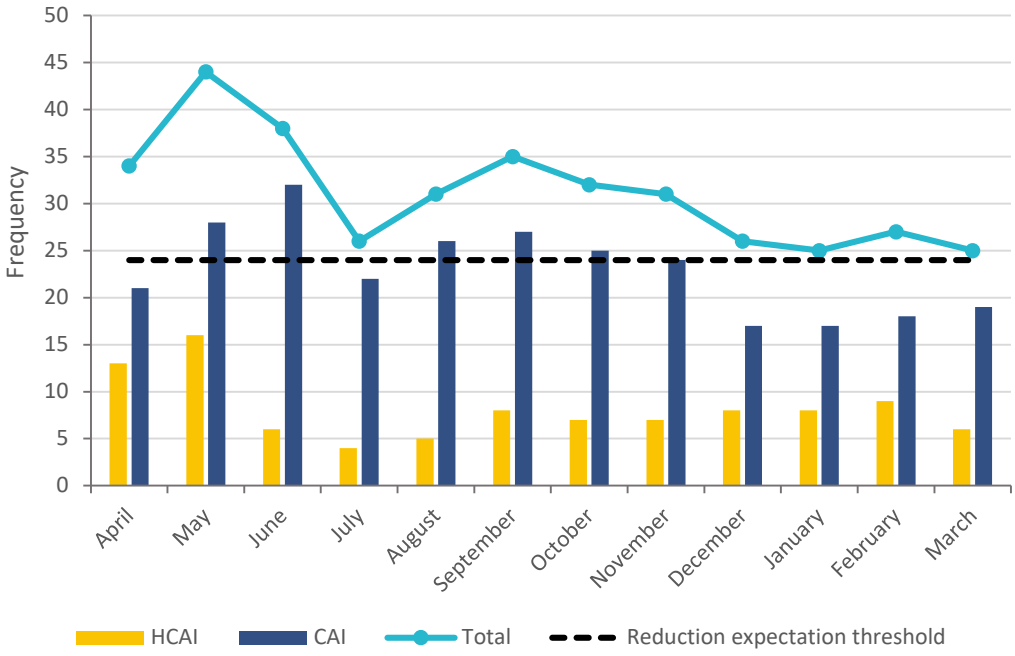
CTMUHB cumulative monthly numbers of E. coli bacteraemia for April 23 to March 24 against the equivalent period in 2022/23



The reduction expectation for 2023/24 was 67 cases per 100,000 population, which equates to no more than 301 cases.

378 E.coli bacteraemia cases were reported April 2023 – March 2024, which is approximately 1% less than the previous financial year. The rate of E. coli bacteraemia for CTM was 85.13 per 100,000 population, which is higher than the All-Wales rate of 72.61. CTM had the third highest rate of E.coli bacteraemia in Wales.

Distribution of E.coli bacteraemia (threshold ≤25 cases/month)



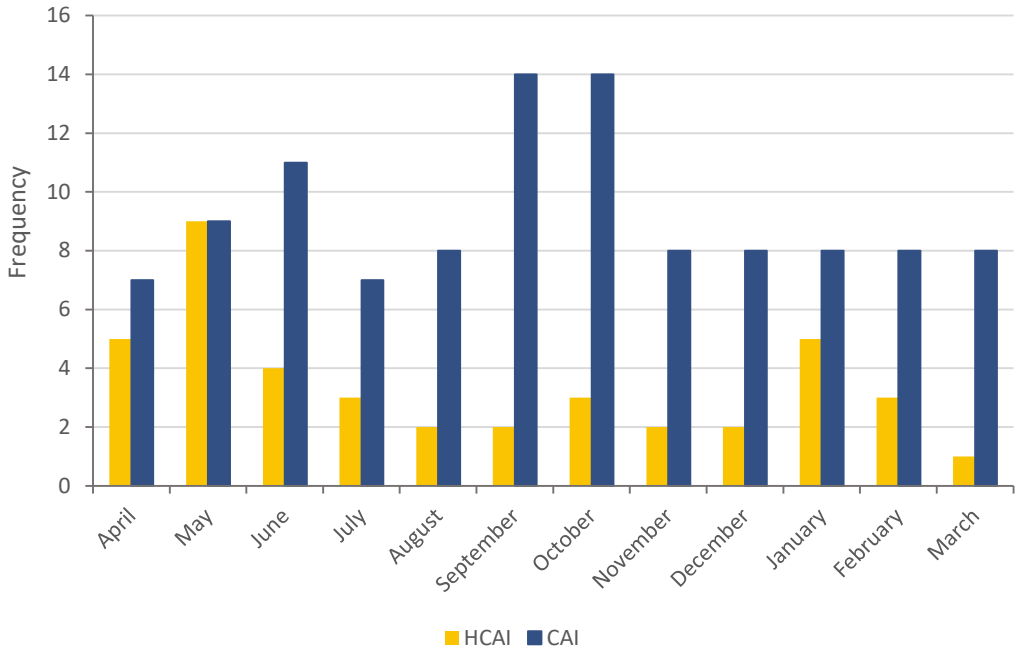
- 22% (82/378) of the cases were healthcare associated

infections based on sample sent >48 hours post admission to hospital or recent admission past 4 weeks. Of the 82 cases, 35% (29/82) had a preventable source –

- 1 IV device associated bacteraemia (central line)
- 28 cases associated with a urinary catheter

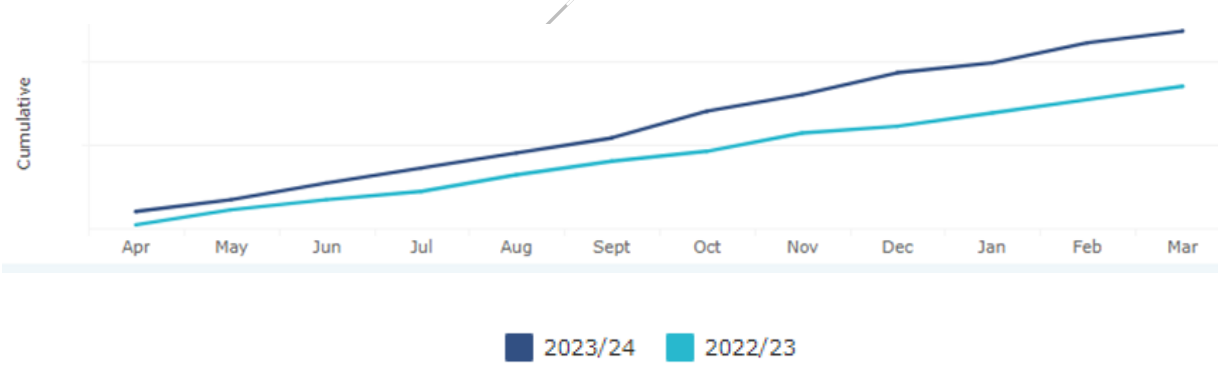
- 78% (296/378) of the cases were deemed to be community acquired infections. 3% were associated with a urinary catheter (8/296).

Counts of E.coli bacteraemia where urinary tract infection or urosepsis was identified as the source of infection.



(D) Klebsiella spp. bacteraemia

CTMUHB cumulative monthly numbers of Klebsiella spp. for April 2023 to March 24 against the equivalent period in 2022/23.

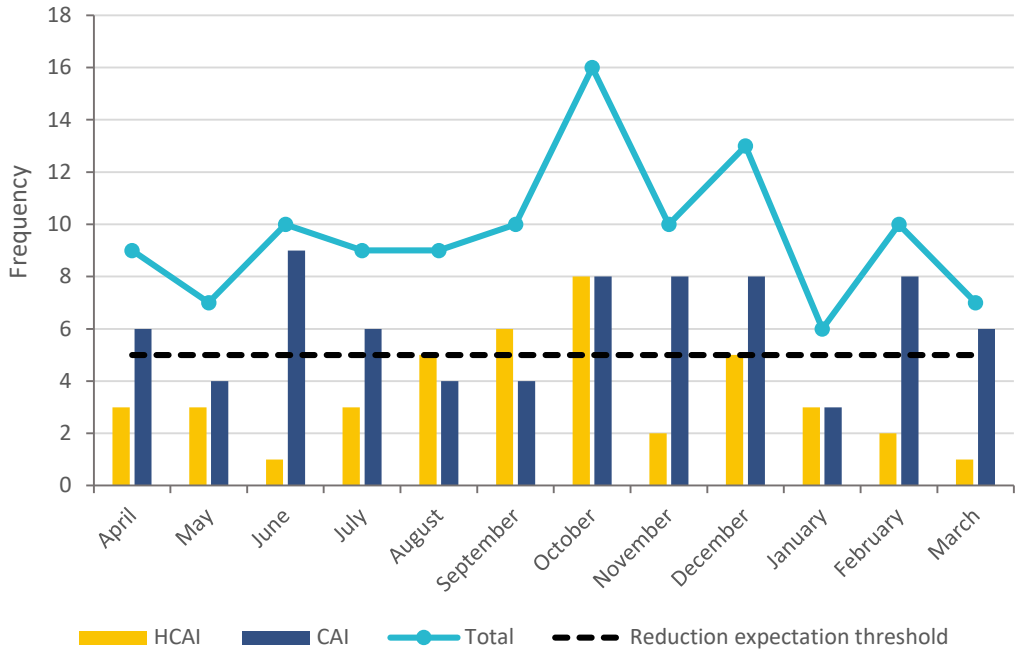


A 10% reduction compared to 2017/18 figures was expected for this period.

118 cases of Klebsiella spp. bacteraemia were reported between April 2023 – March 2024, which is approximately 28% more than the equivalent period in 2022/23. The rate of Klebsiella spp. bacteraemia was 26.57 per 100,000 population, which is higher than the all Wales rate of 23.53.
CTM had the third lowest rate of Klebsiella spp. bacteraemia in Wales.

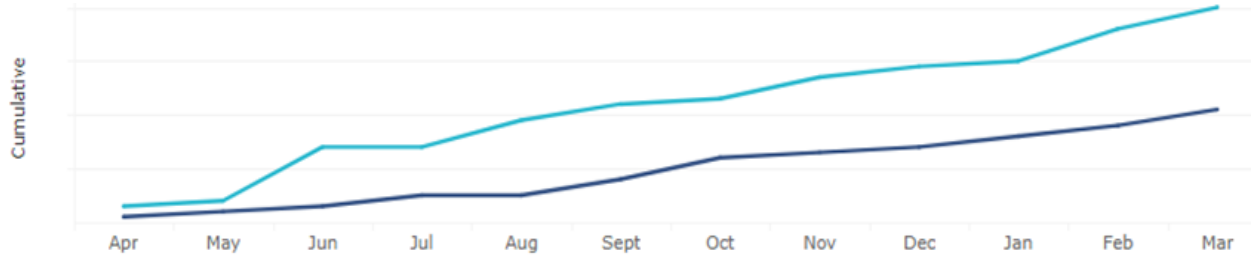
- 32% (38/118) of the cases were healthcare associated infections based on sample sent >48 hours post admission to hospital or recent admission past 4 weeks.
- 13% (5/38) had a preventable source -
  - 1 IV device associated bacteraemia (central line)
  - 4 cases associated with a urinary catheter
- 68% (80/118) were deemed a community acquired infection and 10% of cases were associated with a urinary catheter (8/80).

Distribution of Klebsiella spp. Bacteraemia (threshold ≤5 cases/month)



(E) Pseudomonas aeruginosa bacteraemia

CTMUHB cumulative monthly numbers of Pseudomonas aeruginosa for April 23 to March 2024 against the equivalent period in 2022/23

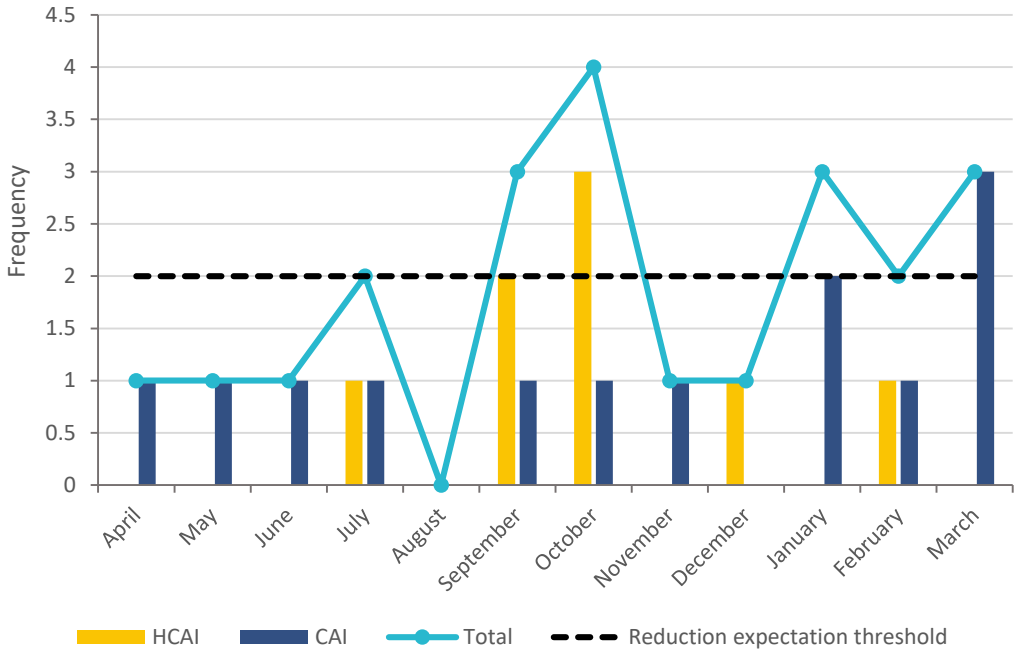




A 10% reduction compared to 2017/18 figures was expected for this period. 21 cases of P. aeruginosa bacteraemia were reported April 2023 – March 2024, which is approximately a 90% reduction in comparison to the same period in 2022/23. The rate of P. aeruginosa bacteraemia in CTM was 4.73 per 100,000 population, which is above the All Wales rate of 4.66. CTM achieved this HCAI improvement goal.

- 33% (7/21) of the cases were deemed to be healthcare associated infections, based on sample sent >48 hours post admission to hospital or recent admission past 4 weeks. 14% (3/21) of the cases were deemed to be preventable –
  - 1 IV device associated bacteraemia (midline)
  - 2 cases were associated with a urinary catheter
- 67% (14/21) of the cases were deemed to be community acquired infections and 14% had a preventable source –
  - 1 IV device associated bacteraemia (PICC line)
  - 1 case was associated with a urinary catheter

Distribution of *Pseudomonas aeruginosa* bacteraemia (threshold ≤1 case/month)



(F) Preventable infections

Clinical line infections

Clinical line infections should be reported via the Datix system. It's the responsibility of the clinical team to alert the relevant stakeholders. Therefore, infection rates are not always comparable.

In 2023/24, 11 clinical line infections were investigated and discussed in a multidisciplinary huddle. 73% of the clinical line infections were associated with a PVC.

IV device related bacteraemia

There was a 28% increase in IV device related bacteraemia compared to the same period in 2022/23.

The IP&CT continue to investigate all IV device associated bacteraemia and the investigations are shared with the clinical teams to influence and inform practice. At the end of 2023, central line study days were organised by the nurse education team for clinical staff in the UHB. The sessions incorporated PICC line management, troubleshooting and ANTT theory/practical sessions. BD representatives also delivered ward based ChloraPrep and PosiFlush refresher sessions to all clinical areas across the Health Board.

The IV steering group needs to be re-established and further work is required to arrange timely IPC huddles and improve compliance with IPC/ANTT training.

Urinary catheter associated bacteraemia

There has been a 37% increase in urinary catheter associated bacteraemia compared to the same period in 2022/23. The majority of cases are considered healthcare associated infections. The IPC team investigate both community and healthcare acquired CAUTI and a 'huddle' is arranged to discuss the cases individually.

A urinary catheter PPS has been undertaken in Royal Glamorgan and Prince Charles Hospital. The IP&CT will continue the urinary catheter PPS across the remaining hospital sites in CTM. The PPS provides baseline data in relation to urinary catheter usage, care bundle compliance and device management. The data will support the planned introduction of all-Wales urinary catheter passports across secondary care.

3. Surveillance

Surgical Site Infection Surveillance (SSI)

CTMUHB participate in the mandatory surveillance of Surgical Site Infections (SSI) for Orthopaedic and C. section surgery. Using standardised methods, allows Health Boards across Wales to analyse their SSI data and improve the quality of care delivered. National surveillance also allows hospitals/ Health Boards to benchmark performance indicators.

Orthopaedic SSI surveillance

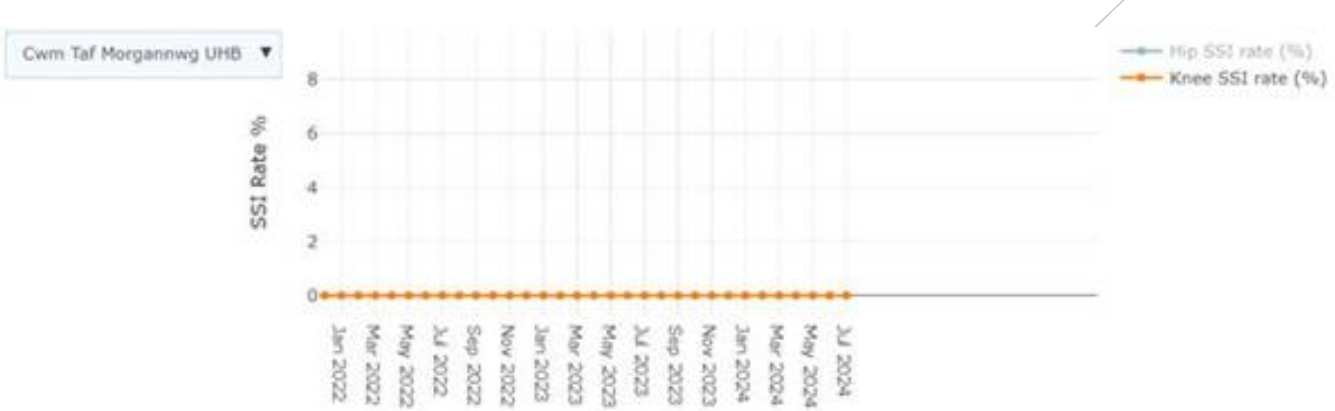
There has been one orthopaedic SSI reported for CTMUHB.
The following SSI data has been provided by the Healthcare Associated Infection, Antimicrobial Resistance and Prescribing Program (HARP) team.

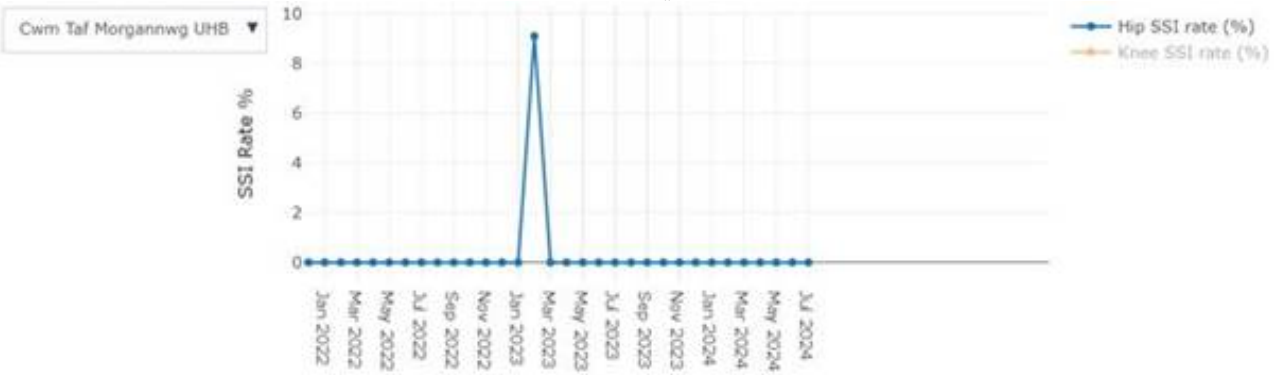
Breakdown of revisions

	Cwm Taf Morgannwg UHB		
	Procedures	*Revisions*	*Revision rate*
Overall	**479**	**39**	**8.1%**
Procedure types			
Hip	244	28	11.5%
Knee	228	11	4.8%
Other/unknown	7	0	0.0%
Age groups			
Under 65	161	8	5.0%
65-74	167	10	6.0%
75-84	122	18	14.8%
85 and over	26	2	7.7%
Unknown	3	1	33.3%
Sex			
Male	213	10	4.7%
Female	259	27	10.4%
Unknown	7	2	28.6%

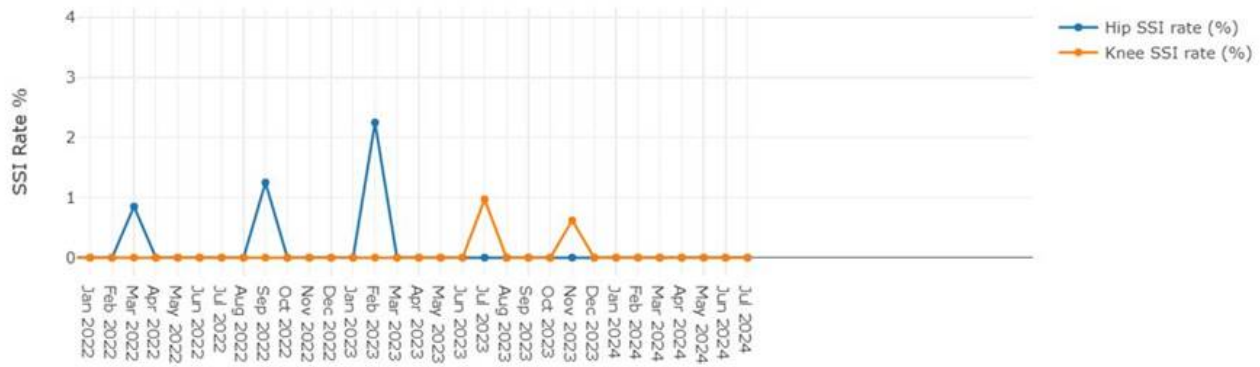
Primary Procedures

	Cwm Taf Morgannwg UHB		
	Procedures	*SSI*	*SSI rate*
Overall	**476**	**1**	**0.2%**
Procedure types			
Total hip	216	0	0.0%
Total knee	191	0	0.0%
Partial knee*	26	0	0.0%
Other/unknown	43	1	2.3%
Age groups			
Under 65	153	0	0.0%
65-74	157	1	0.6%
75-84	104	0	0.0%
85 and over	24	0	0.0%
Unknown	38	0	0.0%
Sex			
Male	203	1	0.5%
Female	232	0	0.0%
Unknown	41	0	0.0%





All Wales primary hip and knee SSI rates



C-section SSI

HARP provide a quarterly C-section SSI report. The all-Wales rate is no longer included in the narrative.

An upsurge in C-section SSIs was identified in Prince Charles Hospital between April and September 2023. Conversely, Princess of Wales Hospital reported a downward trajectory compared to the previous financial year. CTMUHB were not included in the quarter 4 report, as several months of data required validation. Public Health Wales colleagues supported the process. Following evaluation, there appeared to be an element of over-reporting in Prince Charles Hospital. The Consultant Nurse for HARP will lead the improvement work for the UHB, which will consist of robust training programs, systems and standardisation for surveillance/reporting processes.

Due to gaps in the data submitted, the following should be interpreted with caution.

Hospital and CTM data from 1st July 2022 – 30th June 2023

	SSI rate	Change	Data received**	Valid data**
Prince Charles				
Q3 2022 - Q2 2023	5.0%	↓ 12%	100%	97%
Q3 2019 - Q2 2022*	5.7%		91%	83%
Cwm Taf Morgannwg UHB				
Q3 2022 - Q2 2023	3.9%	↓ 17%	99%	97%
Q3 2019 - Q2 2022*	4.7%		89%	81%
Princess of Wales				
Q3 2022 - Q2 2023	2.4%	↓ 33%	99%	99%
Q3 2019 - Q2 2022*	3.5%		85%	74%

*Previous three years data for the hospital/health board.

Prince Charles Hospital



Princess of Wales Hospital



4. IPC Policies Approved in 2023/24

The following Infection Prevention and Control policies, procedures and guidelines were agreed at the Infection Prevention & Control Committee meetings in 2023/24. All documents are made accessible for staff via the Intranet following final approval at Quality and Safety Committee meetings.

IPC15	Creutzfeldt-Jacob Disease (CJD) Procedure for Infection Prevention & Control	18.04.23
IPC21	Meningitis Policy	18.04.23
IPC25	Measles Policy	18.04.23
IPC04	Hand Hygiene Procedure	11.07.24
FAC23	Waste Segregation Procedure	11.07.24

5. Internal Audit Programme and performance

All clinical areas complete monthly hand hygiene, BBE, PPE and environmental audits via the AMaT system. The senior nursing teams monitor/follow up on the audit findings and directly report to the IPC site and IPC committee meetings.

The IPC team has a rolling annual audit programme, which includes inpatient areas and clinical departments for independent verifications. Audit scores and results are shared with the Ward Manager and Senior Nursing teams for information, action and escalation. Infection Prevention and Control training is provided as required to address non-compliance identified during the audit process.

There has been incessant staff sickness/shortages within the IP&CT. As a result of this, the audit program wasn't achieved for 2023/24, however, the vast majority of inpatient areas were completed. PII audits and C.difficile assurance checks were carried out in response to increased incidence/ outbreaks of infection and identification of C.difficile cases. Non-compliance with IPC policies/ practice was addressed at the time of the audit.

Audit Results

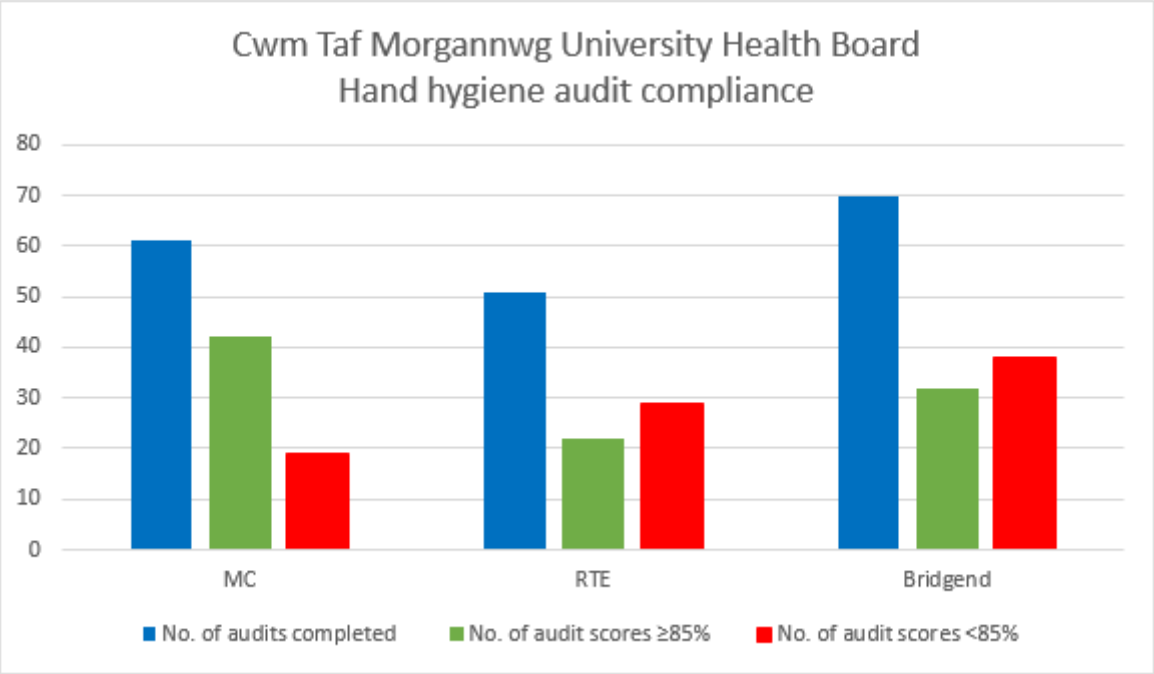
A) Hand Hygiene Audits

Hand hygiene audits are based on the WHO's "5 moments for hand hygiene", which applies to all staff working in the clinical area.

Hand hygiene is the single most important measure to prevent cross infection. Clinical engagement is paramount to improve compliance with hand hygiene practices. Infection prevention and control is everybody's business and

all staff must practice standard infection prevention and control precautions at all times.

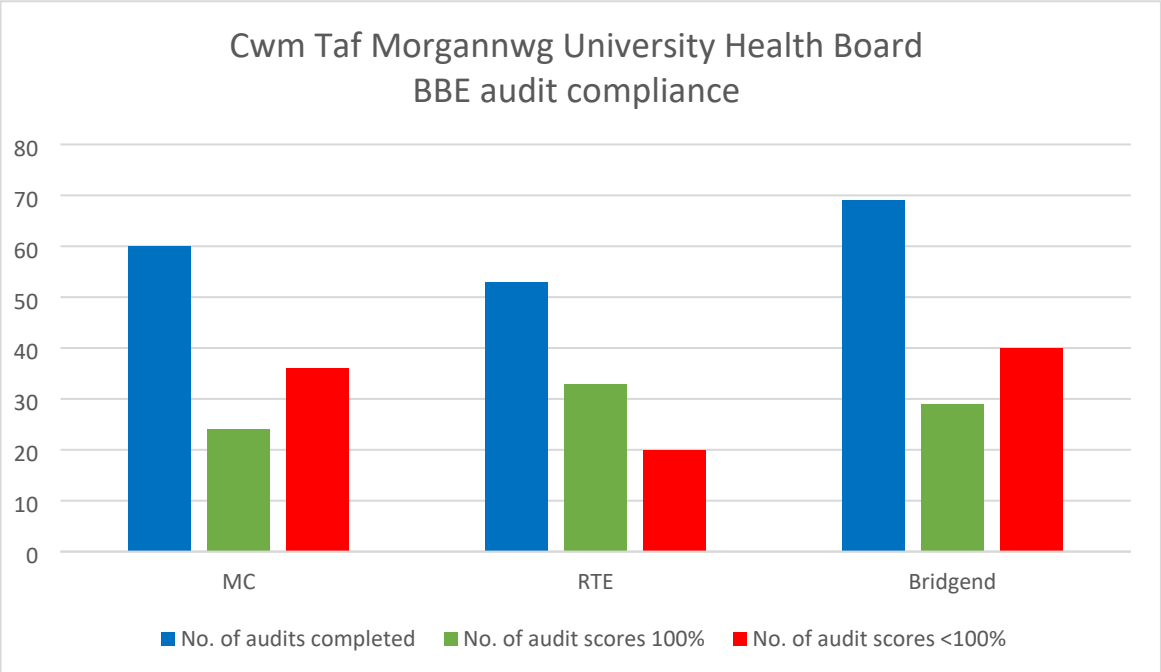
182 hand hygiene audits were completed in 2023/24 but only 53% (96/182) achieved a score of ≥85%. The IPC team provide hand hygiene training in response to poor audit scores where possible.



B) Bare Below the Elbow Audit

It is the responsibility of all clinical staff, irrespective of grade or profession to be bare below the elbow in the clinical environment.

182 audits were performed in 2023/24. 47% (86/182) of the audits achieved a score of 100%. Following review, 16% (31/182) of registered nurses, 33% (60/182) of doctors and 18% (32/182) of HCSWs were non-compliant with BBE practices.



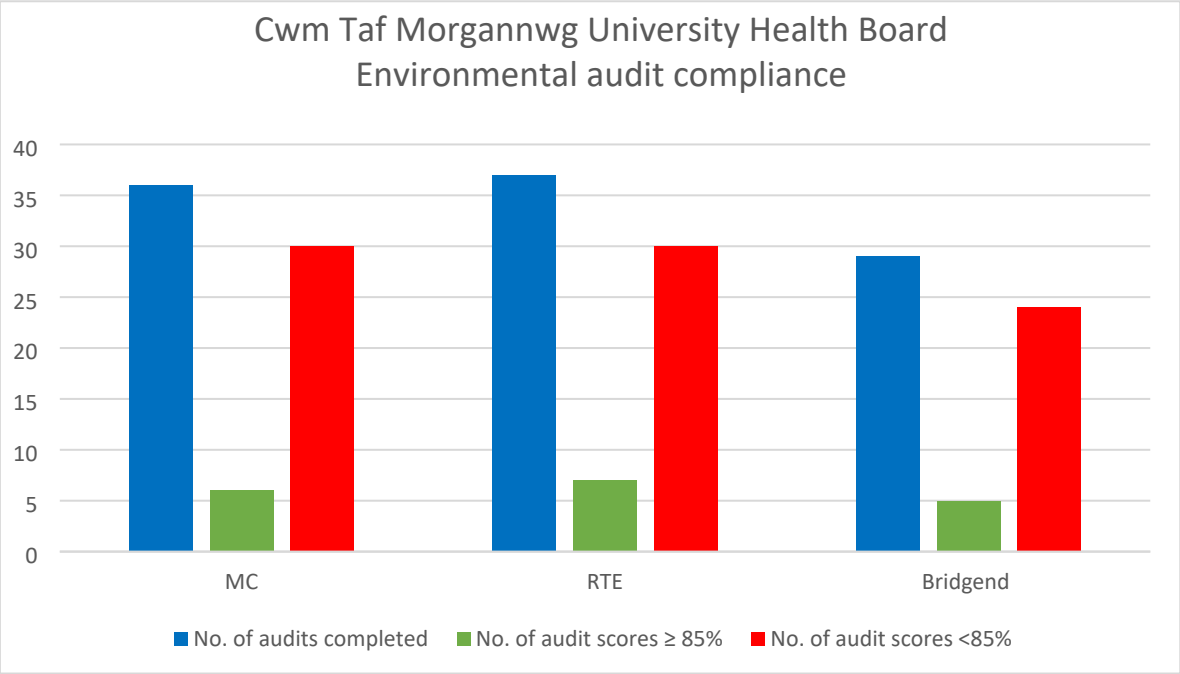
C) Environmental Cleanliness Audits

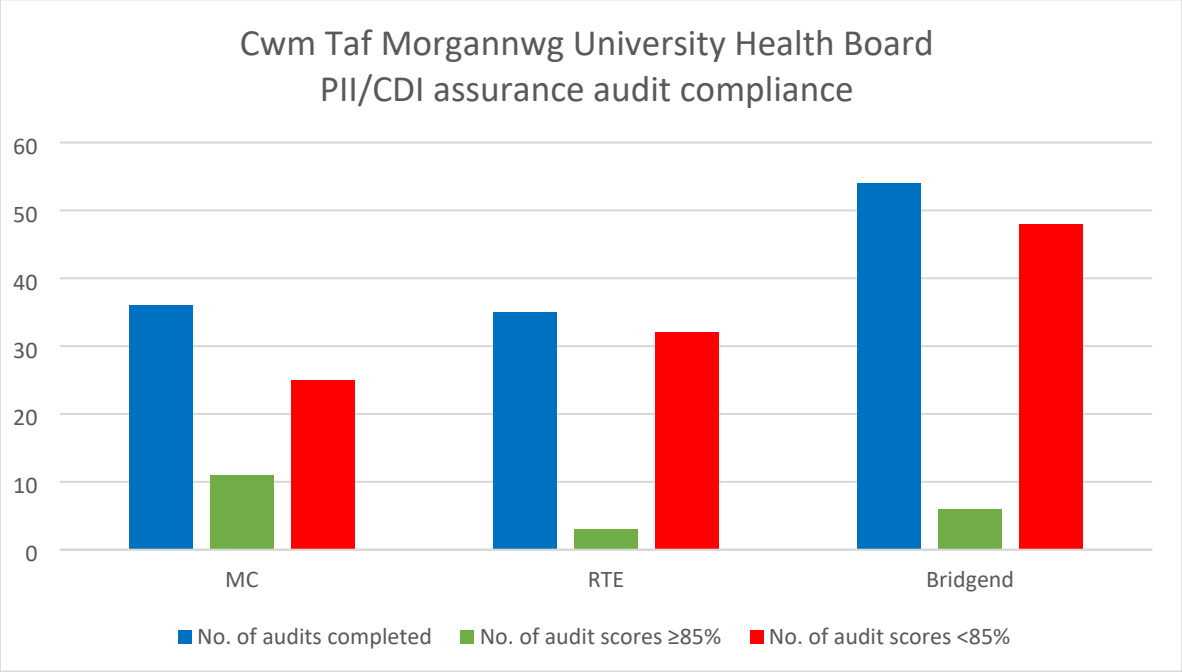
The following environmental audit scores, not only reflect standards of cleaning for housekeeping and nursing staff but also includes any maintenance/ estates issues identified during the audit process.

The increased cleaning hours provided by Welsh Government during the Covid-19 pandemic, was discontinued in 2023. Out of hours cleaning following patient transfer/discharge has now become the responsibility of nursing staff, resulting in either non-compliance due to staffing levels/ time or a possible impact on patient care and safety. Incident reports have been requested for such instances. Furthermore, critical staff shortages within the Facilities team have resulted in intermittent omissions with enhanced cleaning requests and a noticeable deterioration in cleaning standards.
There is an all-Wales task and finish group reviewing the current cleaning standards for Wales. The document will provide a consistent approach for training requirements, cleaning terminology/ frequency and roles and responsibilities.

102 environmental audits and 125 C.difficile and periods of increased incidence assurance checks were completed in 2023/24. Only 14% (14/102) of the audits achieved a score of ≥85%.

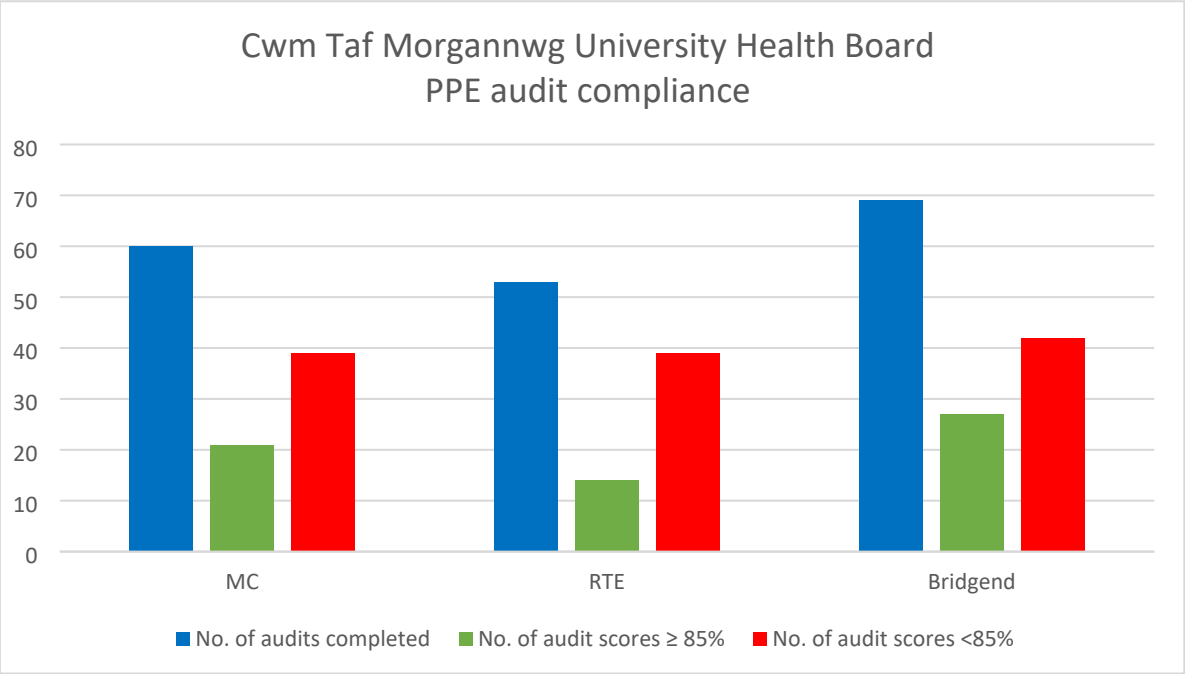
Poor audit scores have been reported across the Health Board. The audit reports have been circulated to nursing, facilities and estates colleagues.





D) Personal Protective Equipment (PPE) Audits

182 PPE audits were performed during 2023/24, only 34% (62/182) of the audits achieved a score ≥ 85%. The IPC team provide PPE training in response to poor audit scores where possible.



6. Outbreaks and Incidents

The IP&CT complete an incident report for each outbreak/ period of increased incidence and a multidisciplinary meeting is arranged. Following review, learning is shared widely to inform and influence clinical practice.
A National Reportable Incident (NRI) may be instigated if duty of care is breached or there is severe disruption to service.

Diarrhoea and Vomiting (D&V)

In order to reduce the risk of transmission, healthcare staff must apply standard infection prevention and control precautions and comply with IPC policies and procedures. Prompt assessment and identification of outbreaks is essential. Furthermore, admission areas must complete an IPC clinical risk assessment to identify possible infection prevention and control risks.

	2021/22	2022/23	2023/24
Total no of Ward Closures & Bay Restrictions (Due to Suspected / Confirmed Viral Diarrhoea and Vomiting)	8	10	9
No. of Patients	50	69	48
No. of Staff	15	32	19 (this may not be accurate)
No. of Bed Days lost	65	4	26

The IPC team advised 7 ward closures as a result of suspected/confirmed Norovirus during 2023/24. Only one ward remained open at risk due to operational pressures on site.

No. of Norovirus Outbreaks on Closed wards	2021/22	2022/23	2023/24
Confirmed	1	3	45
Suspected	2	2	3

There has been an increase in Norovirus cases compared to the same period in 2022/23. Public Health Wales hot labs have been introduced in Prince Charles and Princess of Wales Hospital. The hot labs provide a rapid turnaround service for MRSA, CPO, C.difficile and Norovirus results. Hence, the noted increase in Norovirus positive results.

7. Acute Respiratory Infections (ARIs)

Since the end of the Covid-19 pandemic, there continues to be a high incidence of ARI outbreaks. The IPC team have been integral to interpreting and implementing updated national guidance, providing advice for individual cases of ARI and managing outbreaks of infection to support a timely resolution.

The IPC team advised 102 ward closures for an ARI outbreak during 2023/24, however, only 26% (27/102) of wards remained closed due to operational pressures across the Health Board.
The majority of ARI outbreaks were identified in Royal Glamorgan Hospital and medical wards were the main areas of concern.

No. of ARI outbreaks in CTM	**Covid-19**	**Influenza A/B**	**Other/mixed ARI**	**Total**
Royal Glamorgan Hospital	28	3	13	**44**
Ysbyty Cwm Rhondda Hospital	3	0	0	**3**
Prince Charles Hospital	11	3	4	**18**
Ysbyty Cwm Cynon Hospital	4	1	2	**7**
Princess of Wales Hospital	24	0	4	**28**
Parc Prison	1	0	0	**1**
Glanrhyd Hospital	1	0	0	**1**

Period of Increase Incidence (PII)

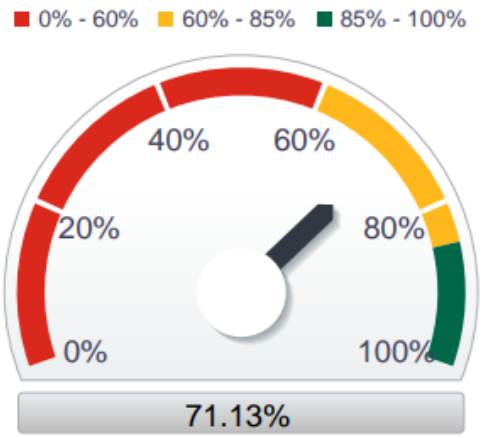
The following PII's were reported in 2023/24.

Location	Period	Organism	Cases
POW Ward 8	May 2023	C.difficile	5
RGH Ward 8	May/June 2023	GDH positive Toxin negative	7 (3 linked via WGS)
POW Ward 6	June 2023	C.difficile	6 (3 linked via WGS)
PCH NNU	July 2023	MRSA	3
RGH Ward 9	September/October 2023	VRE	6 (2 linked via WGS)
POW Wards 18 & 19	September 2023	C.difficile	2 (linked via WGS)
RGH Ward 19	October 2023	C.difficile	2 (linked via WGS)
POW A&E	December 2023	Possible VHF	1
RGH Ward 20	January – March 2024	MARO Klebsiella pneumoniae	5 (2 sets of two typing identical)
POW Ward 15	March 2024	C.difficile	2 (linked via WGS)
PCH Ward 6 & ITU	March 2024	GDH positive Toxin negative	4

8. Education and Training Activities

The IPC team offer a blended approach to training through face-to-face sessions and eLearning. Three levels of IPC training are provided. IPC is a core mandatory training requirement.

Improving compliance with IPC training is a major focus for the ILGs. Compliance is discussed at the IPC site and IPC committee meetings.



Combined Compliance % for all
3 Levels of IPC Training
Up to March 2024

Compliance % by Subject Level up to March 2024

Competence Full Name	Headcount	Competencies Required	Competencies In-date	Compliance %	Competencies Expiring in Next 90 Days	Predicted % in 90 Days
110|LOCAL|Infection Prevention and Control Management Training - No specified renewal|	1141	1141	386	33.83%	1	33.74%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	3997	3997	3341	83.59%	60	82.09%
NHS|CSTF|Infection Prevention and Control - Level 2 - 1 Year|	8230	8230	5782	70.26%	377	65.67%

Overall Compliance % for each Care Groups up to March 2024

Care Group	Headcount	Competencies Required	Competencies In-date	Compliance %	Competencies Expiring in Next 90 Days	Predicted % in 90 Days
110 Bank Care Group	1	1	1	100.00%	0	100.00%
110 Chief Operating Officer Care Group	1164	1168	882	75.51%	39	72.17%
110 Children & Families Care Group	1400	1548	1042	67.31%	71	62.73%
110 Corporates and Hosted Care Group	1309	1325	1135	85.66%	17	84.38%
110 Diagnostics, Therapies & Specialities Care Group	1588	1752	1261	71.97%	43	69.52%
110 Mental Health & Learning Disabilities Care Group	1177	1298	1000	77.04%	51	73.11%
110 Planned Care Care Group	1906	2228	1393	62.52%	77	59.07%
110 Primary & Community Care Group	1512	1625	1253	77.11%	62	73.29%
110 Unscheduled Care Care Group	2137	2423	1542	63.64%	78	60.42%

Aseptic Non-Touch Technique (ANTT)

Aseptic Non-Touch Technique (ANTT) is a comprehensive practice framework for all invasive procedures, from major surgery to maintenance of invasive devices and will affect every directorate and varying disciplines of staff.

All health board employees who perform aseptic procedures as part of their role must complete the ANTT eLearning package which is available via NHS learning Wales. Following the training, their competence is assessed in the clinical areas by designated ANTT trainers.

The IPC Team continue to coordinate and support the roll out of ANTT across the Health Board. Responsibility for monitoring compliance and DOPS assessment has been handed to the ILG teams.

The UHB ANTT Steering Group must be re-established to progress the ANTT roll out across the Health Board and support the Bronze/Silver/Gold accreditation process. ANTT was temporarily "unmandated" at the end of 2023/24, in order to review the ANTT requirements on ESR and update roles with the relevant levels of competency. Therefore, ANTT compliance is not available for the last financial year.

9. Commissioning of new Builds/Refurbishments

The IPC team provide expert IPC advice during the commissioning phase for new builds and refurbishment projects. IPC input must be sought early in the process to ensure advice can be offered in relation to the engineering aspects of IPC and to ensure national guidance and building notes are adhered to.

Derrogations are submitted if IPC advice, national guidance and building standards cannot be met.

10. Decontamination

Centralised Decontamination Facility/JAG Accreditation, Princess of Wales Hospital

The plan for the central decontamination facility in Princess of Wales Hospital has been temporarily halted, as an executive steer for decontamination services across the UHB is required for forward planning.

The endoscopy unit in POW is no longer an accredited service. The annual review for JAG accreditation was undertaken in December 2023. Service improvements are required by the end of July 2024, in order to achieve full JAG accreditation status. Endoscopy are currently sitting as an assessed service.

Mobile Endoscopy Unit, Royal Glamorgan Hospital

A mobile endoscopy unit continues to be used at the RGH site. The contract has been extended for an additional 6 months.

Chemical supply incident

Notification of a chemical supply issue affecting the UK was received in July 2023. The manufacturer (Getinge) detected a quality issue with the Aperlan Poka Yoke Agent A and B chemical bottles. Aperlan is used for the endoscope decontamination process and the shortage would primarily affect Endoscopy, Urology and ENT services across CTM. The care group for planned care arranged daily multidisciplinary operational meetings where updates were received and contingency plans established, to maintain emergency/cancer services across the UHB. Getinge circulated a Field Safety Notice (FSN) for the

defective chemical bottles and stock was released in a controlled manner. The supply issue was rectified by mid-August 2023.

Robotic assisted Surgery
Robotic assisted surgery was introduced to the UHB at the end of January 2024. The Sterile Service Department in RGH is re-processing/sterilising the robotic equipment.

Audit plan
The Decontamination Officer has commenced the annual decontamination audit program. To date, the Sterile Service Departments and Endoscopy units have been completed. Additional decontamination audit tools will be developed for USS probes and dental units.

Decontamination equipment replacement

There have been two porous load sterilisers successfully replaced in the Sterile Service Departments in Royal Glamorgan and Princess of Wales Hospital.

11.0 Challenges this year and priorities for 2024/25

Challenges faced in the past year:

- Increased workload for the IPC team due to the number of ARI outbreaks and periods of increased incidence, vacancies and long-term sickness within the team.
- Unable to support primary care due to the lack of a dedicated IPC resource.
- Unable to achieve annual audit programme.
- Unable to progress with planned improvement work.

Priorities for 2024/25 –

- Implement the IPC Strategy (2024-2027). The IPC team will provide an integrated service across primary, community and secondary care services. More emphasis will be placed on making improvements in primary care to advance patient care and safety and influence a reduction in C. Difficile infection, S. aureus and gram-negative bacteraemia.
- Continue to support the decontamination agenda for both primary and secondary care services.
- To support refurbishment and capital project schemes ongoing across the Organisation, including Llantrisant Health Park.
- Deliver a comprehensive surveillance, audit and training program.

- Recommence improvement work to -
    - Develop and introduce a robust root cause analysis process for all HCAI/CAI cases of C. difficile and preventable infections.
    - Establish a CAUTI/IV device improvement group to support a reduction in device associated bacteraemia.
    - Support improvements in IPC practice.
    - Work towards achieving bronze accreditation for ANTT.
    - Support maternity services to improve surveillance and reporting of C-section surgical site infections.
- Support clinical teams to reduce healthcare associated infections.
- Develop local HCAI improvement goals for the 5 mandatory surveillance organisms in line with the new Care Group model.
- Involved in national work to standardise IPC practice/procedures/ audit and investigative tools.

Agenda Item
8.2.7

Quality & Safety Committee

Cwm Taf Morgannwg Individual Patient Funding Requests (IPFR) Annual Report 2023/24

Dyddiad y Cyfarfod / Date of Meeting	18/09/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Emily Phillips, Commissioning Support Officer
Cyflwynydd yr Adroddiad / Report Presenter	Philip Daniels, Director of Public Health
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Linda Prosser, Executive Director of Strategy & Transformation

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	
AWTTC	All Wales Toxicology and Therapeutic Committee
EU	European Union
HTW	Health Technology Wales
IPFR	Individual Patient Funding Request
PIG	Policy Implementation Group
NICE	National Institute of Clinical Effectiveness
TOR	Terms of Reference
QA	Quality Assurance
WHSSC	Welsh Health Specialised Services Committee
JCC	Joint Commissioning Committee

1. Situation /Background

1.1 This report briefs Board members of the decisions made by the Cwm Taf Morgannwg University Health Board (CTM) Individual Patient Funding Request (IPFR) panel during 2023/24.

1.2 The All Wales IPFR Policy was introduced in 2011 and revised in 2015 and 2017 following Ministerial reviews. Its aim is to ensure there is a fair, transparent and consistent approach to decision making across Wales for medicine and non-medicine treatments not routinely commissioned on the NHS as they are new, novel or experimental. Where a medicine or treatment has not been appraised or approved for use in the NHS in Wales, a clinician can apply for it to be made available under the IPFR process. This process allows access to treatments where there is clear evidence a patient will derive significant clinical benefit from the treatment compared to other patients and that there is evidence that the treatment will be clinically effective and represents a cost effective use of NHS resources. Following a further review in 2023, the IPFR policy is being revised to ensure that the wording in the policy and associated documentation is clear, consistent and fit for purpose.

1.3 The membership of the health boards IPFR panel is outlined in the All Wales IPFR policy. Within CTM, the panel membership is as follows:

- Senior Public Health Medicine Consultant (Chair, under delegated authority from the Director of Public Health)
- Medical Director (Vice Chair)
- Head of Medicine Management
- Director of Nursing
- Director of Therapies
- Assistant Director of Commissioning & Transformation
- Lay representative (2 vacant posts)
- Each member now has a delegated deputy.

1.4 The CTM IPFR panel is scheduled to meet every fortnight to ensure applications are considered in line with the required timescales requested in the application. However, the CTM panel will be cancelled if there are no IPFR applications to consider. There is also an established mechanism to consider urgent applications within 24-48 hours. For urgent/life threatening applications and when a panel cannot be convened or discussion facilitated virtually within 24-48 hours, the Chair of the IPFR panel can undertake Chairs Action. During 2023/24, the CTM IPFR panel was convened on 15 occasions, while Chairs Action was undertaken for 3 cases.

1.5 There are strict process and timescales for IPFR case management for which the health board is audited on a quarterly basis by the Quality Assurance panel. The QA selects an IPFR case chosen at random from the All Wales IPFR database. After each QA panel, the health board will receive a formal update following each QA panel. For 23/24, the health board has performed well and has been consistent in its approach in terms of process and timelines.

1.6 **Governance Structures related to the All Wales IPFR Process**

Following the independent review of the IPFR process in Wales in 2017, a key recommendation was to 'establish a national IPFR quality function to support IPFR panels to ensure quality and consistency in decision making'. It would include facilitation, advice training and auditing of the IPFR process and have an obligation to report on the quality of processes, highlighting any concerns through the existing quality and clinical governance processes in Wales. The Quality Assurance (QA) panel was therefore established to undertake this function and is hosted by The All Wales Therapeutics and Toxicology Centre (AWTTC).

1.7 The governance structure for the established QA panel is clearly laid out in the terms of reference which were approved as part of the IPFR review through existing health board governance structures, including Welsh Health Specialised Services Committee (WHSSC), now Joint Commissioning Committee (JCC) and by the Deputy Chief Medical Officer for Wales for whom the group reports to. The group's role is to scrutinise a randomly selected IPFR from each IPFR panel to ensure the process had been followed in line with the All Wales IPFR Policy.

1.8 The AWTTC plays a pivotal role in supporting IPFR panels, ensuring consistency in approach via the QA group, establishing an All Wales IPFR database which seeks to identity any cohorts thus enabling a rapid review of the evidence and possible early access to treatment, for both medicines and non-medicines, and supporting the requirement for ongoing IPFR training events.

1.9 When a patient cohort is identified through cases submitted to the All Wales IPFR database, this links with the One Wales Commissioning Process.

1.10 **Health Technology Wales (HTW)** forms part of the QA group and are alerted to any non-medicine cohorts identified via the All Wales database thus enabling them to carry out an evidence appraisal. They also provide support for rapid evidence appraisals to IPFR panels when required. During 2023/24, CTM requested 2 rapid appraisal to assist the IPFR panel decision making process. Individual clinicians can also submit a topic for consideration. In addition to rapid appraisals, HTW considered more than

80 new topic referrals from across the health and care communities and published six new HTW guidance documents in 2021/22, including its first social care guidance, as well as nine new evidence appraisal reports.

1.11 **One Wales Interim Pathways Commissioning process**
The IPFR cases considered by the CTM IPFR panel and other health boards across NHS Wales including JCC, is also used to inform other aspects of the AWTTC work programme, and in particular the One Wales Interim Pathways Commissioning process which has been assessing medicines since May 2016. The process has been developed to facilitate one single agreed decision for NHS Wales on access to particular medicines for a group of patients (a patient 'cohort'). Medicines and patient cohorts are identified for the One Wales Interim Pathways Commissioning process by signals from activity in the IPFR panels, from JCC, the Chief Pharmacist Peer Group or clinician groups

1.1.3 Ongoing monitoring of the IPFR data has shown that soon after publication of a positive One Wales Interim Pathways Commissioning (IPC) decision, applications are no longer submitted for these indications. This positively demonstrates that the process effectively reduces the burden on IPFR panels and encourages equity of access to these medicines across Wales. During 2023/24, there have not been any IPFR cohorts identified that have led to One Wales assessments for medicines. This demonstrates that the IPFR route is being correctly used by clinicians; for those individual patients who may have clinical presentations that are different to the patient cohort.

1.1.4 The majority of the assessments are being triggered by requests from the service rather than through collection of IPFR cohort data. This may in part be due to the diversity of requests coming through IPFR but it also shows more awareness by the service of the One Wales Medicines process. In 2023-2024 there was 1 new medicine assessed (dostarlimab for rectal cancer) and 1 re-assessment (rituximab for myasthenia gravis)There are currently 19 positive One Wales decisions enabling access to medicines for the treatment of patients with conditions where there is an unmet clinical need. Within CTMUHB, there are future plans for review of IPFR case patterns which will be facilitated when the newly appointed Head of Commissioning takes up post.

2. Specific Matters for Consideration

2.1 IPFR data 2023/24

2.1.1 The requests submitted to the CTM IPFR panel vary in terms of complexity. The majority of applications relate to non-NICE approved/unlicensed drugs. The number of non-medicine requests

received has been historically low, however a slight increase in the number of requests was noted in **2023/24** (table 1) compared to **2022/23** (table 2). IPFR decisions are recorded centrally on the All Wales IPFR database.

Table 1: Requests submitted to the CTM IPFR panel 2023/24

2023/24	Approved	Not approved	Total
Medicine	26	12	38
Non medicine	3	1	4
Total	29	13	42

Table 2: Requests submitted to the CTM IPFR panel 2022/23

2022/23	Approved	Not approved	Total
Medicine	16	4	20
Non medicine	1	2	3
Total	17	6	23

2.1.2 The following table details the number of Cwm Taf Morgannwg IPFR requests for the financial years 2018/19 to 2022/23, noting a slight increase in the number of applications considered in light of the Bridgend Boundary Change taking effect from April 2019.

Table 3: IPFR applications considered by the CTM panel by year.

	Approved	Not approved	Total
2018/19	9	3	12
2019/20*	12	2	14
2020/21	21	4	25
2021/22	21	7	28
2022/23	17	6	23

2023/24	29	13	42

*Bridgend Boundary Change April 2019

2.1.3 The Health Board has seen an increase in the number of applications received in 2023/24 totalling 42. The AWTTC IPFR Annual report notes that this increase has been seen across Wales in 2023/24.

2.2 Financial Commitment

2.2.1 The very nature of IPFR spend is unpredictable and will vary year by year due to the requests received. The table below highlights an increase in committed spend when compared to previous years, with the number of applications approved by the CTM IPFR panel also increasing when compared to previous years:

Table 4: IPFR financial commitment by year, based on approvals issued.

Year	Total commitment (£)
2018/19	96k
2019/20*	219k
2020/21	308k
2021/22	178k
2022/23	£228k
2023/24	£243k

*Bridgend Boundary Change April 2019

2.3 Amendment to Directions concerning Cross Border Directive (2011/24/EC) and the S2 funding route process

2.2.1 Following the UK's withdrawal from the European Union (EU) on 31st December 2020, the EU Directive funding route ceased. Welsh Government issued the Welsh Health Circular (2021/005) instructing Health Boards that the EEA Directive can no longer be used by UK citizens to access healthcare treatment in the EU, (appendix 1).

2.2.2 Whilst the EU Directive funding route has ceased, S2 arrangements will continue as part of agreed reciprocal healthcare arrangements with Europe post Brexit. The S2 route enables CTM patients to apply to have their planned treatment in another EEA country at the expense of their home state. This can be in state provider or private healthcare provider that accepts an S2 certificate for which treatment will be provided under

the same conditions and payment as for a resident of the country of treatment.

2.2.3 As the Directive route is no longer an option for patients to seek treatment in Europe, the Health Board had anticipated an increase in the number of S2 applications. However during 2023/24 CTM UHB received less than 5 applications, with no requests being approved for treatment in the EU. The Commissioning team will continue to closely monitor the number of S2 applications in 2024/25 and escalate appropriately if the number of requests increase.

3 Key Risks / Matters for Escalation

3.1 CTMUHB representation on the All Wales IPFR panel

Following a revision of the All Wales IPFR Policy, the JCC panel now requires the Health board IPFR Chair to attend (or nominated clinical deputy) at the All Wales IPFR Panel. The Deputy Executive Director for Nursing oversees this function, ensuring clinical representation from Cwm Taf Morgannwg UHB.

3.2 CTMUHB IPFR panel membership

Work has been undertaken in order to strengthen the membership of the CTM UHB IPFR panel. The Deputy Medical Director is now the formal deputy chair of the IPFR Panel and each core member now has a delegated deputy which has assisted greatly in ensuring the quoracy of the local IPFR panel and ensures timely consideration of IPFR cases. This has ensured that IPFR panels proceed as planned as a result of being quorate.

3.3 Lay Representation on the CTM IPFR panel

CTM UHB is required to recruit two lay representatives to the local IPFR panel as per the IPFR TOR. There has been great difficulty in attracting suitable candidates to the role for a number of years across Wales. Renewed efforts will be made to link with Llais and external stakeholders to recruit suitable lay members.

3.4 Commissioning team vacancies

Following the appointment of the Commissioning Support officer in August 2023 (responsible for IPFR, Prior approval and S2 applications) the commissioning team is further being strengthened with the appointment of a new Head of Commissioning, who will commence post 01/09/2024.

3.5 EU Regulations

The Healthcare (International Arrangements) (EU Exit) Regulations 2023 came into force on 18th August 2023: The Healthcare (International Arrangements) (EU Exit) Regulations 2023 (legislation.gov.uk). The regulation places a duty on Health Boards to provide a review mechanism for S2 application and for applicants to be made aware of their ability to

apply for a review. To ensure a consistent approach across NHS Wales, the IPFR Policy Implementation Group has agreed to process such request in line existing review process in place for IPFR and Prior Approval request.

For the period of 2023-24 there have been no such requests submitted to the Health board for consideration.

3.6 **Framework for Funding Healthcare abroad in exceptional circumstances**

Under the Healthcare (International Arrangements) Act 2019, the Department of Health and Social Care (DHSC) can now implement reciprocal healthcare arrangements with any global partner. DHSC has brought forward new regulations to give the Secretary of State new powers to fund healthcare abroad in exceptional circumstances, in countries where the UK has a healthcare arrangement. These changes came in to force on 18 August 2023.

Following a period of consultation, the UK Government has decided to implement the Reciprocal healthcare policy framework for the funding of healthcare abroad in exceptional circumstances - GOV.UK (www.gov.uk)

This requires health boards to inform patients of the Exceptional Circumstances policy, when S2 applications do not fulfil the criteria within the S2 policy. Patients will now have the right to apply directly to the UK Secretary of State if they consider there to be exceptional circumstances relating to their S2 application. The Secretary of State will consider the factors set out in the 'Funding healthcare abroad in exceptional circumstances' section of this framework when making discretionary funding decisions under the Healthcare (International Arrangements).

For the period of 2023-24 there have been no such requests submitted to the Health board for consideration.

3.7 **All Wales IPFR policy**

An IPFR application considered by the All Wales IPFR panel (WHSSC) was subject to a Judicial Review in December 2021. WHSSC were tasked by Welsh Government to undertake a *de minimis* review of the All Wales IPFR policy. WHSSC proposed a number of changes however following discussion at the WHSSC Joint Committee on 18 July 2023, members of the Joint Committee informed WHSSC to engage and agree the revisions with the IPFR Policy Implementation Group (PIG). While the IPFR PIG agreed a version in July 2023, concerns have been raised by the All Wales Quality Assurance panel with regards to the interpretation of an element of the policy. This is currently being worked through to ensure a consistent approach to implementing the policy across Wales.

3.8 **All Wales IPFR Workshop**

AWTTC hosted the seventh annual IPFR workshop in May 2024 at Cardiff City Stadium. The workshop was open to IPFR panel members, IFPR teams,

clinicians who complete IPFR application and those interested in learning more about the IPFR process. A total of 72 attendees were present on the day and all health boards were represented. CTMUHB were well represented with 6 colleagues attending from Pharmacy and Commissioning. The event provided delegates the opportunity to network and develop links across health boards. Delegates could also find out more information about the work of AWTTC and Health Technology Wales, by visiting stands throughout the day. A series of presentations were made to delegates and topics covered included:

- Medicines access in Wales – new initiatives
- IPFR QA feedback and updates
- Clinician training session on completing IPFR application forms
- Patient experience of IPFR
- Assessing value for money
- Comparators
- IPFR Panel cases; giving delegates the opportunity to form 'panels' to consider examples of IPFR cases.

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**	Data to Knowledge If more than one applies please list below:

(Duty of Quality Statutory Guidance (gov.wales))	
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Safe
	If more than one applies please list below: Effective, 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: There are no specific quality and safety implications related to the activity outined in 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: EQIA undertaken on an All Wales basis.

Cyfreithiol / Legal	Yes (Include further detail below) Healthcare (International Arrangements) Act 2019
Enw da / Reputational	Yes (Include further detail below) Activity where performance falls short of the Health Board's performance measures may result in impact to the trust and confidence in the Health Boards service provision.
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	Yes (Include further detail below) Workforce and financial resources are required to process and implement IPFR applications within the Health Board.

5 Recommendation

5.1 The Quality & Safety Committee are asked to **NOTE:**

- The contents of this report; and
- The need to recruit lay representation to the CTM IPFR panel;
- The new EU Regulations.

6 Next Steps

6.1 Following consideration by the Committee, this report will now be submitted to the Health Board meeting on the 26th September 2024 for noting.

Agenda Item
8.2.8

Quality & Safety Committee

All Wales Learning from Events Framework

Dyddiad y Cyfarfod / Date of Meeting	18/09/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Stephanie Muir, Assistant Director of Concerns and Claims
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**
Executive Quality & Safety weekly Meeting	27/08/2024	Approved
Operational Management Board	04/09/24	Approved and advised for noting and receiving at the next Q&SC
Acronyms / Glossary of Terms		
WRP	Welsh Risk Pool	
CTM	Cwm Taf Morgannwg	
Q&SC	Quality & Safety Committee	

1. Situation /Background

1.1 A scoping exercise undertaken as part of the Welsh Risk Pool (WRP) Enhancing Learning Programme, feedback from the chairs of the WRP Learning Advisory Panel and outcomes of a series of WRP assessments of Health Boards and Trusts concerns management indicated that processes in respect of organisational learning would benefit from strengthening across a number of areas in health bodies. On review, the majority of policies and procedures referenced the importance of learning from events but did not detail how this was enacted, reported, and monitored in the organisation.

1.2 This model document has been developed through the Welsh Risk Pool Enhancing Learning Programme in partnership with Health Boards, Trusts, Special Authorities, and through engagement with key stakeholders including the NHS Wales Executive and the Medical Examiner Service. This framework has been locally adapted to reflect learning within Cwm Taf Morgannwg University Health Board.

2. Specific Matters for Consideration

2.1 Engagement on this Framework has taken place with:

Name Title	Date Consulted/Completed
Equality Impact Assessment	During the development and final assessment undertaken 20th August 2024
Informal Consultation with interested parties	Engagement with various interest parties over the past 6 months
Formal Consultation	Commenced 24th June 2024 Completed 13th July 2024
Operational Management Board	Presented by Nigel Downes, Assistant Director Quality & Safety for Approval on 04 September – Approval received
Quality & Safety Committee – For receiving & noting	18th September 2024

2.2 The framework was developed by the Enhanced Learning Programme Group with partnership across NHS Wales and therefore is consistent with the approach across NHS Wales and any relevant legislation.

2.3 All NHS Organisations across Wales have been engaged in the All Wales consultation.

2.4 Key stakeholders within CTM were involved in the local adaption of this framework and it was circulated across CTM during the formal consultation.

2.5 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:

It was noted that the initial draft of the framework was skewed to learning from patient safety incidents.

In collaboration with Health and Safety the framework was amended to include learning from organisational and health and safety incidents.

Hyperlinks have also been included within the framework.

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	Learning, Improvement & Research

(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	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: This policy covers key areas of learning from quality, safety, experience and health and safety	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: Will provide the report in Welsh if required
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

5.1 The Quality, Safety & Experience Committee are asked **RECEIVE & NOTE** the All Wales Learning from Events Framework which has received Approval by the Operational Management Board on 04 September 2024.

6. Next Steps

6.1 The author will share the Policy with the Corporate Governance Team for publication on SharePoint and the Health Board Internet Site.











All Wales Learning from Events Framework

Cwm Taf Morgannwg University Health Board

January 2024

Document Control

Document control	
Document reference	
Group responsible for developing the document	Welsh Risk Pool Enhancing Learning Programme Group
Authorised / ratified by	
Authorised / ratified on	
Accountable Executive Director/Director	Greg Dix, Executive Director of Nursing
Date of implementation	July 2024
Review date	July 2025
Review	This document will be reviewed prior to the review date if a legislative change, or another event otherwise dictates.
Distribution date	September 2024
Contact point for queries	At the Health Board

Version	Status	Date	Approval Route	Summary of Amendments
Version 1	DRAFT	18/09/24	Quality, Safety & Experience Committee	

Related Policies / Procedures

Reference	Document
	Concerns Management Policy
	Incident Management Framework
	Learning from Events SOP

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1. Introduction

The Cwm Taf Morgannwg University Health Board (the health board) recognise that organisational learning plays a vital role in the continuous improvement of services and outcomes of patients and the ongoing development of healthcare organisations. Creating a culture of learning within the NHS is crucial for organisational improvement and the delivery of person centred, high quality services, whilst supporting staff wellbeing.

The key ingredients for healthcare organisations that want to be safe are:

- **Staff who feel psychologically safe.**
- **Operating in a Just Culture, one that is constructive and undertake a fair evaluation of the actions of staff involved in patient safety incidents.**
- **Actively listening to those who use the services and key stakeholders.**
- **Valuing and respecting diversity.**
- **A compelling vision.**
- **Good leadership at all levels.**
- **A sense of teamwork and openness and support for learning.**

Research suggests that organisations with a strong learning culture tend to exhibit higher levels of innovation, employee engagement, and overall performance. This includes encouraging a mindset of curiosity, experimentation, and knowledge sharing among staff members. Leadership behaviours such as setting clear goals, providing resources for learning, and recognising and rewarding learning achievements can positively influence the learning climate within the Health Board and wider NHS.

Learning outcomes can include:

- **Improved safety and reduced harm.**
- **Improved patient outcomes.**
- **Improved patient and family experience.**
- **Informed decision-making.**
- **Increased efficiency or productivity.**
- **Enhanced job enjoyment.**
- **Better communication and teamworking.**
- **Reduced costs and appropriate use of NHS resources.**
- **Less stress or frustration.**
- **More effective leadership.**
- **Service redesign.**
- **Increased efficiency or productivity.**



2. Purpose

A scoping exercise undertaken as part of the Welsh Risk Pool (WRP) Enhancing Learning Programme, feedback from the chairs of the WRP Learning Advisory Panel and outcomes of a series of WRP assessments of Health Boards and Trusts concerns management indicated that processes in respect of organisational learning would benefit from strengthening across a number of areas in health bodies. On review, the majority of policies and procedures referenced the importance of learning from events but did not detail how this was enacted, reported, and monitored in the organisation.

Themes from Audit Wales reviews of quality governance arrangements (2022) identified that frequently systems in NHS organisations to share learning and good practice were not always embedded or systematic. A common theme was that more could be done to promote and support learning. The scoping exercise and outputs from the Audit Wales reviews also identified excellent practice and processes which provides brilliant opportunities to scale up and spread these across NHS Wales and wider.

This model document has been developed through the Welsh Risk Pool Enhancing Learning Programme in partnership with Health Boards, Trusts, Special Authorities, and through engagement with key stakeholders including the NHS Wales Executive and the Medical Examiner Service to provide a framework for local adaptation, whilst providing a consistent approach pan NHS Wales.

This Framework covers learning for both clinical and non-clinical events occurring within organisations. Aligned with our commitment to continuous improvement and knowledge sharing, the Health Board's Listening and Learning Framework has been incorporated into this policy and this operates in tandem with the Shared Learning Repository. These serve as a guiding principle for fostering a culture of learning, innovation, and adaptability within the health board – with a clear focus on safety and patient outcomes. It outlines the processes, resources, and responsibilities necessary to support ongoing learning initiatives and ensure that insights gained are effectively captured, shared, and utilised across all levels of the health board. By integrating this policy with existing frameworks and repositories, we aim to maximise the impact of our collective learning efforts and drive sustainable growth and development.



3. Learning in Healthcare

The Institute of Medicine (IOM, 2013) describes a learning healthcare system as one in which "science, informatics, incentives, and culture are aligned for continuous improvement and innovation, with best practices seamlessly embedded in the care process, patients and families are active participants in all elements, and new knowledge captured as an integral by-product of the care experience".

The relevance of organisational learning for the NHS was acknowledged in 2000 in the report 'An organisation with a memory' and was subsequently reaffirmed in the 'Berwick Review' ('A promise to learn – A commitment to act') following the public inquiry into the deaths at Mid Staffordshire NHS Foundation Trust and more recently in reviews of maternity services in NHS England and NHS Wales.

The Berwick Review called on the NHS to aspire to become a system devoted to continuous learning and improvement. Organisational learning in practice has often been reduced to the investigation of serious incidents or cataloguing of frequently occurring harms, for example patient falls. This has limited effectiveness to bring about positive organisational change. Learning is often considered as a one-off event where the problem is focused upon for a short time but moves on to new priorities as they emerge, so that sustained learning is lost.



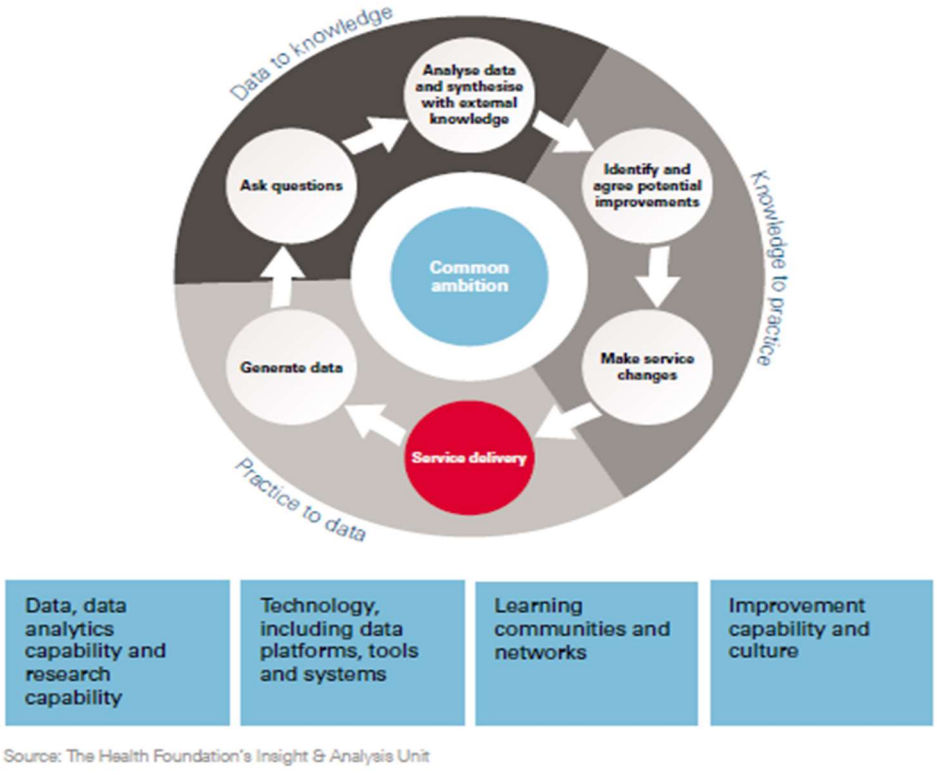
Organisational learning is a continuous cycle of action and reflection, which takes place at different levels, including the individual, the team or department, the organisation, and the NHS as a whole. Like any learning activity, organisational learning is essentially a social process where we take a step back, collectively make sense of our experiences, and reflect on and challenge our assumptions in order to trigger change and improvement. This is sometimes referred to as double-loop learning to distinguish it from the focus on quick fixes, or single-loop learning.

Systems thinking learning is a process of understanding how things influence one another within a whole. healthcare organisations are made up of interconnected complex systems and processes important to improving the quality of care delivered.



The Health Foundation (2022) define a learning health system as a way of describing a team, provider or group of providers in the health and care system that, working with a community of stakeholders, have developed the ability to learn from its own delivery of routine care and improve as a result. A learning healthcare system comprises a set of activities and assets that enable continuous learning and improvement of services. Learning Health Systems are an important method for improving the quality, efficiency and effectiveness of health and care services providing improved outcomes for patients. The Health Foundation consider the capabilities and infrastructure that typically underpin them – in other words, going beyond thinking about the activities of the learning and improvement cycle to consider the assets on which these activities rely which are:

- **Data, data analytics capability and research capability, including skilled researchers and analysts.**
- **Technology, including data platforms, tools, and systems, as well as an organisation's wider digital maturity.**
- **Learning communities and networks, along with mechanisms, spaces, and support for convening, deliberating, and sharing knowledge.**
- **Improvement capability and culture, along with resources to enable the planning, design and implementation of improvements to care.**



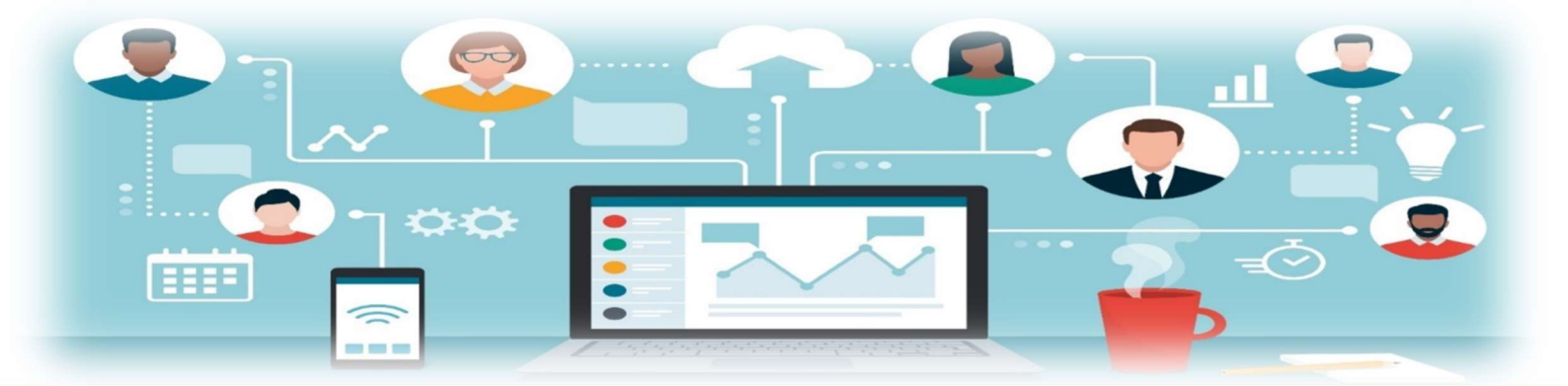
Source: The Health Foundation's Insight & Analysis Unit

A frequently used and practical example of systems thinking applied to healthcare is the Systems Engineering Initiative for Patient Safety (SEIPS) model, which takes as a starting point the patient's journey through the health system and describes this as a series of encounters with different work systems, e.g., hospital, GP etc.

The NHS in England has recently moved to the SEIPS model in the Patient Safety Incident Response Framework (2022) (PSIRF) with an education programme supported by the Health Services Safety Investigations Body (HSSIB), previously the Healthcare Safety Investigation Branch (HSIB).

Organisational learning should address both immediate issues as well as longer-term strategic changes. Fast changes are not the only goal but they are important if there is a specific need or risk, for example, something that requires immediate consideration. Fast changes can also be useful to demonstrate commitment to change to staff and show that their concerns are being taken seriously. In this way, quick wins can help avoid participation fatigue. The Chartered Institute of Ergonomics and Human Factors have recently developed a guide to assist people working in the health and social care systems to capture valuable practice and improvements made during their response to COVID-19. The aim is to contribute to organisational change at a policy, strategic and operational level. An overview of the Framework can be found in Appendix H.

The focus of learning does not have to be exclusively on what goes wrong (Safety II) and how barriers, safeguards and protocols can be introduced to prevent repetition. This is especially true in complex systems like healthcare where people have to deal with many unforeseen situations and have to negotiate multiple, often competing, priorities with finite resources. Through their ability to anticipate and to adapt to surprises and conflicts, staff ensure that things go right most of the time.



The NHS Wales Duty of Quality Statutory Guidance and Health and Care Quality Standards published in April 2023 recognise our healthcare system creates the conditions and capacity for an organisation and system-wide approach to continuous learning, quality management and quality improvement and innovation. Learning is seen as one of the six quality enablers in the new Health and Care Quality Standards. These new publications support the existing Putting Things Right Regulations (2011) which are currently undergoing a comprehensive review.



Learning from what goes right (Safety II) supports organisational resilience by strengthening the ability to anticipate, to monitor and to adapt to changing demands and surprises. The recently released NHS Wales National Policy on Patient Safety Incident Reporting & Management (May 2023) adopted by all Health Boards and Trusts references in the supporting guidance the ambition to adopt Safety-II thinking. Additional information at: Patient Safety Incidents - Delivery Unit (nhs.wales).

Oversight of the NHS Wales National Policy on Patient Safety Incident Reporting & Management (May 2023) collective analysis of Nationally Reportable Incidents occurs at a national level through the newly established NHS Wales Executive. The NHS Wales Executive are also responsible for publishing and overseeing compliance with national alerts.

As part of the national restructures (April 2023) Improvement Cymru now forms part of the NHS Wales Executive. Their branding will remain and the Achieving Quality and Safety Improvement Strategy (2021-2026) outlines the ambitions of the Safe Care Partnership bringing NHS Wales organisations together with the Institute of Healthcare Improvement (IHI) Publication 'Framework for Safe, Reliable and Effective Care' providing the evidence-based roadmap to shape the partnership and beyond.

The IHI Framework describes the domains of culture and the learning system, outlining what is involved with each and how they interact. It provides definitions and implementation strategies for the nine components (leadership, psychological safety, accountability, teamwork and communication, negotiation, transparency, reliability, improvement and measurement, and continuous learning). Patient and family engagement is at the centre of the Framework.

Edmondson (2019) highlights that adapting as the environment requires, staff need to feel supported within a compassionate and inclusive environment. Psychological safety operates at the level of the group not the individual, with each individual knowing they will be treated fairly and compassionately by the group if things go wrong or they speak up to stop problems occurring. It means staff do not feel the need to behave defensively to protect themselves and instead opens the space in which they can learn. Appendix D includes the NHS England Just Culture guide which has been adopted by NHS Wales.



The Medical Examiner Service in NHS Wales is hosted by NHS Wales Shared Services Partnership and provides an independent scrutiny of all deaths that are not investigated by the coroner. Scrutiny is undertaken by a Medical Examiner, who is an experienced doctor with additional training in death certification and the review of documented circumstances of death. They will ensure that an accurate cause of death of recorded, identify any concerns surrounding the death itself which can then be further investigated if required, and take the views of the bereaved into consideration.

This independent process, alongside the adoption of the NHS Wales National Mortality Review Framework (in development) is extremely valuable in determining learning and improvements at an individual case level and also from a collective intelligence perspective (incidents, complaints, claims, engagement outputs etc) by analysing patterns, themes and trends at organisational and system level.

In order to ensure the highest level of independent scrutiny of the cause of, and circumstances surrounding, a death, all Medical Examiners and Medical Examiner Officers in Wales are directly employed by NHS Wales Shared Services Partnership, and Medical Examiners will generally not be involved in the scrutiny of deaths in the area in which they work. Updates can be found at: Medical Examiner Service - NHS Wales Shared Services Partnership.



4.0 Approach to Organisational Learning (corporate)

Organisational learning is more than the dissemination of safety information to staff. The biggest threat to successful learning is the failure to relate lessons to frontline clinical and nonclinical, e.g., housekeeping, portering and clerical.

There is consensus in the literature that the NHS might be reasonably good at collecting and aggregating incident data but that very little actionable learning is created by that. Staff should be encouraged to take ownership of change and improvements and should be involved in the learning process. This can help to ensure that learning is relevant to practice and that sustainable change can take place.

Taking a systematic approach to learning involves a conscious decision to capture valuable lessons that will inform best practices and future activities to give the greatest chance of improved outcomes. Making access to data and learning resources easier is a priority for the organisation. Appendix B details the key reports relating to organisational learning.

Duties and responsibilities

Role	Duties and responsibilities
Board	The Board Statutory responsibility for ensuring compliance with the incident reporting system lies with the Health Board, with the following reporting arrangements to provide assurance: • The Quality, Safety & Experience Committee and other relevant Board Committees and Sub-Committees will receive quarterly reports detailing trends, themes and lessons learnt • Care Groups and Central Directorates will receive regular reports detailing trends, themes and lessons learnt.
Chief Executive	The Chief Executive has overall accountability, on behalf of the Health Board, for ensuring the implementation of this policy throughout the organisation.
Executive Director of Nursing, Deputy CEO / Executive Director for People	The Directors delegate their responsibilities for day to day matters to the designated Care Group Directors, Service/Directorate Managers and professional leads for ensuring that learning is identified and appropriate action is taken to reduce incidence of similar issues arising again.
Medical Director	The Medical Director delegate their responsibilities for day to day matters to the designated Care Group Directors, Service Managers and professional leads for ensuring that learning is identified and

	appropriate action is taken to reduce incidence of similar issues arising again.
Assistant Director Quality & Safety / Assistant Director of Health, Safety & Fire	The Assistant Director will provide operational leadership, vision, inspiration oversight and rigour of the health boards quality, safety and learning.
All Managers	Care Group Directors, Service Managers and professional leads will be responsible for ensuring that appropriate arrangements are in place within their areas to identify and monitor trends/problems, and for taking appropriate action. They will be responsible for sharing Organisational Learning and ensuring that lessons are shared across the Health Board i.e. across Care Groups.
Heads of Quality & Safety/ Patient Safety Team / Quality Team / Health & Safety Team etc	Responsible for ensuring that the findings/outcomes of investigations are acted upon appropriately with lessons being learned across the organisation and corrective action being taken.
Staff Groups	Staff are responsible for: • Engaging in learning and outcomes from investigations • Raising concerns to their line manager through the incident reporting system or as outlined within 'Speaking Up Safely' regarding the delivery of care / services to patients • Raising concerns about the safety of their environment or work activities, in line with the Health Board's Health & Safety policy.

The health board developed a Listening & Learning Framework in September 2022, which has been integrated into this All Wales Learning from Events Framework. The framework demonstrates how learning will be identified, triangulated, disseminated and implemented in practice to facilitate and embed a culture of appreciative enquiry and continually improving health care services and the experience of our workforce. The framework recognises that the Care Groups and Clinical Service Groups and Corporate Functions have internal governance and learning structures. This Framework, therefore, seeks to complement and build on these arrangements by adding a strategic approach to support the organisation to listen and learn lessons from a range of internal and external sources, to record, store and use this learning to share knowledge, shape change and create opportunities to develop excellence in practice.

The framework is intended to enable the health board to become a Learning Organisation and fulfil the following objectives:

- Ensure that patients, our workforce and key stakeholders have their voice heard and that this informs service design, provision, change and improvement.
- Ensure that relevant performance data is captured, analysed and reported to inform decisions and priorities.
- Ensure that the health board expectations are clear in respect of organisational learning to support continuous improvement.
- Ensure that the workforce in the health board is suitably trained and skilled, and benefit from relevant, appropriate and timely, high quality training and development opportunities, which reflects organisational learning.
- Support a culture, which is restorative rather than punitive when things do not go as expected, to ensure our workforce feels safe and supported to raise concerns and over time, build confidence that the health board will learn from these events.
- Ensure that the health board Annual Plans are informed, and focused, on relevant priorities.
- Ensure that learning is continually captured within an accessible Learning Repository, Shared Learning Repository building an Organisational Memory.

The principles underpinning the framework is to consistently review our practice through the lens of quality and safety:

- There is a culture of continuous learning and improvement across the health board, identifying opportunities to draw on good practice, understand and minimise the risk of poor practice or reinventing the wheel.
- A restorative culture, avoiding blame when things do not go as expected to develop a supportive, psychologically safe environment where the workforce can flourish and grow.
- Stakeholders such as Clinical Educators, People Directorate, Clinical Audit, Quality Improvement and Value-Based Healthcare Teams and our local University will be key investors in building knowledge and learning within the organisation.
- Care Groups and Corporate Functions take ownership and responsibility for disseminating learning to all colleagues, using appropriate methodologies and evidence.
- Practitioners should be fully involved in learning activities and be invited to contribute their perspectives within a positive learning environment that fosters a safe space for learning and development.
- Improvement is sustained through monitoring, and learning makes a real impact on quality, safety, experience and outcomes.
- Sustained improvement is evidenced through review and monitoring.
- Patients are actively asked about their clinical outcomes and experiences following interventions and listened to, helping identify areas for improvement and change.
- People who use our services, and our communities, are fully engaged with Health Board service improvement and are encouraged and supported to contribute to our continuous learning processes.
- The health board will share its learning with other organisations in the interests of national and global improvements to quality and safety of healthcare.

What can we learn from?

Listening	Learning	Sharing Learning	Implementing Learning	Monitoring Learning
Actively seeking experience and feedback Actively seeking clinical outcomes before, during and after health intervention Make it quick/ easy to give feedback/ raise concerns and facilitate a range of formats/ languages Make it quick/ easy for teams to submit the feedback/ concerns that they receive Make it easy for teams to submit ideas for improvement and change Analysis of feedback/ concerns and way to quickly/ easily share this back to services Dashboard reports for instant access to experience, compliments, incidents, complaints, themes & trends 'You said, we did' in public areas so that everyone can see	Patient Reported Experience Measures (PREMs) Patient Reported Outcome Measures (PROMs) Incidents Complaints Claims Inquests Case Reviews Public Service Ombudsman Wales Audit & Research Peer review Patient Safety Clinics Internal Reviews External Reviews National Learning Patient Safety Solutions	Listening & Learning Forum Bi-annual listening and learning event CTM wide Quality Assurance Group Care Group QSRE meetings People & Culture Committee Local Partnership Forum Local Negotiating Committee Professional Fora SharePoint/Learning Hub Audit Meetings Grand Round Mortality/Morbidity Meetings Safety Huddles Improvement celebration and sharing events Communications (Social Media, Newsletters, Bulletins, Alerts) Learning from Events Reports National Networks	Policy Groups Process & Systems Reviews SMART Action Planning Thematic Action Planning Improvement Projects Value Based Healthcare Projects Learning from Events Reports Training & Education	Board Committees Board Assurance Framework Quality, Safety & Experience Committee Audit & Risk Committee People and Culture Committee Local Partnership Forum Local Negotiating Committee Integrated Operational Management Board Safeguarding Executive Group Quality Assurance Group Care Group Quality, Safety & Experience Committee Clinical Service Group Quality, Safety & Experience Committee Value-Based Healthcare Steering Group Performance reports Incident/Complaints/Risk themes & trends/Triangulation with Performance & Assurance

that we take action as a result of their feedback Evidence of a Restorative Culture & Psychological Safety	National and Local Safety Standards for Invasive Procedures (NatSSIPPs & LocSSIPs) Risks identified and logged on the HB Risk Register	Patient Stories at Q&S Committee & Board meetings		Patient/staff feedback themes and trends Training compliance Audits Quality Assurance Checks Learning from Events Reports

All colleagues have a responsibility for contributing and responding to learning and improvement activity by:

- Actively asking and listening to our patients and communities
- Celebrate and share your learning!
- Complete a We Listened and Learned! Sharing e-sheets to let others know and contribute to organisational knowledge & learning.
- Link your learning to where it originated from i.e. incident, feedback, inquest, research for further information on the event.
- Ensuring any action planning is SMART – Specific, Measurable, Attainable, Relevant and Timely
- Suggesting ideas for improvement

All colleagues who lead and manage other people have a responsibility to:

- Provide space, time and opportunities for individual and team learning.
- Ensure individuals attend statutory, mandatory and professional training and learning events.
- Ensure appropriate use of Datix modules to ensure actions and learning are captured to support Health Board responsibilities in relation to Putting Things Right Regulations.
- Encourage a Listen, Learning and Improving restorative culture without blame to ensure individuals feel safe to raise concerns/incidents.
- Support individuals when things do not go as expected. Showcase your team's learning at the Shared Listening & Learning Forum and any relevant organisational forums that celebrate good practice and improvement such as the Nursing & Midwifery Forum, Innovation & Improvement Board, Improvement and Value Based Healthcare Celebration events.
- Engaging in the Clinical Service Group and Care Group Quality Assurance, Patient Safety & Patient Experience meetings.

- Providing performance information to the Clinical Service Group and Care Group Quality Assurance, Patient Safety & Patient Experience Meetings to enable the groups to monitor data linked to learning and improvement.
- Providing a representative on the Health Board's Clinical Policy and Workforce Policy Groups to support, contribute and drive changes to policies etc. to be implemented;
- Ensuring that lessons learnt are widely disseminated through changes to policies and procedures; updating of internal training programmes and through the implementation of action plans.
- Providing a representative to sit on the Health Board's Training Group to ensure that learning is embedded into all training programmes. Ensuring that lessons learnt are widely disseminated through changes to policies and procedures; updating of internal training programmes and through the implementation of action plans.
- Embedding learning into practice and using systems of Quality Improvement, evaluation, audit and survey to quantify the impact of learning on practice and outcomes.
- Sharing findings from external inspections, internal reviews and Quality Assurance and audit activity.

Peoples Experience Forum

The Health Board have a number of avenues it utilises to gain feedback/identify learning from our communities and third sector stakeholders. Our PALS (Patient Advisory Liaison Service) work proactively across the sites to resolve any issues but are also able to establish themes and trends they encounter, also linking in with the Clinical Bereavement Lead, Unpaid Carer's Co-ordinator, Chaplaincy and Volunteer teams to pull further resource within this. The People's Experience portfolio also supports the collection of feedback in conjunction with the Values Based Healthcare Team to identify themes and trends – focusing on patient experiences and outcomes.

The health board utilised a number of methods to collect this data to meet the needs of all our services users, such as "Have Your Say" cards, QR codes, SMS, paper format, Patient Reported Experience Measures (PREMS), Patient Reported Outcome Measures (PROMS).

The health board has setup a People's Experience Forum that enables the bringing together of qualitative and quantitative data across the Care Groups/departments to enable a strategic discussion, challenge and development of recommendations to drive continuous quality service improvement and shared learning/co-production of ideas, to continually provide high standards of care across our services. The Forum is chaired at Executive level by our Executive Director of Nursing, Midwifery and Patient Care.

Continuous Improvement and Patient Outcomes

Quality Improvement

Quality Improvement (QI) in healthcare is essential for enhancing patient outcomes, increasing safety, and ensuring efficient care delivery. Organizational learning about QI involves adopting systematic processes to identify, analyze, and address gaps in healthcare practices. By fostering a culture of continuous improvement, healthcare organizations can implement evidence-based strategies, engage staff in collaborative problem-solving, and leverage data to drive measurable improvements. This proactive approach not only elevates care standards but also aligns with regulatory requirements and patient expectations, ultimately leading to a more resilient and responsive healthcare system. All teams have access to support and training from iCTM and the expectation is that all should be using time series data for improvement and embedding the principles of QI in their day-to-day work.

Value-Based Healthcare

Value-Based Healthcare (VBHC) is crucial for a safe learning organisation in by focusing on patient outcomes relative to what matters most to patients, resource utilisation, equitable delivery and sustainability. VBHC emphasises patient-centered care, tailoring treatments to individual needs and preferences, which enhances safety by promoting effective and necessary interventions. It encourages continuous improvement through the systematic measurement of patient outcomes and experiences using PROMs and PREMs, fostering transparency and accountability. This data-driven approach enables healthcare professionals to learn from performance and make evidence-based adjustments, at patient, service, specialty, organisational and National levels. Additionally, VBHC supports interdisciplinary collaboration, vital for a learning organisation, allowing healthcare teams to share insights, best practices, and innovations, leading to better patient outcomes. This collaborative environment empowers team members to voice concerns, share knowledge, and learn from each other, thereby enhancing patient safety and care quality.

Restorative Culture

A Restorative, Just & Learning approach promotes openness and transparency and considers wider systemic issues when things do not go to plan. When taking a restorative approach we do not apportion blame but consider who has been hurt and how relationships and trust can be restored. The emphasis is on creating healthier working relationships, role modelling civility and ensure we have compassionate working environment, where staff feel supported. This will enable staff to be open and honest, raise concerns, admit mistakes and prioritise learning without fear of punishment or sanctions.

The approach encourages compassionate engagement to gain an understanding of what happened from multiple perspectives. It is important to understand the factors that affect performance and behaviour, and to understand why it made sense for our people to do what they did. Accountability is forward looking to enable learning from such events and emphasis is on taking action to transform behaviours, processes and systems to improve our employee and patient experiences.

Our Focus at CTMUHB

To ensure we have an approach that is person-centred and supports **compassionate** and **restorative** principles within the organisation, where relationships and trust is strengthened and our workforce role-models **civility and respect** through its behaviours and actions.

We will seek **to listen, learn and understand concerns and adverse events** to ensure we are fair and proportionate and enable improvement and proactive and preventative action. We will seek to understand **what was responsible for things not going to plan** rather than looking at **who was to blame**. Accountability will be forward looking promoting learning, development and personal growth.



Commissioned Organisations

Engaging with NHS commissioned services regarding learning from events involves a structured approach to ensure that the lessons learned from events are effectively communicated and implemented.

The health board engage with commissioned service providers in various ways, such as GP CPD Days, Practice Managers Forum, Primary Care Collaborative meetings.

Engaging in collaborative learning networks has proven to be beneficial for the NHS. Research suggests that participating in inter-organisational collaborations, sharing best practices, and learning from other healthcare organisations can lead to improved processes, increased efficiency, and enhanced patient outcomes. Collaborative learning platforms and initiatives facilitate the exchange of ideas and experiences among professionals.

Appendix C details the networks across NHS Wales and wider that the organisation is engaged with and details of how the learning from these networks influence practice, organisational plans including the Integrated Medium Term plan and education programmes.



5. Care Groups/Departments Approach to Learning

Role	Duties and responsibilities
Heads of Quality and Safety aligned to specific Care Groups / Health & Safety Team	**To ensure that learning from Incident investigations are shared across the Care Group/Department and wider organisation by:** ➢ Feedback to reporter via DATIX Incident module ➢ Feedback via team meetings ➢ Feedback and discussion at Care Group QSRE meetings ➢ Complete 7 minute briefing ➢ Care Group incidents added to Central Patient Safety Newsletter. ➢ Completion of Learning from Event reports for Welsh Risk Pool ➢ Promotion of Listening and Learning framework and Learning Repository. ➢ Listening and Learning Event ➢ Analysis of Care Group data in order to identify themes and trends for highlighting at QSRE meetings ➢ Collaborative approach by Heads of Quality in order to ensure learning is shared across Care Groups. ➢ Feedback from external reviewer eg HIW, WRP ➢ Development of training packages / Review and evaluation ➢ Contribution to development of SOP / Policy / Guidelines. ➢ Providing a "Psychologically Safe" environment , utilising a "Just Culture" approach in line with CTM Values and Behaviours ➢ Participation in Quality Improvement projects. ➢ Promote a culture of continuous learning ➢ Ensuring that the principles set out in the Duty of Candour legislation are met in relation to open , honest and transparent feedback to patients and families following an incident or complaint. ➢ Joint review process with Welsh Ambulance NHS Trust ➢ Maternity and Neonatal Improvement Safety Board ➢ PROMS and PREMS, thematic analysis ➢ Patient Experience forum ➢ Quality Assurance panels ➢ Patients Lived Experience – Child and Adolescent ➢ Audit Days – per Care Group and Specialty



Effective knowledge management is critical for organisational learning in the NHS. Research indicates that healthcare organisations can benefit from strategies that capture, codify, and disseminate knowledge across different departments and teams. This includes utilising technology platforms, establishing communities of practice, and promoting knowledge sharing through regular meetings and discussions.

The Once for Wales Concerns Management System Programme was developed from the recommendations made by Keith Evans in the Welsh Government report 'The Gift of Complaints' and is aimed at bringing consistency to the use of the electronic tools used by all NHS Wales.

The table below details the functionality that NHS Wales organisations currently have within Datix Cymru. All the functionalities have specific investigation panels built within these functions to capture the Investigation outcome, learning and actions. The key fields are mandated, and it is critical that these are completed with accurate information prior to the record being closed in order for organisations to analyse their outcome data. These Investigations panels were developed by the workstreams independently and we are working with them to align the investigation panels.

Functionality	
Incidents	Live
Feedback (include Complaints/PALS/Compliments)	Live
Redress	Live
Claims	Live
Inquest	Live
Mortality Review	Live
New Functionality	
Investigations	On hold

There is a specific Investigations Module within the Datix Cymru system that can be used to capture the investigation from any type of event. The Investigation Workstream is currently on hold whilst discussions are being held with the NHS Executive in respect of the model / tools to be used. The intention is to make this available in 2024/2025. Updates can be found at: Once for Wales Concerns Management System - NHS Wales Shared Services Partnership.

6. Knowledge Management

Patient clinical outcome and experience feedback

The Health Board uses an online system to gather and analyse outcome and experience feedback from patients, relatives and other users of health and care services.

The Patient Feedback system helps us to listen to people who use our services, the detailed Patient Reported Experience Measures (PREMS) and Patient Report Outcomes Measures (PROMs), feedback enables us to learn and continuously improve. The data and insights the system provides are used to shape service design across the whole of the NHS in Wales.

A Shared Learning Repository

Our learning repository is an online database that provides a central location to record, collect, manage, contribute, access and share our organisational learning. This will be available on SharePoint to access any available learning on any themes, to support the development of action plans, improvements, tools, evidence of learning, research, reports and responses. This can be accessed on the link Shared Learning Repository.



The Audit Management & Tracking System

The Audit Management & Tracking System (AMaT) is used by the organisation Clinical Audit & Effectiveness team to manage and monitor all clinical audit activity and to record national and local clinical guidance e.g. NICE clinical guidelines and standards across the organisation. The system also enables the collection of ward and community team operational audits and produce compliance dashboards and reports on a monthly and ad-hoc basis.

The AMaT system uses cloud based software ensuring that the system can be accessed inside and outside of the organisation; facilitates the management of audit / NICE governance meetings with attendance alerts; enables the recoding of external inspection action plans from HIW; ensures that the organisations national clinical audit plan and compliance position can support internal scrutiny via the health board Audit Committee, Welsh Government and is available for external auditors when required.

The system also enables clinicians to utilise the information contained within the system for quality improvement programmes of work and learning purposes including support of the learning from events process.

Staff Ideas Scheme

All staff in CTM have access to the ideation platform 'SimplyDO'. This offers all teams a route to submit ideas for improvement and can be used as part of the learning process to help teams implement change. Submitted ideas are considered by a multi-disciplinary panel that includes corporate and external stakeholders to ensure the right support is offered. SimplyDo also oberated as a collaborative space allowing others in the organisation to contribute to ideas and to pass on their own experience in dealing with the issues presented.

7. Learning Governance

Oversight and monitoring by the Quality,Safety & Experience Committee is critical to ensure changes have the expected impact on outcomes, e.g., improved patient safety and patient experience, staff wellbeing, etc. Situations and demands will continue to change and organisational learning is a cycle with feedback triggering new insights and new learning.

The health board standing orders provide that "The Board may and, where directed by the Welsh Government must, appoint Committees of the UHB either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees".

Quality, Safety & Experience Committee

The Cwm Taf Morgannwg University Health Board (CTMUHB) Standing Orders provide that "The Board may and, where directed by the Welsh Government must, appoint Committees of the Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees".

In accordance with Standing Orders (and the CTMUHB scheme of delegation), the Board shall nominate annually a committee to be known as the **Quality, Safety & Experience Committee (QSEC).** The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set in this document.

The Committee will provide:

- evidence based and timely ***advice*** to the Board to assist it in discharging its functions and meeting its responsibilities with regard to quality, safety and experience of health services;
- ***assurance*** to the Board on the setting of local organisational Quality and Safety standards and supporting an organisational safety culture.
- evidence based and timely ***advice*** to the Board to assist it in discharging its functions and meeting its responsibilities with regard to the quality, safety and experience of health care provided and secured by CTMUHB, and that at all levels, it has the right governance arrangements and strategies in place to ensure that the care planned or provided across the breadth of the organisation's functions, is based on sound evidence, clinically effective and meeting agreed standards.

- ***assurance*** to the Board in relation to CTMUHB's arrangements for safeguarding and improving the quality and safety of patient and citizen centred health improvement and care services in accordance with its stated objectives and the requirements and standards determined for the NHS in Wales;
- ***assurance*** to the Board in relation to improving the experience of patients, carers citizens and all those that come into contact with our services including those provided by other organisations or in a partnership arrangement.
- ***assurance*** that the Board is operating in accordance with the Health and Social Care (Quality and Engagement) (Wales) Act 2020.
- ***assurance*** that the Board has an effective strategy and delivery plan(s) for improving the quality and safety of care patients receive, commissioning quality and safety impact assessments where considered appropriate.

Weekly Executive Quality & Safety Meeting

The Health Board has an Executive Quality and Safety weekly meeting. The purpose of the meeting is to provide a weekly forum for the Clinical Executive Directors to jointly consider:

- Urgent quality and patient safety related issues that require oversight and direction
- To receive weekly quality and safety data i.e. patient experience, concerns, national reportable incidents, early warning notifications, , claims, redress, inquests and learning from events along with themes and trends.
- Issues of concern, e.g. inquests or delays in investigations of patient safety incidents or complaint responses
- Issues requiring escalation to the wider executive team
- External regulatory activity
- Requests to services for a position statement and/or assurance in relation to matters of concern
- To provide oversight to and assurance of performance where concerns are raised related to quality and patient experience
- Feedback on soft intelligence, walk arounds etc

Listening and Learning Forum

The Shared Listening and Learning Forum has been established to provide oversight and assurance of the Health Board's framework for listening and learning from concerns and experiences and links with the Restorative Just Culture approach.

This takes place quarterly and alternates between a virtual team meeting and an in person conference style event.

This an open in-person event and is held in a conference style and is a structured gathering where multi-disciplinary colleagues from the Health Board come together to exchange knowledge, skills, and experiences in a collaborative and interactive environment. The primary goal of these events is to foster a culture of openness, transparency to share learning and develop mutual understanding, improve competencies, and encourage the application of shared insights in real-world contexts.

Care Group Quality, Safety Risk & Experience Group

Each Care Group have a Quality, Safety, Risk & Experience Group (QSRE). These groups provide assurance to the Care Group and the Health Board's Quality,Safety & Experience Committee on the provision of safe and high quality patient care and experience to the population we serve.

The Quality, Safety, Risk & Experience Groups 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 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.

Redress & Claims

In respect of redress and claims cases the Welsh Risk Pool is a risk-pooling scheme, which reimburses member NHS Wales health bodies in relation to losses incurred as a result of certain categories of claim made against them or due to incidents which occur in relation to the conduct of health body activities.

The WRP service has been delegated responsibility to administer the risk pooling arrangement for NHS Wales and this includes the management of reimbursement to member organisations once claims have been settled. Under the Putting Things right process the Welsh Risk Pool team works with NHS organisations in Wales to ensure that steps are taken to learn from events and identify and implement improvements.

There are three main drivers which underpin the principles of the WRP reimbursement process which are laid out in the WRP Case Reimbursement Procedure (2023):

- **Scrutiny of learning, intervention & improvement which ensures an independent review of the actions taken in response to the findings of the case investigation, aimed at reducing the potential for a re-occurrence or limiting the impact of any repeat incidents and sharing learning throughout all member health bodies.**
- **Review of Case Management enabling consideration to be given to the steps taken to manage the case efficiently and within the appropriate legislative framework – sharing learning and good practice throughout NHS Wales.**
- **Financial analysis which entails collation and review of all financial elements of a case presented for reimbursement, to ensure that organisations demonstrate compliance with scheme rules and standing financial instructions.**

The national WRP Learning Advisory Panel reviews the Learning from Events Reports (clinical and non-clinical cases) and evidence of learning and improvements from all NHS healthcare providers ahead of reimbursement being approved. Panel members are from NHS organisations pan Wales from a range of specialities.

The suite of key performance indicators to enable assurance to be provided internally locally and corporately at Board / Board sub-committees and externally to WRP Committee are contained in Appendix F.



8. Education Programmes

The use of technology and e-learning platforms has gained prominence in supporting organisational learning within the NHS. Research highlights the benefits of utilising online learning modules, virtual simulations, and mobile applications for staff training and development. These technologies provide flexible learning opportunities, enhance knowledge retention, and support continuous learning in a digital age.

The Health Board covers learning from events in many educational programmes as follows:

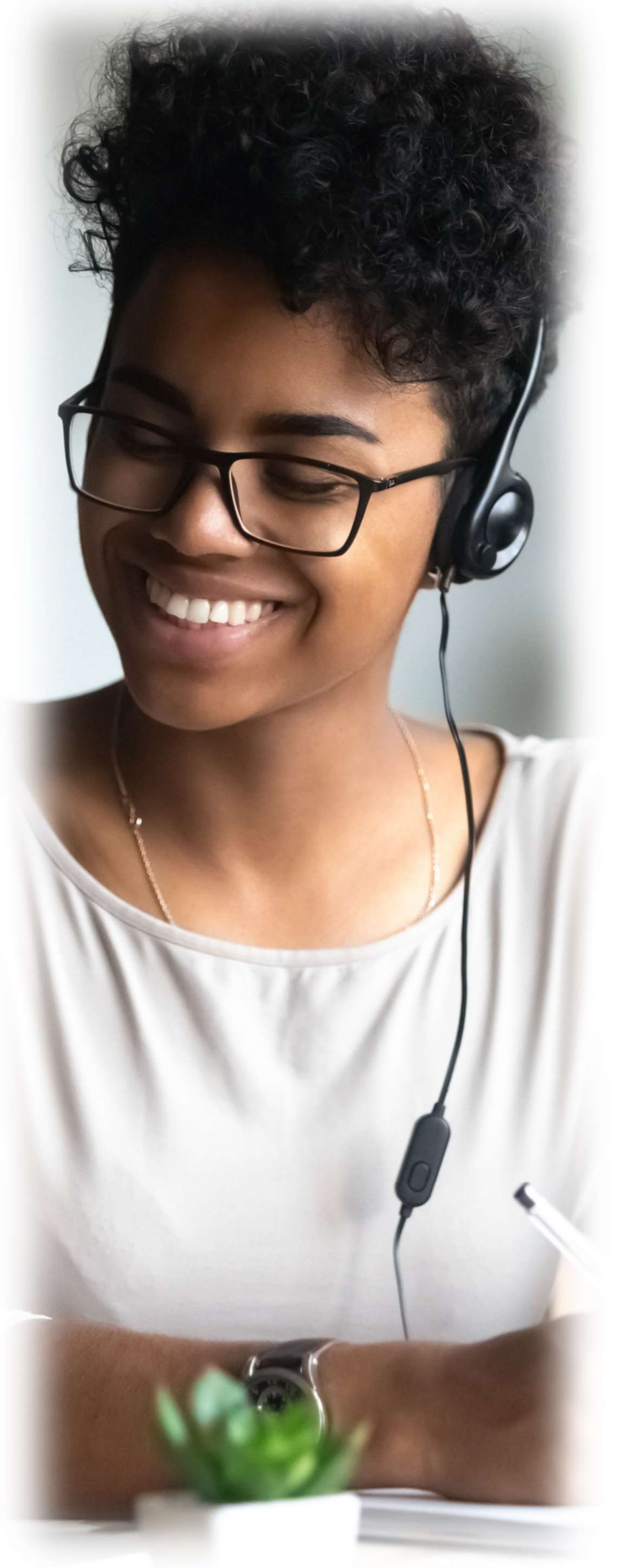
- The Listening and Learning Forum in person conference.
- Investigation training, featuring an articulate package on learning, in addition to a number of case studies for learning.
- Patient Safety Clinics
- Learning from Events training
- Continuous Improvement Training

WRP education materials for the completion of the WRP Learning from Events documents are available via the organisation's safety & learning advisor contact: WRPS.ClaimsReimbursement@wales.nhs.uk .

9. Horizon Scanning

Horizon scanning is a systematic examination of information sources and networking to detect early signs of important developments which may provide key learning opportunities.
This is a critical activity for identifying and analysing emerging trends, challenges, and opportunities that could impact the future of healthcare in NHS Wales. A proactive approach helps in strategic planning, policy development, and ensuring that the health board system remains responsive to future needs.

Identifying areas where we can learn from is crucial for continuous improvement and innovation within the health board (outlined in Appendix A). By systematically pinpointing these areas, the health board can harness valuable insights to enhance patient care, streamline operations, and address emerging challenges effectively. Learning from both successes and setbacks allows for evidence-based decision-making, fostering a culture of accountability and resilience. It also ensures that best practices are disseminated widely, reducing variability in care and improving overall health outcomes.



Appendices



10. Appendices

A. Sources of Learning & Approaches to Sharing & Improvement.
B. Key Reports Containing Learning (corporate & local).
C. Engagement in National Networks.
D. NHS England Just Culture (adopted by NHS Wales).
E. Corporate / Local Learning Structure Chart(s).
F. Welsh Risk Pool Learning from Events Reports Key Performance Indicators for Health Board / Trust local and corporate reporting and oversight.
G. Key References & Related Documents.
H. Speaking up Safely
I. Chartered Institute of Ergonomics and Human Factors Guide.



Appendix A: Sources of Learning & Approaches to Sharing & Improvement

It is important to understand where from and when we can learn.



PSOW – Public Services Ombudsman for Wales
LRI's – Locally Reportable Incidents
Nationally Reportable Incidents
Never Events

The Health Board will use a variety of methods to share learning and disseminate this widely.



	Area of potential learning / new learning	Who is responsible for identifying what the learning should be and sharing this?	How will learning be shared?	Where will oversight and monitoring occur, including learning outcomes?
1	Aggregated analysis of patient safety data to determine patterns, themes, and trends	Corporate Quality & Safety Teams Local leads Heads of Quality & Safety Business Intelligence Team Triumvirate Teams Clinical Leads	Face to face safety briefings Education programmes (rolling induction) Digital platforms Dashboards/Reports Bi-annual CTM wide Listening and Learning events Patient safety clinics Shared Learning repository	Corporate & Directorate/Divisional Board meetings and patient safety reports and dashboards.
2	*Analysis of individual incidents*	Heads of Quality & Safety and their teams (moderate and above) Local leads Business Intelligence Team Triumvirate Teams Clinical Leads Heads of Nursing Medication Management Group	Weekly Executive Patient Safety Meeting Q&S Business Meeting Quality & Safety Newsletter 7 Minute Briefings Care Group QSRE Meetings Clinical Audit Meetings Health & Safety Meetings Shared Learning repository Patient safety clinics	Dashboard/tracker Incident management process (RAPID review etc.) Weekly Executive Patient Safety Meeting Q&S Business Meeting Action planning/improvements Quality Improvement Team

	Area of potential learning / new learning	Who is responsible for identifying what the learning should be and sharing this?	How will learning be shared?	Where will oversight and monitoring occur, including learning outcomes?
			Service-led serious incident learning events	
3	*Analysis of individual complaints*	Head of Concerns Business Intelligence Team Triumvirate Teams Local leads Clinical Leads Heads of Nursing	Quality & Safety Newsletter Care Group QSRE Meetings Weekly Executive Patient Safety Meeting Q&S Business Meeting 7 Minute Briefings Care Group QSRE Meetings Clinical Audit Meetings Health & Safety Meetings Shared Learning repository	Weekly Executive Quality & Safety meeting Care Group QSRE meetings Quality, Safety & Experience Committee (via Quality & Safety Dashboard)
4	*Analysis of individual claims / redress*	Head of Legal Services Triumvirate Teams Local leads Clinical Leads	Learning from Events Reports Doctrina National Newsletter Quality & Safety Newsletter Care Group QSRE Meetings	Weekly Executive Quality & Safety meeting Care Group QSRE meetings Quality, Safety & Experience Committee (via Quality & Safety Dashboard)

	Area of potential learning / new learning	Who is responsible for identifying what the learning should be and sharing this?	How will learning be shared?	Where will oversight and monitoring occur, including learning outcomes?
			Weekly Executive Patient Safety Meeting Q&S Business Meeting 7 Minute Briefings Care Group QSRE Meetings Clinical Audit Meetings Health & Safety Meetings Shared Learning repository	
5	*Clinical audit*	Head of Clinical Audit & Informatics Triumvirate Teams Local leads Clinical Leads	Clinical Audit Days Quality & Safety Newsletter	Quality, Safety & Experience Committee (via Quality & Safety Dashboard)
6	*Healthcare Inspectorate Wales inspections (internal & external)*	Assurance & Compliance Team	Quality & Safety Newsletter Care Group QSRE Meetings Weekly Executive Patient Safety Meeting Q&S Business Meeting 7 Minute Briefings Care Group QSRE Meetings Clinical Audit Meetings Health & Safety Meetings	Audit Management and Tracking (AMAT)

	Area of potential learning / new learning	Who is responsible for identifying what the learning should be and sharing this?	How will learning be shared?	Where will oversight and monitoring occur, including learning outcomes?
			Shared Learning repository	
7	*Health & Safety Executive*	Assistant Director of Health, Safety & Fire and their teams Local leads Triumvirate Teams Clinical Leads Heads of Nursing	Q&S Business Meeting 7 Minute Briefings Care Group QSRE Meetings Clinical Audit Meetings Health & Safety Meetings Shared Learning repository	Quality, Safety & Experience Committee Health, Safety & Fire Sub-Committee Care Group Health, Safety & Fire Groups Care Group QSRE Meetings
8	*Independent reviews and public inquiries (internal & external)*	Heads of Quality & Safety and their teams Local leads Triumvirate Teams Clinical Leads Heads of Nursing Safeguarding Board	Weekly Executive Patient Safety Meeting Q&S Business Meeting Quality & Safety Newsletter 7 Minute Briefings Care Group QSRE Meetings Clinical Audit Meetings Health & Safety Meetings Social Media	Weekly Executive Patient Safety Meeting Quality, Safety & Experience Committee

	Area of potential learning / new learning	Who is responsible for identifying what the learning should be and sharing this?	How will learning be shared?	Where will oversight and monitoring occur, including learning outcomes?
9	*Patient, service user, family, and public engagement activities.*	Head of Patient Experience Local leads Triumvirate Teams Clinical Leads Head of Engagement Heads of Nursing	Sharepoint Social Media Board Level Quality, Safety & Experience Committee Peoples Experience Forum Executive Board	Quality, Safety & Experience Committee Peoples Experience Forum Executive Board
10	*Patient, service user, family, and public feedback e.g., patient stories*	Head of Patient Experience Local leads Triumvirate Teams Clinical Leads Heads of Nursing	Sharepoint Social Media Patient Stories at various Q&S Committees Have your say cards QR Coded surveys PROMS & PREMS Care Group QSRE Meetings	Weekly Executive Patient Safety Meeting Quality, Safety & Experience Committee Board Level Quality, Safety & Experience Committee Peoples Experience Forum Executive Board
11	*National networks (See Appendix C)*	Health Board network lead	Weekly Executive Patient Safety Meeting Q&S Business Meeting Quality, Safety, Risk & Experience Quality & Safety Newsletter	Weekly Executive Quality & Safety meeting Care Group QSRE meetings Quality, Safety & Experience Committee (via Quality & Safety Dashboard)

	Area of potential learning / new learning	Who is responsible for identifying what the learning should be and sharing this?	How will learning be shared?	Where will oversight and monitoring occur, including learning outcomes?
			7 Minute Briefings Care Group QSRE Meetings Clinical Audit Meetings Health & Safety Meetings Social Media	
12	*Working collaboratively and learning with colleagues across the health system and wider (e.g. Joint Investigation Framework)*	Heads of Quality & Safety and their teams Local leads Triumvirate Teams Clinical Leads Heads of Nursing	Weekly Executive Patient Safety Meeting Q&S Business Meeting Quality & Safety Newsletter 7 Minute Briefings Care Group QSRE Meetings Social Media WAST JiF weekly MDT panel Welsh Risk Pool LAP	Weekly Executive Quality & Safety meeting Care Group QSRE meetings Quality, Safety & Experience Committee (via Quality & Safety Dashboard)
13	*Learning from Deaths (mortality reviews)*	Mortality Manager Mortality Lead Triumvirate Teams Clinical Leads Heads of Nursing	Mortality Newsletter Feedback to teams	Weekly Mortality Review Screening Panel

	Area of potential learning / new learning	Who is responsible for identifying what the learning should be and sharing this?	How will learning be shared?	Where will oversight and monitoring occur, including learning outcomes?
14	*Feedback from the Medical Examiner Service*	Mortality Manager Mortality Lead Triumvirate Teams Clinical Leads Heads of Nursing	Mortality Newsletter Feedback to teams	Weekly Mortality Review Screening Panel
15	*National alerts, thematic reviews e.g. NHS Wales Executive reports.*	Assistant Director of Quality & Safety	Care Group Governance Meetings	Quality, Safety & Experience Committee
16	*Board level engagement activities walkarounds, 15 Steps etc.*	Assistant Director of Quality & Safety	Care Group Governance Meetings	Quality, Safety & Experience Committee
17	*Staff engagement activities, surveys, exit interviews, safety culture assessments, appraisals etc.*	Workforce and Organisational Development Line Managers Personal Development Review	Sharepoint Staff engagement Q&A Sessions Global communication emails Bi-annual Listening and Learning event	Workforce & OD Committee

	Area of potential learning / new learning	Who is responsible for identifying what the learning should be and sharing this?	How will learning be shared?	Where will oversight and monitoring occur, including learning outcomes?
18	*Engagement / feedback from Trade Union Partners.*	Assistant Director of Quality & Safety	Weekly Executive Patient Safety Meeting	Executive Board
19	*Service reconfiguration, projects, and programmes.*	Executive Director of Strategy & Transformation	Sharepoint Staff engagement Q&A Sessions Global communication emails Bi-annual Listening and Learning event	Executive Board
20	*Educational organisations & surveys e.g., Health Education and Improvement Wales, Universities etc.*	Deputy Executive Director of Nursing	Nursing student feedback forms	
21	*Professional bodies e.g., Health& Care Professional Council, General Medical Council, Nursing and Midwifery Council, Royal Colleges etc.*	Executive Directors		
22	*Quality improvement projects / programmes.*	Assistant Director of Quality Improvement	Weekly Executive Patient Safety Meeting Q&S Business Meeting	

	Area of potential learning / new learning	Who is responsible for identifying what the learning should be and sharing this?	How will learning be shared?	Where will oversight and monitoring occur, including learning outcomes?
23	*Planning processes including the development and implementation of the Integrated Medium Term Plan.*	Assistant Director of Transformation – Strategic & Operational Planning		
24	*Internal and external audit reports e.g., internal audit and Audit Wales.*	Head of Patient Experience Local leads Triumvirate Teams Clinical Leads Heads of Nursing	Weekly Executive Patient Safety Meeting Q&S Business Meeting Quality & Safety Newsletter 7 Minute Briefings Care Group QSRE Meetings Social Media	Weekly Executive Quality & Safety meeting Care Group QSRE meetings Quality, Safety & Experience Committee
25	*WRP National Learning Advisory Panel including publications e.g. Doctrina.*	Head of Legal Services	Doctrina Newsletter Weekly Executive Patient Safety Meeting Q&S Business Meeting Quality & Safety Newsletter 7 Minute Briefings Care Group QSRE Meetings Clinical Audit Meetings	Weekly Executive Quality & Safety meeting Care Group QSRE meetings Quality, Safety & Experience Committee

	Area of potential learning / new learning	Who is responsible for identifying what the learning should be and sharing this?	How will learning be shared?	Where will oversight and monitoring occur, including learning outcomes?
			Health & Safety Meetings	
26	*WRP Learning from Events Hub (in development).*			
27	*Safety II – learning from what went well.*	Assistant Director of Quality & Safety Heads of Quality & Safety	Weekly Executive Patient Safety Meeting Q&S Business Meeting Quality & Safety Newsletter 7 Minute Briefings Care Group Quality & Safety Governance Meetings	Weekly Executive Quality & Safety meeting Care Group QSRE meetings Quality, Safety & Experience Committee
28	*National clinical audits including Stroke (SSNAP), falls & fragility fracture audit programme, National Vascular Registry, Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE).*	Head of Clinical Audit & Quality Informatics	Weekly Executive Patient Safety Meeting Q&S Business Meeting Quality & Safety Newsletter 7 Minute Briefings Care Group QSRE Meetings	Weekly Executive Quality & Safety meeting Care Group QSRE meetings Quality, Safety & Experience Committee Clinical Audit Committee

Appendix B: Key Reports Containing Learning (corporate & local).

	Report	Key Content	Overseeing Local Group / Committee / Board	Overseeing Corporate Group / Committee / Board
1	*Learning from Deaths Report* ***Example***	*Outcomes & learning from mortality reviews with patterns, themes, trends, collective intelligence, and RAMI.*	*Medical Directorate Clinical Board*	*Quality Committee* *Health Board / Trust Board*
2	Quality and Safety Dashboard	Activity from: Complaints PSOW Incidents Nationally Reportable Incidents Duty of Candour Peoples Experience	Quality, Safety & Experience Committee	Quality, Safety & Experience Committee
3	Patient Experience highlight report	Activity from: Patient Advisory Liaison Service Veterans/Armed Forces Volunteers Chaplaincy	Peoples Experience Forum	Quality, Safety & Experience Committee
4	Investigation Reports and action plans (NRIs, RCAs) NRI outcomes reports to NHS Executive.	Care & Service Delivery issues Contributory factors Notable practice Professional practice concerns Learning & improvement actions	Triumvirate teams	Executives

	Report	Key Content	Overseeing Local Group / Committee / Board	Overseeing Corporate Group / Committee / Board
5	Learning from Events Reports	Investigation findings Harm caused from event Issues and actions taken Learning assurance plans Sharing the learning	Weekly Executive Quality & Safety Meeting Care Group QSRE Meetings	Quality, Safety & Experience Committee
6	Clinical Audit Reports/Presentations			Quality, Safety & Experience Committee
7	SBAR and low/no harm local DATIX investigations.	Complaints Incidents Learning from PSOW and NRIs	Care Group QSRE Meetings	Quality, Safety & Experience Committee
8	WAST joint review investigation reports (SBARs)	Investigation findings Contributory Factors Recommendations Learning	Care Group QSRE Meetings	Quality, Safety & Experience Committee

Appendix C Learning Networks – Organisational Engagement

	Network	Key Attendees	Method of feedback / sharing learning	Overseeing Local Group / Committee / Board	Overseeing Corporate Group / Committee / Board
1	WRP Heads of Patient Experience (HOPE)	Assistant Director of Quality & Safety Assistant Director of Concerns & Claims	Quality & Safety Business Meeting Care Group Business Meeting	Weekly Executive Quality & Safety Meeting	Quality, Safety & Experience Meeting
2	Maternal / Neonatal Network				
3	NHS Wales Executive Mortality Reviews Working Group	Mortality Review Manager	Mortality Newsletter	Quality & Safety Business Meeting	Weekly Executive Quality & Safety Meeting
4	WRP Datix Cymru Coding / Capture Network	Assistant Director of Concerns & Claims	Quality & Safety Business Meeting	Quality & Safety Business Meeting	Weekly Executive Quality & Safety Meeting
5	WRP Duty of Candour Network	Assistant Director of Concerns & Claims	Quality & Safety Business Meeting	Quality & Safety Business Meeting	Weekly Executive Quality & Safety Meeting Meeting

	Network	Key Attendees	Method of feedback / sharing learning	Overseeing Local Group / Committee / Board	Overseeing Corporate Group / Committee / Board
6	WRP Redress / Claims Network	Legal Services Manager Head of Claims & Inquests Claims Investigation Officers	Legal Services Weekly Team Meeting	Quality & Safety Business Meeting	Weekly Executive Quality & Safety Meeting
7	Learning Advisory Panel (WRP) Clinical Negligence	Various key stakeholders from Care Groups along with representatives from Quality & Safety and Claims	Outcome feedback from WRP Shared with Care Groups	Quality & Safety Business Meeting	Weekly Executive Quality & Safety Meeting
8	Learning Advisory Panel (WRP) Personal Injury Claims	Various key stakeholders from Care Groups along with representatives from Quality & Safety and Claims	Outcome feedback from WRP Shared with Care Groups	Quality & Safety Business Meeting	Weekly Executive Quality & Safety Meeting
9	WG PTR Regulations Consultation	Head of Concerns & Business Intelligence	Quality & Safety Business Meeting	Weekly Executive Quality & Safety Meeting	Weekly Executive Quality & Safety Meeting
10	WRP Feedback Network	Head of Concerns & Business Intelligence	Quality & Safety Business Meeting	Weekly Executive Quality & Safety Meeting	Board Quality, Safety & Experience Committee

	Network	Key Attendees	Method of feedback / sharing learning	Overseeing Local Group / Committee / Board	Overseeing Corporate Group / Committee / Board
11	Safe Care Collaborative	Heads of Quality & Safety	Quality & Safety Business Meeting		Quality, Safety & Experience Committee
12	All Wales Health & Safety Managers Forum	Assistant Director of Health, Safety & Fire	Health, Safety & Fire Sub-Committee Care Group Health, Safety & Fire Groups Care Group QSRE Meetings	Care Group Health & Safety Groups	Health, Safety & Fire Sub-Committee Quality, Safety & Experience Committee
13	Manual Handling Group	Manual Handling Adviser	Health & Safety Co-ordinating Group	Care Group Health & Safety Groups	Health, Safety & Fire Sub-Committee Quality, Safety & Experience Committee
14	All Wales Violence & Aggression/Case Management Group	Personal Safety Adviser	Health & Safety Co-ordinating Group	Care Group Health & Safety Groups	Health, Safety & Fire Sub-Committee Quality, Safety & Experience Committee

Appendix D: A Just Culture Guide

NHS

A just culture guide

Supporting consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents

This guide supports a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely. Action singling out an individual is rarely appropriate - most patient safety issues have deeper causes and require wider action.

The actions of staff involved in an incident should **not** automatically be examined using this just culture guide, but it can be useful if the investigation of an incident begins to suggest a concern about an individual action. The guide highlights important principles that need to be considered before formal management action is directed at an individual staff member.

An important part of a just culture is being able to explain the approach that will be taken if an incident occurs. A just culture guide can be used by all parties to explain how they will respond to incidents, as a reference point for organisational HR and incident reporting policies, and as a communication tool to help staff, patients and families understand how the appropriate response to a member of staff involved in an incident can and should differ according to the circumstances in which an error was made. As well as protecting staff from unfair targeting, using the guide helps protect patients by removing the tendency to treat wider patient safety issues as individual issues.

Please note:

- **A just culture guide** is not a replacement for an investigation of a patient safety incident. Only a full investigation can identify the underlying causes that need to be acted on to reduce the risk of future incidents.
- **A just culture guide** can be used at any point of an investigation, but the guide may need to be revisited as more information becomes available.
- **A just culture guide** does not replace HR advice and should be used in conjunction with organisational policy.
- **The guide** can only be used to take one action (or failure to act) through the guide at a time. If multiple actions are involved in an incident they must be considered separately.

Start here - Q1. deliberate harm test

1a. **Was there any intention to cause harm?**

→ Yes — **Recommendation:** Follow organisational guidance for appropriate management action. This could involve: contact relevant regulatory bodies, suspension of staff, and referral to police and disciplinary processes. Wider investigation is still needed to understand how and why patients were not protected from the actions of the individual. → END HERE

No go to next question - **Q2. health test**

2a. **Are there indications of substance abuse?**

→ Yes — **Recommendation:** Follow organisational substance abuse at work guidance. Wider investigation is still needed to understand if substance abuse could have been recognised and addressed earlier. → END HERE

2b. **Are there indications of physical ill health?**

2c. **Are there indications of mental ill health?**

→ Yes — **Recommendation:** Follow organisational guidance for health issues affecting work, which is likely to include occupational health referral. Wider investigation is still needed to understand if health issues could have been recognised and addressed earlier. → END HERE

if **No to all** go to next question - **Q3. foresight test**

3a. **Are there agreed protocols/accepted practice in place that apply to the action/omission in question?**

3b. **Were the protocols/accepted practice workable and in routine use?**

3c. **Did the individual knowingly depart from these protocols?**

→ If No to any — **Recommendation:** Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual. → END HERE

if **Yes to all** go to next question - **Q4. substitution test**

4a. **Are there indications that other individuals from the same peer group, with comparable experience and qualifications, would behave in the same way in similar circumstances?**

4b. **Was the individual missed out when relevant training was provided to their peer group?**

4c. **Did more senior members of the team fail to provide supervision that normally should be provided?**

→ If Yes to any — **Recommendation:** Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual. → END HERE

if **No to all** go to next question - **Q5. mitigating circumstances**

5a. **Were there any significant mitigating circumstances?**

→ Yes — **Recommendation:** Action directed at the individual may not be appropriate; follow organisational guidance, which is likely to include senior HR advice on what degree of mitigation applies. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. → END HERE

if **No**

Recommendation: Follow organisational guidance for appropriate management action. This could involve individual training, performance management, competency assessments, changes to role or increased supervision, and may require relevant regulatory bodies to be contacted, staff suspension and disciplinary processes. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. → END HERE

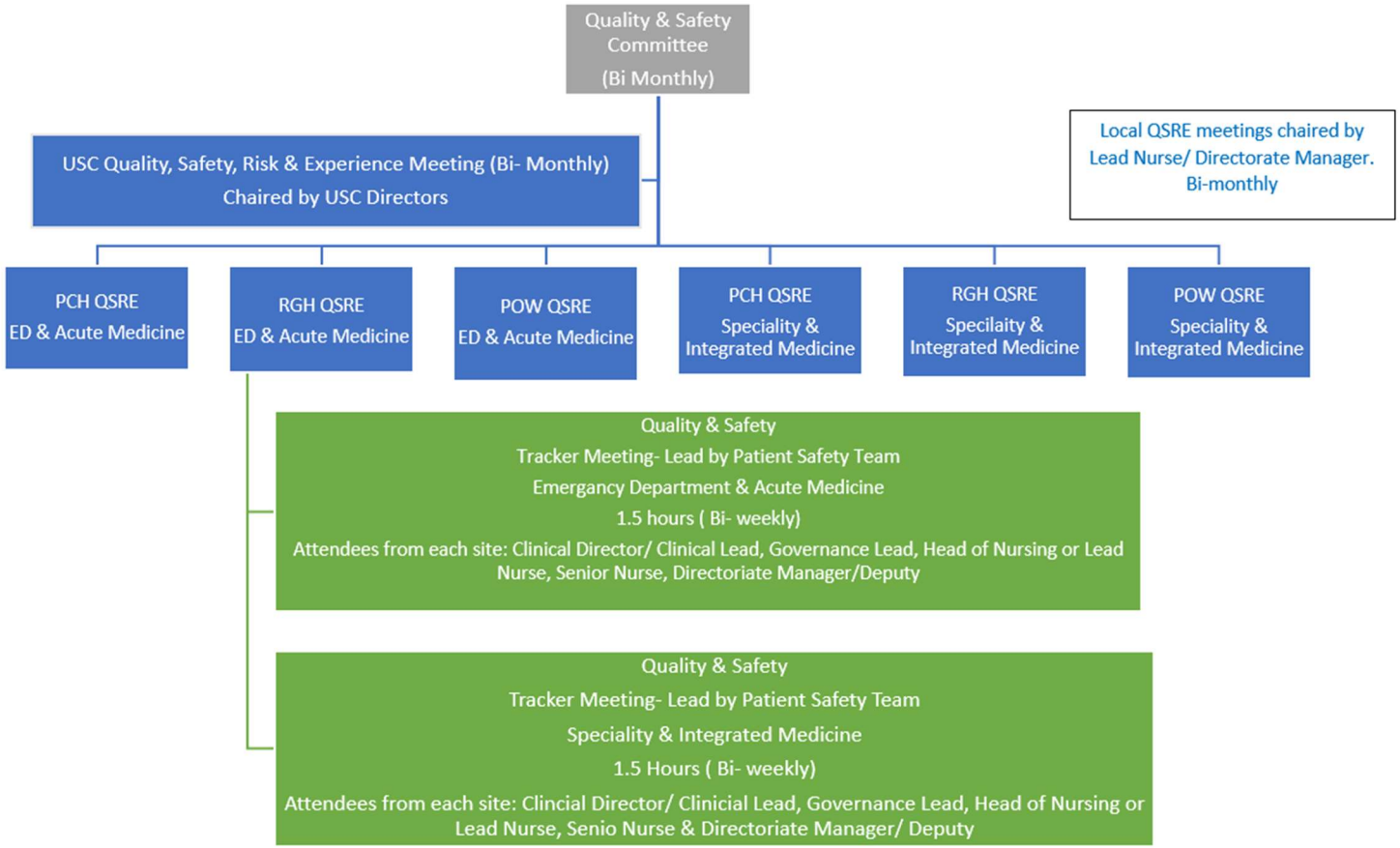
improvement.nhs.uk

Based on the work of Professor James Reason and the National Patient Safety Agency's Incident Decision Tree

Supported by:

NHS England and NHS Improvement

Appendix E: Corporate / local learning structure chart(s)

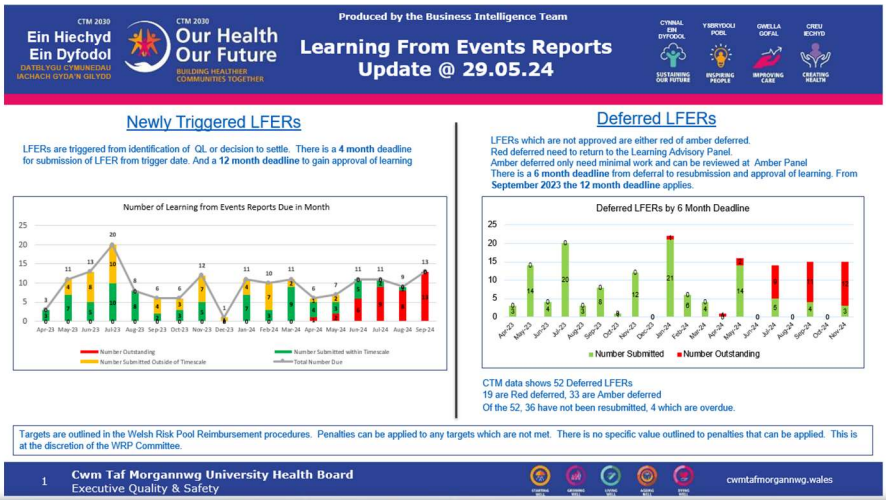


Appendix F

Cwm Taf Morgannwg University Health Board Welsh Risk Pool Learning from Events Key Performance Indicators (KPIS) for local and corporate reporting, oversight and assurance and assurances externally to WRP Committee.

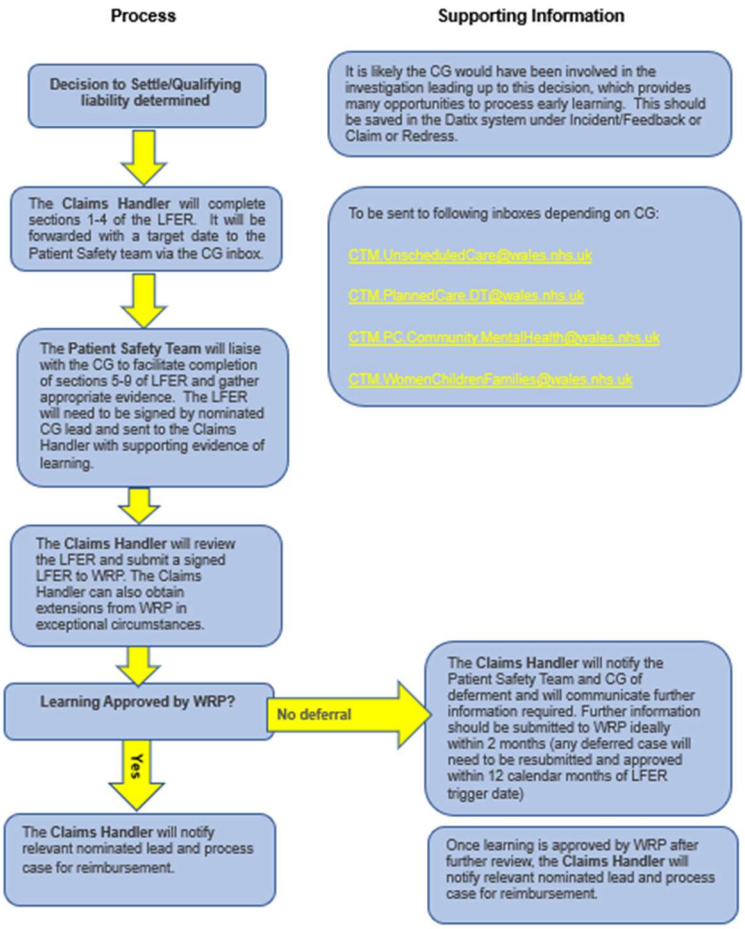
- **KPIs to cover from when the time the WRP Learning from Events Reports (LFERs) (Redress / Claims) was triggered to the final approval stage (within 12 months)**
- **Include the number of LFERs awaiting completion following triggering.**
- **Timescales for the completion and approval of the Learning from Events Reports and quality check of the evidence at local and corporate level.**
- **Timescales for the response times at local and corporate level to the feedback from the Learning Advisory Panel and WRP Committee (Red / Amber cases) and**
- **Escalation routes for the legal services team and quality & safety teams to obtain support with learning / evidence.**
- **Details of the accountable local and corporate group / committee with accountability for the KPIs (note financial implications) – transparency of position ('Always On' reporting quality management systems).**
- **Monthly reporting of the position above – to include WRPC outcomes (bi-monthly).**

The Health Board monitor the Learning from Events KPIs in the weekly Executive Quality and Safety Meeting. This is displayed in a dashboard as follows:





LFER Flow Chart



Welsh Risk Pool Learning from Events are monitored via the Business Quality & Safety Meeting and the Weekly Executive Quality & Safety Meeting.

Appendix G: References & related documents

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5. NHS Wales National Policy on Patient Safety Incident Reporting & Management (2023). du.nhs.wales/files/incidents/national-policy-on-patient-safety-incident-reporting-2-0-pdf/.
6. The Health Foundation (2022) Developing learning health systems in the UK: Priorities for action. Developing learning health systems in the UK: Priorities for action - The Health Foundation .
7. Institute for Healthcare Improvement (2017) A Framework for Safe, Reliable, and Effective Care. Developing learning health systems in the UK: Priorities for action - The Health Foundation .
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9. Department of Health (2000) An organisation with a memory. [ARCHIVED CONTENT] An organisation with a memory: Department of Health - Publications (nationalarchives.gov.uk) .
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12. NHS England Patient Safety Incident Response Framework (2022) B1465-1.-PSIRF-v1-FINAL.pdf (england.nhs.uk).

Appendix G: References & related documents

13. Berwick (2013) A promise to learn – a commitment to act. A promise to learn – a commitment to act – Improving the Safety of Patients in England (publishing.service.gov.uk).
14. NHS Wales Learning and Improving Quality and Safety (2021). Quality and Safety Framework: Learning and Improving (gov.wales).
15. Achieving Quality and Safety Improvement Cymru Strategy (2021-2026). https://phw.nhs.wales/services-and-teams/improvement-cymru/improvement-cymru-strategy/.
16. From Safety-I to Safety-II: A White Paper (2015). From Safety-I to Safety-II: A White Paper. | PSNet (ahrq.gov).
17. WHO Learning Strategy (2021). WHO Learning Strategy.
18. The Chartered Institute of Ergonomics and Human Factors (2020) Achieving sustainable change: Capturing lessons from COVID-19. Achieving Sustainable Change | CIEHF (ergonomics.org.uk) .
19. NHS Wales Executive All Wales Learning from Mortality Review Model Framework (2023). Patient Safety Incidents - Delivery Unit (nhs.wales).
20. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (2013). Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: executive summary HC 947, Session 2012-2013 (publishing.service.gov.uk)



Appendix H: Speaking up Safely

In September 2023, the Welsh Government introduced an all-Wales Framework for Speaking up Safely. This means that all NHS organisations in Wales now have consistent and robust pathways for members of staff who want to speak out about their concerns.

Speaking up about things that get in the way of providing safe and effective care for our patients is both our duty and right as NHS Wales employees. At CTM we want this process to be as accessible to all colleagues as possible. As an organisation we are committed to listening, learning and improving so it is important that we have the processes in place to allow this to happen. You can access the speak up safely page here Speaking Up Safely - Home

Appendix I: Chartered Institute of Ergonomics and Human Factors Guide

The Chartered Institute of Ergonomics and Human Factors Guide (July 2020) explains the two key areas in achieving effective organisational learning - mindset and action. The guide breaks down the There are two templates, one for **mindset**, the other for **action**. While all organisations have the capacity to adapt, learn quickly and demonstrate agility in dealing with complexity and chaos, they can be equally good at forgetting good practice.

As leaders change, systems evolve and technology and regulations advance, new operating procedures are adopted and corporate memory of good practice can be lost. As a consequence, organisations spend time and money reinventing the wheel. The leadership and management of the impact of COVID-19 on the health system required people to work at pace in response to a rapidly changing environment. This affected all levels through to the clinical frontline. The Guide makes links to the Chartered Institute of Ergonomics and Human Factors' recent White Paper on "Learning from Adverse Events" and explains the synergy between learning from good practice and from adverse incidents. The framework is detailed below and the link to site is: Homepage | CIEHF (ergonomics.org.uk).

